

[H.A.S.C. No. 114-4]

WOUNDED WARRIOR PROGRAM UPDATE

HEARING

BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

OF THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

HEARING HELD
FEBRUARY 3, 2015



U.S. GOVERNMENT PUBLISHING OFFICE

94-091

WASHINGTON : 2015

SUBCOMMITTEE ON MILITARY PERSONNEL

JOSEPH J. HECK, Nevada, *Chairman*

WALTER B. JONES, North Carolina

JOHN KLINE, Minnesota

MIKE COFFMAN, Colorado

THOMAS MACARTHUR, New Jersey, *Vice*

Chair

ELISE M. STEFANIK, New York

PAUL COOK, California

STEPHEN KNIGHT, California

SUSAN A. DAVIS, California

ROBERT A. BRADY, Pennsylvania

NIKI TSONGAS, Massachusetts

JACKIE SPEIER, California

TIMOTHY J. WALZ, Minnesota

BETO O'ROURKE, Texas

JEANETTE JAMES, *Professional Staff Member*

CRAIG GREENE, *Professional Staff Member*

COLIN BOSSE, *Clerk*

CONTENTS

	Page
STATEMENTS PRESENTED BY MEMBERS OF CONGRESS	
Davis, Hon. Susan A., a Representative from California, Ranking Member, Subcommittee on Military Personnel	2
Heck, Hon. Joseph J., a Representative from Nevada, Chairman, Sub- committee on Military Personnel	1
WITNESSES	
Breining, CAPT Brent M., USN, Director, Navy Wounded Warrior-Safe Har- bor, United States Navy	4
Doherty, Brig Gen Patrick J., USAF, Director, Air Force Services, United States Air Force	6
Rodriguez, James D., Deputy Assistant Secretary of Defense, Warrior Care, Department of Defense	3
Toner, COL Chris R., USA, Commander, Warrior Transition Command, United States Army	3
Williamson, Paul D., Command Advisor, Wounded Warrior Regiment, United States Marine Corps	6
APPENDIX	
PREPARED STATEMENTS:	
Breining, CAPT Brent M.	56
Doherty, Brig Gen Patrick J.	69
Heck, Hon. Joseph J.	31
Rodriguez, James D.	32
Toner, COL Chris R.	39
Williamson, Paul D.	79
DOCUMENTS SUBMITTED FOR THE RECORD:	
[There were no Documents submitted.]	
WITNESS RESPONSES TO QUESTIONS ASKED DURING THE HEARING:	
Mr. Coffman	90
Mrs. Davis	89
Mr. Jones	91
QUESTIONS SUBMITTED BY MEMBERS POST HEARING:	
Mr. Jones	95

WOUNDED WARRIOR PROGRAM UPDATE

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
SUBCOMMITTEE ON MILITARY PERSONNEL,
Washington, DC, Tuesday, February 3, 2015.

The subcommittee met, pursuant to call, at 3:30 p.m., in Room 2212, Rayburn House Office Building, Hon. Joseph J. Heck (chairman of the subcommittee) presiding.

OPENING STATEMENT OF HON. JOSEPH J. HECK, A REPRESENTATIVE FROM NEVADA, CHAIRMAN, SUBCOMMITTEE ON MILITARY PERSONNEL

Dr. HECK. Go ahead and call the Military Personnel Subcommittee meeting to order.

I would like to welcome everyone to the first hearing of the Military Personnel Subcommittee for the 114th Congress. I especially want to welcome the new members of the subcommittee and look forward to working with each of you during the coming year.

I am very pleased that Congresswoman Susan Davis from California will continue to be the subcommittee ranking member. Over the past 4 years, I have valued her years of experience on this subcommittee as chairwoman and as ranking member. I look forward to working with you as well as we shape the work of the subcommittee over the next year.

The past several days have been very busy with the release of the Military Compensation and Retirement Modernization Commission's report and the President's budget for fiscal year 2016. I know that the information in both of these documents are at the forefront of everyone's mind, and I want to assure everyone that the Military Personnel Subcommittee will have several opportunities to thoroughly review and discuss them in the coming months.

But today we meet to continue the subcommittee's effort to improve the care of injured and wounded troops as they recover and transition either back to duty or to civilian life. The Department of Defense [DOD] and the military services have had many years to develop the policies and programs to assist wounded, ill, and injured warriors and their families through the recovery process. I recognize that this was and continues to be a tremendous effort by very dedicated and professional individuals, both military and civilian, that crosses all military communities.

However, it has not been without its fits and starts and has not been without problems. Our purpose today is to learn the current state of the Wounded Warrior programs. I am interested to know whether the programs still serve the needs of the wounded, ill, and injured service members and their families. Are they viewed by

DOD and the services as enduring programs, or are there plans to reevaluate the need for such programs in their current state as the mission in Afghanistan winds down and those deployments taper off.

I am interested in hearing the witnesses' views on these questions. Before I introduce our panel, let me offer Congresswoman Davis an opportunity to make opening remarks.

[The prepared statement of Dr. Heck can be found in the Appendix on page 31.]

STATEMENT OF HON. SUSAN A. DAVIS, A REPRESENTATIVE FROM CALIFORNIA, RANKING MEMBER, SUBCOMMITTEE ON MILITARY PERSONNEL

Mrs. DAVIS. Thank you, Mr. Chairman, and I certainly look forward to your very dedicated leadership. Glad you are here.

I also wanted to welcome Mr. Rodriguez, Brigadier General Doherty, Colonel Toner, Captain Breining, if I have it right, and Mr. Williamson.

After more than 13 years of combat, the military has significantly reduced the number of service members in direct combat, but we still have many military members in harm's way with a real risk to being wounded.

The military services and Congress have provided ample needed resources to help organize and care for our wounded military and their families as they either transition out of the military or become healthy enough to continue to serve. And as the population of the services of Wounded Warrior programs has been reduced, I am concerned that we will lose focus on providing care for those who truly need it, especially as fiscal pressures continue.

So I look forward to hearing from our witnesses today on whether the policies that were instituted in 2009 are still applicable today, and what do you all think we should do to ensure the Wounded Warrior programs assist the intended personnel.

Thank you very much and thank you for your leadership as well.

Dr. HECK. Thank you, Mrs. Davis.

We are joined today by an outstanding panel. We would like to give each witness the opportunity to present his or her testimony and each member an opportunity to question the witnesses. I would respectfully remind the witnesses that you should summarize to the greatest extent possible the high points of your written testimony in 5 minutes.

I assure you that your written comments and statements will be made part of the hearing record. So let me welcome our panel. We have Mr. James Rodriguez, Deputy Assistant Secretary of Defense for Warrior Care Policy; Brigadier General Patrick Doherty, Director of Air Force Services, United States Air Force; Colonel Chris Toner, Commander, Warrior Transition Command of the United States Army; Captain Brent Breining, Director, Navy Wounded Warrior-Safe Harbor, the United States Navy; and Paul Williamson, Command Advisor, Wounded Warrior Regiment of the United States Marine Corps.

Secretary Rodriguez, the time is yours.

**STATEMENT OF JAMES D. RODRIGUEZ, DEPUTY ASSISTANT
SECRETARY OF DEFENSE, WARRIOR CARE, DEPARTMENT OF
DEFENSE**

Mr. RODRIGUEZ. Chairman Heck, Ranking Member Davis, distinguished members of the subcommittee, thank you for the opportunity to appear before you today to discuss the Department of Defense's Wounded Warrior programs.

One of the Department's highest priorities is ensuring the Nation's wounded, ill, and injured service members, their families, and caregivers receive the support they need for recovery, rehabilitation, and reintegration.

Today, our major combat operations are declining, but our national security challenges and responsibilities endure. Therefore, we are resolute in assuring all the needs of our wounded warriors are met and they have the best available care and administrative management while being treated with dignity and respect from point of injury or illness to return to duty or transition from service. The Office of Warrior Care Policy provides concise policy oversight that allows the services to deliver consistent high quality care and support for recovering service members.

We are conducting site assistance visits to assist the Wounded Warrior programs with Department of Defense policy compliance for recovery care at the installation level, and we have established a quality assurance program to standardize all services' disability evaluation requirements. Additionally, we provide nonmedical programs that support service member engagement in adaptive sports and activities, professional skill building, internships, and employment preparation to assist in their recovery and transition process.

DOD has also developed information technology systems to streamline case management, established the caregiver support initiative to provide peer-to-peer forms for caregivers, and formed the interagency care coordination committee to update existing DOD-VA [Department of Veterans Affairs] processes to deliver benefits and services in a more accurate and timely manner.

Even as our Nation reduces combat operations, our wounded, ill, and injured service members will continue to exist, and we must ensure our commitment to these individuals is not compromised. The American public and our leaders require it, and our service members and their families deserve the best services and support we can provide.

Thank you for your support of the brave men and women who serve our Nation and your dedication to ensuring the services have the most efficient systems in place to care for wounded, ill, or injured and recovering service members. I look forward to your questions.

[The prepared statement of Mr. Rodriguez can be found in the Appendix on page 32.]

Dr. HECK. Thank you, Mr. Rodriguez.
Colonel Toner.

**STATEMENT OF COL CHRIS R. TONER, USA, COMMANDER,
WARRIOR TRANSITION COMMAND, UNITED STATES ARMY**

Colonel TONER. Chairman Heck, Ranking Member Davis, and distinguished members of this committee, thank you for the oppor-

tunity to appear before you today to discuss the Army's Warrior Care and Transition program and to inform you of Army initiatives to address our wounded, ill, and injured soldiers and their families.

Since their inception in June 2007, Warrior Transition Units [WTUs] have helped over 65,000 soldiers to heal and transition. Today, the Warrior Care and Transition program consists of 25 Warrior Transition Units supported by military and civilian cadre on installations throughout the United States and in Germany.

Within the WTUs, soldiers receive personalized support from a triad of care. This includes a nurse case manager, a squad leader, and a primary care manager. This triad of care coordinates clinical and nonclinical issues to successfully transition the soldier and their families either back to the force or onward towards successful civilian lives.

With the support of our committed and dedicated cadre, clinicians, and staff, our soldiers and families are assisted to take an in-depth and realistic look at where they are today and where they want to go along the road to recovery. This process is referred to as the comprehensive transition plan or CTP. The CTP is the overarching methodology to support a soldier's rehabilitation and ultimately reintegration back to the force or to the community as a productive veteran.

The CTP is developed by the soldier for the soldier and is a future-oriented action plan to establish goals and map a soldier's transition plan towards self-reliance and independence. The soldier owns their CTP, and it empowers them to take charge of their own transition with the support of their family, cadre, clinicians, and specialized staff members.

The Warrior Care and Transition program remains a highly effective program, and there are many success stories. Though the Warrior Care and Transition program has seen fewer wounded and more ill and injured soldiers, the WTU population remains complex, and the need for the Army to continue to resource and provide centralized oversight, guidance, and advocacy for this population will remain an enduring requirement.

We have come a long way since the days of the medical holding company and long wait times for our injured soldiers. We will not return to that setting. Warrior care remains an Army priority and our sacred obligation.

Again, thank you for the opportunity to appear before you today to discuss the Army's enduring commitment to the care of our wounded, ill, and injured soldiers and their families, and I look forward to your questions.

[The prepared statement of Colonel Toner can be found in the Appendix on page 39.]

Dr. HECK. Captain.

**STATEMENT OF CAPT BRENT M. BREINING, USN, DIRECTOR,
NAVY WOUNDED WARRIOR-SAFE HARBOR, UNITED STATES
NAVY**

Captain BREINING. Chairman Heck, Ranking Member Davis, distinguished members of the subcommittee. Thank you for the opportunity to testify before you today.

I am Captain Brent Breining, Director of Navy Wounded Warrior–Safe Harbor, the nonmedical recovery care program for the Navy and Coast Guard. Since its establishment in 2005, Navy Safe Harbor has strived to provide the very best in nonmedical care for our seriously wounded, ill, and injured sailors and Coast Guardsmen, their families, and caregivers.

Nine years later, Navy Safe Harbor enrollments have grown more than tenfold. A staff of nonmedical care managers and recovery care coordinators are located at military treatment facilities and Department of Veterans Affairs Polytrauma Rehabilitation Centers across the Nation.

As of January 1, 2015, Navy Safe Harbor supported 3,283 service members. As you may know, enrollment is extended to Active Duty and Reserve sailors and Coast Guardsmen with service-connected serious injury sustained while in the line of duty, including combat wounds, shipboard and shoreside training accidents, liberty accidents, and motorcycle vehicular accidents.

Sailors and Coast Guardsmen diagnosed with a serious illness such as cancer, brain disease, stroke, or post-traumatic stress are also eligible for enrollment. Only 19 percent of Navy Safe Harbor enrollees are combat wounded. The vast majority are enrolled as a result of noncombat conditions.

Because of the size of its population and relatively lower incidents of combat exposure, the Navy has employed a decentralized program for providing Wounded Warrior support. With the most service and Coast Guardsmen remaining attached to their current commands, Navy Safe Harbor support includes, but is not limited to, comprehensive recovery plan development, addressing pay and personnel issues, connecting family members and caregivers with available support resources, providing adaptive sports and recreational opportunities, and linking enrollees to education and job training benefits.

Navy Safe Harbor has experienced continuous program growth since its inception, increasing by 19 percent in fiscal year 2013 and 34 percent in fiscal year 2014. This growth is a result of increased awareness across the fleet due to an effective outreach and marketing campaign as well as an observed change in attitude of Navy and Coast Guard service members willing to overcome the stigma of seeking help.

The program will likely continue to grow commensurate with the average rate of incidents of serious illness and injury across the fleet. The Navy Safe Harbor program addresses an enduring need, and must remain capable of responding when or if the Nation engages in a future conflict.

I thank you again for holding this hearing and continuing to shed light on these important issues.

I look forward to answering your questions.

[The prepared statement of Captain Breining can be found in the Appendix on page 56.]

Dr. HECK. General Doherty.

**STATEMENT OF BRIG GEN PATRICK J. DOHERTY, USAF,
DIRECTOR, AIR FORCE SERVICES, UNITED STATES AIR FORCE**

General DOHERTY. Good afternoon, Mr. Chairman, members of the committee.

It is an honor and a privilege to be speaking with you this afternoon about the incredible men and women of the United States Air Force who are recovering from combat wounds, serious injuries, and debilitating and life-threatening illnesses, and the focused efforts of the Air Force Wounded Warrior program.

At the start of 2015, we have 4,165 airmen enrolled in our Wounded Warrior program. The goal of our program is to assist our airmen and their caregivers through recovery and rehabilitation, helping them reach the best level of self-sufficiency they can attain, and always being available in the event they are in need of assistance anytime in the future.

Our program is designed to help our airmen face devastating situations and overcome adversity they may encounter. We hope to prepare them to return to duty if their situation allows or prepare them for a successful life of purpose out of uniform. Our success is counted not by numbers, but by the ability of our airmen to realize that an abundant life is ahead of them, and to see them set their focus on each day ahead, and succeed in taking that first step to recovery. But through it all we realize, because each person is different, we will face situations with them and their families we may not have seen before.

So we are always seeking and implementing improvements to the continuum of care. We have developed our program to be flexible and adaptable to adjust our program to meet the needs of our wounded, ill, and injured airmen. We are proud of the airmen and the efforts of our professionals that care for them. The Air Force is totally committed to ensuring our Nation's sons and daughters who voluntarily raise their right hands to defend this great Nation, and specifically our wounded ill and injured, are cared for with the utmost compassion, skill, and dedication. That is our sacred trust, and that is what we will always keep as one of our top priorities.

Thank you for your keen insights and endless support for our airmen, and in particular, our wounded warriors, ill and injured.

I look forward to your questions.

[The statement of General Doherty can be found in the Appendix on page 69.]

Dr. HECK. Okay. Mr. Williamson.

**STATEMENT OF PAUL D. WILLIAMSON, COMMAND ADVISOR,
WOUNDED WARRIOR REGIMENT, UNITED STATES MARINE
CORPS**

Mr. WILLIAMSON. Thank you, Chairman Heck, Ranking Member Davis, and distinguished members of the subcommittee.

It is my privilege to appear before you today to discuss the service and support provided to our Marine Corps' wounded, ill, and injured Marines and their families through the Wounded Warrior Regiment. I have served in the Department of the Navy for more than 45 years. In that time, many positive changes have been made in how we care for our service men and women and their families, especially our wounded warriors.

I can report to you today that the quality of care provided to your Marines has never been better. The best recovery care for complex cases requires a coordinated team approach. In the Marine Corps, we find success by placing warrior care under the leadership of a commander who has the responsibility, authority, and accountability for the health and welfare of those in his command.

Our common objectives in warrior care have enhanced the partnership of the Marine Corps, Navy Medicine, the Department of Veterans Affairs, Department of Defense, and other services in ways that had not existed in the past. We are united by a common goal to ensure comprehensive recovery care for our Marines from the onset of their illness or injury through all phases of recovery and transition.

Warrior care is not a process, but rather an individual relationship that exists between the recovering Marine and the family and the recovery care team. To ensure that we remain responsive to their needs, the Marine Corps seeks to be informed by the voice of our wounded warrior and their family. Annual care coordination surveys, townhall meetings, focus group, and social media feedback provide valuable input, which has resulted in additional capabilities and refinements of existing ones.

As we focus on our current drawdown, fiscal pressures, and other important issues, one wonders about the future of warrior care. Our Commandant's 2015 planning guidance addresses the matter very clearly and succinctly. Our commitment to our wounded Marines and their families is unwavering.

I look forward to answering your questions today, and I thank you for bringing us forward to address you.

[The prepared statement of Mr. Williamson can be found in the Appendix on page 79.]

Dr. HECK. Thank you.

I would like to thank you all for your testimony. We will now begin with a 5-minute round of questioning by the members, and I will start off.

Secretary Rodriguez, given that each military service has a unique program to provide support to recovering service members and their families, how does DOD ensure that the service programs are meeting the needs of the wounded warrior? So what is DOD's role when problems or deficiencies are identified in a service Wounded Warrior program?

Mr. RODRIGUEZ. Mr. Chairman, thank you for that question, and I assure you that DOD takes our role very seriously, and we have policy oversight of the programs that are being executed by all of the services.

One way we do that is by conducting site assist visits within each of the services. In 2014, we conducted 27 site assistance visits, that again with each one of the services. And during the site assist visits, we reviewed the service's policies on care, transition—the transition programs as well as their care management as well. We wanted to ensure that they have a process in place that meets all the standards required as set forth in the policy.

Dr. HECK. So DOD has an overarching policy that each one of the service programs needs to meet. When you go out and do those site

visits, what is the metrics that you are using to evaluate the service programs?

Mr. RODRIGUEZ. Sir, DOD has an overarching policy, yes, sir. And so when we do the site assist visits, we assure that, again, that they are meeting the standards set forth in that particular policy.

Dr. HECK. And if you find a site visit where the policy prescriptive guidance is not being met, what actions are taken? What is the procedure for corrective action?

Mr. RODRIGUEZ. Understanding that there is always areas for improvement, we work directly with the leadership at the sites. While we are conducting site assistance visits, we have leadership representation there with us.

Upon completion of the site assist visits, we provide a report to the leadership. Upon completion of that report, we have 30 days for the leadership to respond on how they plan to implement those program revisions. And then we go back. In 2015, we are going back and we are going to look at each additional site that we visited in 2014 and ensure that those policies and/or revisions are put in place.

Dr. HECK. All right. Thank you.

Colonel Toner, there has been some recent reporting of some issues at some of the WTUs, specifically down in Texas. How has the Warrior Transition Command responded to those concerns, and what role has the ombudsman position played in answering those concerns?

Colonel TONER. Yes, sir. So just a summary. You know, the concern is largely associated with disrespect, harassment, belittlement of soldiers within the three WTUs in Texas. And so it is important to know that the information that generated the reporting coming out of this was our own oversight program. So our ombudsman report that you alluded to was provided to the investigative team.

And so at the end of the day, you know, it concerns me, and I take very seriously, when I have a soldier or a family member that does not believe that they have received the world-class care that they deserve or they believe that they were belittled or harassed in any way, that is a serious concern to me, first and foremost. My expectation is all soldiers and family members are treated with dignity and respect.

Coming out of the report and the things that we address. So prior to the publishing of the article and the series of reports out of Texas, the Sergeant Major and I went down to Texas and visited each of the WTUs down there because I personally wanted to get an assessment of whether or not we had issues. They were off track in terms of policy and procedures.

And so we went down to Fort Bliss, Fort Hood, and Brooke Army Medical Center, and visited WTUs down there. It was not a white glove visit by any means or account. This was the Sergeant Major and I holding sensing sessions with family members, cadre, service members, clinicians down there to understand if we had a resident problem.

It is important to note that the material that was provided to the reporter was from the 2009 to 2013 timeframe, and certainly those conditions existed as was in the ombudsman report. It is important

to also note that those ombudsman's reports were resolved to the satisfaction of the soldier and satisfaction of the chain of command in each one of those instances.

At the end of the day, what is important to me is that again we have a world-class program and the soldiers feel like they are getting the support they need. And what is also important to me is that we maintain our oversight. And so we have a robust oversight program that allows us to maintain visibility. And from the feedback of those soldiers and family members to the ombudsman program, Sergeant Major and I get those reports every day, as does the chain of command, and it is important that we can rapidly react to soldier and family issues.

But more importantly, if we have some sort of policy or procedural issue that is indicating some sort of trend or systematic problem in the program, we can address that immediately.

Dr. HECK. So based on the cluster that you found in Texas, do you feel or did you get any reports from other WTUs either CONUS [continental United States] or OCONUS [outside the continental United States]?

Colonel TONER. So within the context of the reporting, 2009 to 2013, I think if you look at all the WTUs, you will see kind of the similar types of issues and challenges, and that is everything from a soldier issued in their disability rating to administrative stuff. So I think if you look at the program in total, you will see a lot of same challenges out there.

I have been to seven WTUs. I have been in command about 6 months. I have been to seven of the WTUs. We are getting ready to head out on another round out there. We do organizational inspection programs which is a 5- to 7-day, 17-person process where we get out there and take a look at it.

I am confident that the program and policies and procedures that are in place now have the program going in the right direction, but again, more importantly, that we have the oversight out there in case we have some sort of challenge within the program, we can address it immediately.

Dr. HECK. Thank you. Mrs. Davis.

Mrs. DAVIS. Thank you.

Again, thank you all for being here.

I wonder if you could speak to the extent to which the population of service members that are participating in the Wounded Warrior programs has changed. We know it has changed to some extent, and I wondered about the enrollment process, particularly, and who is included, who is not included, eligibility in terms of the seriousness of wounds.

Mr. Rodriguez, you might have the overall view of that, but I wondered whether—do you know, are there major differences in the services in terms of enrollment, and the proportion, I guess, of the population's wounded warriors from the Iraq and Afghanistan, more particularly, or injuries that people have suffered in the course of their careers?

Mr. RODRIGUEZ. Thank you for your question, ma'am.

And as you mentioned, I believe my colleagues from the services can probably speak more diligently about their individual processes within the services, but I can tell you from an OSD [Office of the

Secretary of Defense] standpoint, we have noticed that the service members that are becoming part of the WTU population are in the injured and ill category now.

Understanding that again each service member's injury and illness is unique, and the processes in which they arrive in the WTUs or warrior care programs is a unique process as well. We want to ensure that every service member has the opportunity to be part of the program and receive all of the care and/or resources that are available within the WTUs or the warrior care programs in general.

Mrs. DAVIS. Uh-huh. And I don't know whether—if you wanted to speak briefly about that. Is there something that jumps out at you in terms of the way that your programs are progressing right now that may be different from what it was a few years ago?

Colonel TONER. Yes, ma'am. And again, I appreciate the question. Let me give you a snapshot right now, if you can see the program where we are right now. So the Army has 4,139 soldiers in the program. Of that 4,139, 1,863 are Active Duty, so that is about 45 percent. So we have 55 percent of Reserve Component, a balance of National Guard and Reserve. Of that total population, 81 percent of that over 4,000 have deployed. That doesn't mean their condition is related to a deployment. That means they have deployed.

I think another interesting statistic you would probably be appreciative of is almost 2,000 of those soldiers, so about 47 percent, have a—some sort of diagnosis for PTS [post-traumatic stress] or behavioral health, could be a primary, secondary, or tertiary diagnosis, and of that, 84 percent have been deployed. So that is kind of representative of the population right now.

With respect to your question on intakes and enrollments, I think, who gets in the program, there is a difference in the Army program with respect to an Active Duty soldier and a Reserve Component soldier. So an Active Duty soldier, to get into the Warrior Transition Unit, you are looking at, just generally speaking, 6 months of complex care requirement. So they have a profile that prohibits them from doing their military occupational specialty. They require some sort of complex clinical care, and they are allowed to come into the program.

Now, I would caveat that with senior mission commanders can enter somebody into the program from Active Duty. So for instance, if you have a soldier that has some sort of severe behavioral health incident or issue, that commander may designate that that individual gets the focused clinical care that is resident in the WTU and they can enter them in the program.

For the Reserve Component, there is a difference. And so a Reserve Component soldier, if they require more than 30 days of care and it has been determined in the line of duty that their medical requirement occurred while they were on duty, then that soldier can apply to be entered in the WTU. The processing of admittance to the WTU is the same for an Active Duty or Reserve Component soldier. It still goes through the triad of leadership, the WTU commander, the medical treatment facility commander, and the senior mission command board to evaluate the entry of that soldier into the process.

Mrs. DAVIS. Thank you.

And what about the Navy then, Captain? Is there anything very different from him?

Captain BREINING. Yes, ma'am. We are, since Congress and OSD gave the services the ability to kind of shape our programs to what are our individual needs, I believe the last time that you heard testimony from us was in 2008, and Vice Admiral Robinson was the Surgeon General of the Navy at the time, came up and talked about a steady state for the Navy of about 250 cases. Through proactive outreach, we have expanded quite significantly since then.

So 250 back in 2008, 1,000 in 2010, and today we have helped 3,283. Our active caseload on any given day is a little over 1,600. That is about 600 Active Duty service members and reservists as well as around 1,000 transition service members in veteran status. So considerable program growth over the years as we have launched out.

As far as the Navy's criteria for enrollment, we don't look at black and whites, but in generalities, about two back-to-back windows of a year period. If the recovery is going to take longer than that, that would be considered a category 2 and eligible for lifetime enrollment.

Less than that, we will continue to assist that service member with their individual needs, but in all likelihood, they are going to be returned to duty, and the upfront costs, as far as support, is going to be for the first few months, and then once we get them back on their feet, they will return to the force. But we will continue to monitor that service member if anything changes as far as a prognosis or condition, we will relook at the case and then they will be eligible potentially for enrollment down the road.

Mrs. DAVIS. Okay. Thank you.

I know my time is up, and perhaps for the record, I don't know, you want to have the Air Force and—

Dr. HECK. Well, I think we might have another round.

Mrs. DAVIS. Come back. Okay. Thank you.

Dr. HECK. Mr. Coffman, recognized for 5 minutes.

Mr. COFFMAN. Thank you, Mr. Chairman.

I am wondering if the respective branches of service could tell me what percentage of your caseload in the Wounded Warrior program are of PTSD [post-traumatic stress disorder]?

Colonel TONER. So, sir, if you don't mind, I will take that first one.

So, again, 4,139 in the program right now in the Army, 1,929 of those have a PTS or behavioral health-related issue. That could be a primary, secondary, or tertiary issue. So it could be, you know, part of their medical challenge. So that is 47 percent.

Mr. COFFMAN. Okay. Out of your experience with the program, how many of those that have behavioral health issues or PTSD are returned to duty?

Colonel TONER. I will have to take that for the record and see if we can get back, you know, the specifics on that.

Mr. COFFMAN. Okay.

[The information referred to can be found in the Appendix on page 90.]

Colonel TONER. I am sure we track that to some degree.

Mr. COFFMAN. And what is the regimen of treatment for those personnel?

Colonel TONER. Yes sir, it depends on how, you know, obviously the complexity of the case and how it is treated. But within the Warrior Transition Units, they have the clinicians, behavioral health specialists, the social workers that can treat that. They also have the access to the primary care managers, the doctors—

Mr. COFFMAN. Right.

Colonel TONER [continuing]. That can administer the program to them there. So that is within the WTU, which is unique to what we do. This is not separate from the organization. So those clinicians are inside the formation with those soldiers on a day-to-day basis.

Mr. COFFMAN. Okay. Captain.

Captain BREINING. Yes, sir. About 25 percent of our illnesses are PTSD. I would like to take that for the record as far as the exact number.

[The information referred to can be found in the Appendix on page 90.]

Mr. COFFMAN. Sure.

Captain BREINING. But that is a, you know, ballpark figure.

Mr. COFFMAN. And return to duty?

Captain BREINING. I will have to take that one for the record as well, sir.

[The information referred to can be found in the Appendix on page 90.]

Mr. COFFMAN. Okay. And regimen of treatment?

Captain BREINING. Very similar. We provide nonmedical support for Safe Harbor, so that is all done in the Bureau of Medicine and Surgery's side, but there are very good programs on that side that we collaborate with very closely for treatment.

Mr. COFFMAN. General.

General DOHERTY. Yes, sir. Similar process in play and probably about the similar numbers. I will take for the record, though, to get you the finite details with our occurrences.

[The information referred to can be found in the Appendix on page 91.]

General DOHERTY. As you understand, our program is a little bit different as far as we use the unit organization to be the—basically the mothership of care for that wounded warrior and family and the local facilities.

Probably about a quarter of our wounded warriors do have PTS, and if it is of a significant nature or their injuries or their care require a significant nature, then we have patient squadrons. We have one on the East Coast and we have one down in San Antonio and one on the West Coast that we can bring them for a significant amount of time to make sure that they are getting the world-class care that they deserve.

Mr. COFFMAN. Okay. And I am looking at the Army's numbers and I am looking at the Air Force numbers, and it seems that your numbers are larger than the United States Army's, if I am right or not. I think the Army is 4,139; is that correct?

Colonel TONER. That is correct.

Mr. COFFMAN. And your number is 1,000—well, not—1,165. Am I correct in that?

General DOHERTY. Yes, sir. We have 1,125 on Active Duty right now, 300 of them are due to combat related and the other are due to illness and injuries, yes, sir.

Mr. COFFMAN. It is surprising, I mean given the size of the United States Air Force relative to the size of the Army, that your numbers are actually larger than the United States Army's.

Okay. Well, if I—for the record—I would like you to tell me, out of those PTSD, how many are returned to Active Duty.

[The information referred to can be found in the Appendix on page 91.]

Mr. COFFMAN. To the Marine Corps.

Mr. WILLIAMSON. Yes, sir. The numbers of individuals who are reporting treatment for a psychological cause is around 59 percent. Now, the protocols that the Bureau of Navy Medicine and Surgery provide for in treatment, as Captain Breining pointed out, is subject to the needs of that individual patient.

Mr. COFFMAN. I am sorry. What was the—what is the total number for Marine Corps? For the Wounded Warrior program?

Mr. WILLIAMSON. Yes, sir. I reported that as 59 percent, but what that is is the number of individuals surveyed who reported that they were receiving treatment for psychological health issues.

Mr. COFFMAN. Okay. But I am sorry, what is the total number on the Wounded Warrior program, not just PTSD, the total number?

Mr. WILLIAMSON. Right. So you must understand that the Marine Corps' approach to recovery care was initiated by General Conway, who stated that his desire was that Marines would recover with their parent unit so long as that unit could support them in recovery.

Mr. COFFMAN. Okay.

Mr. WILLIAMSON. The most needy cases would be brought, if you will, into residence—

Mr. COFFMAN. Okay.

Mr. WILLIAMSON [continuing]. At the Wounded Warrior Regiment. Presently, there are 501 Marines who are currently in residence—

Mr. COFFMAN. Okay.

Mr. WILLIAMSON [continuing]. With the Wounded Warrior Regiment. We have another 374 who are being supported at their parent unit—

Mr. COFFMAN. Okay.

Mr. WILLIAMSON [continuing]. By a recovery care coordinator.

Mr. COFFMAN. Okay. So the ones in the Wounded Warrior Regiment, what percentage of those would be post-traumatic stress? Is that at 59 percent?

Mr. WILLIAMSON. Fifty-nine percent, yes, sir.

Mr. COFFMAN. That is the 59 percent. And do you have any data as to how many who have processed through the Wounded Warrior program who are claiming PTSD who have been returned to Active Duty—who have been diagnosed with PTSD who have been returned to Active Duty?

Mr. WILLIAMSON. Most often PTSD is a comorbid condition with some other disabling condition. That is why they were joined as an in-resident—

Mr. COFFMAN. Okay.

Mr. WILLIAMSON [continuing]. With the Marine Corps Wounded Warrior Regiment. So 97 percent of those who are joined to a Wounded Warrior Regiment—

Mr. COFFMAN. Okay.

Mr. WILLIAMSON [continuing]. Element are disability separated or retired, so there is approximately a 3 percent return to duty.

Mr. COFFMAN. Approximately 3 percent, okay.

Thank you, Mr. Chairman. I yield back.

Dr. HECK. Thank you. Mr. Cook, you are recognized for 5 minutes. Mr. Cook.

Mr. COOK. Yes, sir. Thank you very much.

I was trying to—I was obviously sleeping on the switch there and trying to digest some of those facts there.

The number of post-traumatic stress disorders is very, very high. First of all, I had the opportunity to visit a unit down there at Camp Lejeune when I was down there for the 2nd Marine Division reunion. I was very impressed.

And I got to be honest with you, and I am going to make a statement now. You know, I was on the VA [Veterans Affairs] Committee and I was chair of the Veterans Committee in California, and it bothers me, and listening to you and some of the things in the past, I just think you do a better job of taking care of the troops.

Now, I am going to put you on the spot. If you believe that same thing, and anyone in the panel can ask this, and you all know about the problems with the VA [Department of Veterans Affairs] and everything else. Now, I think we have dropped the ball on this in terms of the overall mission of taking care of the troops, and it seems like you still have that major concept why you are doing this. And just off the top of my head, I think you are doing a better job.

Do you have any feelings—I know you probably don't want to throw the VA under the bus, but everybody else has, and they have had some serious problems, and a lot of us are concerned that we have got to—maybe it is just too large, too bureaucratic; but it seems to be working for you, and I think you are doing a great job.

Anyone have any comments on that statement at all? Controversial as it may be.

Colonel TONER. Sir, I guess I will jump in being the infantryman at the table.

Mr. COOK. Good. So am I.

Colonel TONER. Sir, I would like to approach it this way, and unfortunately, I won't help you out in talking specifically to the VA, but what keeps me up at night is the simple truth that, you know, we are going to be taking care of these soldiers and family members for 70 to 80 years. That is the fact of the matter. And I have them, we have them for an extremely short amount of that time.

And what concerns me is, there is a lot of attention, there is a lot of focus into our programs, we are looking down, we all are looking down. But what concerns me is what are we doing out in

our communities? What are we doing to set the conditions for success, and I know I am preaching to the choir, in our communities.

And it is comprehensive in nature, because what we want to do is we want to make the soldiers and family members feel like they have something that they are transitioning to. We want to reduce that stress. And so it is more than just adaptive sports, adaptive reconditioning, disabled sports, U.S.A., Ride of Recovery, it is more than that.

It is great companies that are, you know, improving their habitat inside the workplace for disabled people, not just veterans, Americans. It is the folks that are revamping the college campuses that come and talk to us about how they are creating veteran campuses and how they are focusing more on how does a soldier who has PTS, how do they adapt to an educational environment.

And so, you know, to me, that is where I would ask for help. That is where I would ask for focus in terms of what are we doing. Because there is great islands out there in the communities, and we know them, but what are we doing to join them together and make this more of a continental effort?

Mr. COOK. Anyone else have any responses?

Mr. WILLIAMSON. Yes, sir, if I may.

The Marine Corps has focused our efforts on ensuring that the Marine understands that they are going to be in our program for a couple years. And as Colonel Toner indicated, we are going to be looking out after their welfare well into the future. But they are going to be veterans for the rest of their lives. So we want to introduce them to the capabilities and ensure that they understand the capabilities that the VA has for them and their competence and their desire to be of service to them.

Mr. COOK. I don't mean to cut you off, but I am going to run out of time.

Let me cut to the chase real quick. Why is it working for you and not the VA? Is it the concept that maybe they have missed the boat about taking care of troops and the military mission, or maybe I am trying to get a simplistic answer to something that is a very, very difficult question because I think you are absolutely right in everything you are saying.

Captain BREINING. Sir, if I may.

This question came up in Recovery Warrior Task Force back in April. And I think what works well for us is we do collaborate, as Mr. Williamson said, very closely with the VA. We have the inter-agency coordination care committee that we work with the VA on. And what works well for us is for those enrollees in our program that have hit veteran status, we have that hands-on care.

So while the VA is providing those resources, we are an extra line of defense for that service member if there is any issues and we directly inject right into the VA and solve the problems. I have a VA fellow recovery coordinator on my staff that if anything comes up, I can go right to her and she knows the touch point within the VA.

So from our perspective, it is working very well, but that is for our population.

Mr. COOK. Thank you.

Yield back.

Dr. HECK. Thank you.

Mr. O'Rourke.

Mr. O'ROURKE. Thank you, Mr. Chairman. I appreciate you asking after the WTUs in Texas.

And Colonel Toner, thank you for your personal attention to this issue, and specifically for visiting El Paso and Fort Bliss. And I wanted to ask you about that, and you—you touched on this in the answer to the chairman's question, but was there in fact cause for concern at the WTU at Fort Bliss?

Colonel TONER. So, sir, during the context of the reporting document, so 2009 to 2013, there were challenges at Fort Bliss beyond a shadow of a doubt, kind of multifaceted, cadre, soldiers, just programmatic-type issues. What I found in my visit down at Fort Bliss, solid program, senior mission commanders fully involved down there, fully engaged, and their program is on track.

As you know, demob/mob [demobilization/mobilization] site, so they have got a large population of Reserve Component soldiers down there, but a phenomenally engaged cadre and clinician staff down there. And I am satisfied that the program is on track and where it needs to be.

Mr. O'ROURKE. And I do want to keep our focus forward, but if I could summarize. You were able to corroborate or confirm that there was indeed cause for concern. Could you just touch on what led to that and what changed so that you feel comfortable going forward?

Colonel TONER. Absolutely. So, again, so these reports that the reporter had FOIA'd [Freedom of Information Act], these were our records. These were our oversight programs, so it is important to acknowledge that. So these were our—

Mr. O'ROURKE. You are talking about there was a TV broadcast station in Texas?

Colonel TONER. Right. The investigative team, Scott Friedman in Texas.

So, again, the reports that he based his story on were our matters of record, our oversight mechanisms. And so the things that we used to change the program, to make the program better, the feedback that we get from the soldiers and family members, and more importantly, we addressed the soldiers' needs. So if a soldier has a concern, the expectation is, through the ombudsman, that that issue is going to be resolved.

So since 2009 to now, our program has largely been built and adjusted based off of this type of input, soldier and family input. And that is—

Mr. O'ROURKE. Something—but I do want to make sure, and I apologize for interrupting you. I do want to make sure that you answer the question. What was going wrong? What was the specific challenge? Was it leadership? Was it processes? Was it procedures? Lack thereof?

Colonel TONER. All of the above. So we are talking about a period of time from 2009 to 2013.

Mr. O'ROURKE. Okay.

Colonel TONER. So you had multiple issues over that time. Everything from cadre members that did not have the right approach to the soldiers and the family members, to failure to implement proce-

dures and policies that created some issues in the program down there.

Mr. O'ROURKE. And you feel those are resolved now—

Colonel TONER. Absolutely.

Mr. O'ROURKE [continuing]. Going forward. And I will just tell you anecdotally, I took office in January of 2013, and family members of service members who were at the Bliss WTU brought these issues to our attention. And we saw press reports prior to this recent broadcast report from this past year. And essentially, you got the family member saying that the service member was being humiliated or being treated with disrespect, and then you got commanders saying, well, these are folks who in some cases just don't want to get in line, and we need to maintain discipline and order going forward. Some of them are going to be deployed and be re-integrated.

We also found—we dug a little deeper, to touch on Mr. Cook's point, that there were some problems at the VA because, you know, a certain percentage of these service members were going through the IDES [Integrated Disability Evaluation System] process as they roll out into civilian life, and that we had a hangup at this DRAS [Defense Retiree & Annuitant Pay System] processing facility in Washington State where we were not able to get the ratings, and these soldiers were literally languishing at the WTU there. And I think as that delay has come down and we are able to process these soldiers through the IDES process, I think that has improved things as well. I don't know if you want to comment on the VBA [Veterans Benefits Administration] aspect of it?

Colonel TONER. Well, so—you know, it all comes down to communication. That is the number one complaint that we get out there when we talk to soldiers and family members is communicating through the process. And so there is known entities that we can talk to them about and say, okay, this is known to us. But for a soldier and family member in transition, it is an extremely stressful time in their life. I mean, they are going through a medical process where it is stressful, and they are going through transition where it is stressful.

So, you know, our ability to give them some sort of prediction on when they are going to be separated and transitioned in civilian side of the house is extremely important to the soldier and family member so they can make that part of their comprehensive transition plan.

So, you know, from when I was a battalion commander in 2006 to when I was a brigade commander in 2009, you know, we have broken the window down to where we can give them a pretty good idea. Ninety days, okay, we expect to get your ratings back and we will know this and we will be able to transition you at this point in time. It has been a pretty large accomplishment since 2006, when we couldn't predict that. But at the end of the day, it would be nice to be able to tell the soldier, absolutely, we know you are going to transition on 6 June, it is going to happen on that day, your ratings are going to come back, we can get some predictability into their lives, et cetera.

I think you reduce that and you mitigate that by having that conversation with those soldiers and family members out there so

they understand what part of the process is. There is also an appeal process where a soldier can choose to do that. So that is part of—part of what we are doing out there. And I don't want to leave you, sir, with the idea that, you know, at Fort Bliss it was just a matter of we are replacing leaders and everything else. No, this is—you know, Fort Bliss sort of represents, in a good way, our ability to react to soldier input, family input, and cadre input and adjust the program.

And so it is much more than changing leaders at Fort Bliss. It is readjusting our training program in San Antonio. It is readjusting the way that we select cadre members. It is our approach to the training that those folks get that allow them to adjust the program down there. So it is much more than just that.

Mr. O'ROURKE. Thank you.

Thank you, Mr. Chairman.

Dr. HECK. Mr. Jones.

Mr. JONES. Mr. Chairman, thank you very much.

And for those of us on this committee who have been here 20 years, we have really seen, and I want to commend the commitment made by not only you, but those before you to see this Wounded Warrior program become what it is today. And nothing is perfect in government and outside of government. You have done a magnificent job to get to this point.

I have the privilege to represent the district in North Carolina, the home of Camp Lejeune Marine Base and Cherry Point Marine Air Station, and I have had a chance to visit the Wounded Warrior program many times down at Camp Lejeune. And I saw it from the old barracks to a new facility. It has been a tremendous commitment made by our government to those who have given so much physically and mentally.

What I would like to ask each one of you, for those—and I know you said the numbers are down, which is a good thing, I would hope—that are still in the program from their mental and physical wounds from the Afghan and Iraq war, how many of those that are still in the program that are being medicated, meaning that they are still on prescription drugs for their treatment of PTSD or TBI [traumatic brain injury] or it could be another issue.

If you could give me some idea of the percentage from the Army, Navy, Air Force, and Marine Corps, of those that are still in the Wounded Warrior program and the percentage of those that are being medicated.

And if you don't have it now, if we could get it for the record. That is really one of my biggest concerns, because I do still have a lot of communications, as certainly you have more than I do, but there are still those that are in much need, particularly the PTSD, of trying to be able to grip with their problems. And so if you could give me—maybe you know it now. If you could share it with me, I would appreciate it.

Colonel TONER. Sir, I will have to take that for the record and get you the number there.

[The information referred to can be found in the Appendix on page 91.]

Colonel TONER. From a polypharmacy or pharmaceutical standpoint, you know, again, the Army program has come a long way,

so we have that one primary care manager that manages the care of that individual soldier so that we reduce the aspect of polypharmacy. And the first approach being, you know, how can we treat, how can we do this pain manager or how can we do the management of your condition through things other than some sort of medicated approach.

Mr. JONES. Does anyone have any—the reason I am asking this because a few of us for a number of years have been trying to get the opportunity of a soldier, Marine, or airman, Navy, whichever, the ability to—with the doctor's prescription, to be treated by hyperbaric oxygen treatment. And it has been a frustration for many of us in the Congress in both House and Senate that we continue to get roadblocks not from you—this is above the Wounded Warrior program—but of getting this treatment approved to the point that if prescribed by the doctor on base and that the patient believes it could be helpful.

So that is the reason I would like to see these numbers that I have asked for, that if you could provide each service how many are still in the Wounded Warrior program that are from the Afghanistan—excuse me—or Iraq war and they are still in the program and how many are being medicated. I really would appreciate it very much.

General DOHERTY. Yes, sir. That is a great question. I will take it for the record and get you the details on that.

[The information referred to can be found in the Appendix on page 91.]

General DOHERTY. But just our experience, I am retiring Captain Mitchell Kieffer on the 20th of February down at Langley Air Force Base, a phenomenal airman, and he just went through that treatment, and he was telling me about the superb results that he got from that treatment. And so I see firsthand that—from one case, he had very good results—

Mr. JONES. I want to thank you for sharing that story with this committee because I hope, Mr. Chairman, we talked about it earlier, that we will hold a hearing on the treatment programs and the success of hyperbaric oxygen treatment. And I have got stories, too, but I really appreciate it. It is more important that you share that with this committee than me share the stories that I might have. So thank you very much for that comment.

Dr. HECK. Okay.

Mr. Walz.

Mr. WALZ. Well, thank you, Chairman and Ranking Member, and thank all of you.

I kind of like to echo Mr. Jones' sentiments on this. As the current conflict ramped up and as the need to approach our care of our warriors changed, I want to applaud all of you for going forward on that, doing the things. And I think all of us know this is a zero sum proposition. If one warrior is left behind or if the care is substandard, we failed, and that is—that is kind of the nature of it, but it doesn't dismiss the positive lessons, the things that are moving forward.

I had the opportunity to visit Wounded Warrior Battalion West at Pendleton. And I think the American people would be pleased

to see the facilities and the care and the outstanding treatment that is being delivered. And that is important.

Colonel Toner, you hit on this point, and I know my colleagues here, Mr. Cook, Coffman, O'Rourke, and myself either previously or do now serve on the VA [Veterans' Affairs] committee. And I've talked for decades till I am blue in the face that the lack of seamless transition hampers us in so many ways, whether it was electronic medical record or it was a commitment of care on a continuum. And again, we have you here but no one from the VA [Department of Veterans Affairs].

Now I do know they are embedded with you. There is things that happen. But I truly believe we are going to have to crack that. We are going to have that make that better. We are going to have to see it, that it is all of our responsibilities, because Colonel Toner, your comments were dead on. You are going to care for them in the big scheme of things for a relatively short amount of time. It is going to seem like an eternity to them if they are with you for 2 years and their family and waiting for orders and everything else that goes with it. But the true eternity is right, the next 70 years. And our inability to shape that policy holistically, I think, is hampering us. And I think it causes great frustration. So I just echo that as a statement.

A couple of things I would ask, though. You mentioned this, and I am concerned about this when I was out there and looked at it. The folks that are providing the care, the care providers in the cadre, how is their morale? How are they doing? And I know these are people that are self-selecting many cases because that is exactly where they want to be, doing exactly what they want. But this is tough work, and it wears on you.

So if I could just get—I know this is subjective, but your assessment of how you see those providers from each of you.

Colonel TONER. Yes, sir. So from the Army perspective, you know, a lot—a majority of these folks, especially the cadre, are volunteers. They want to be a part of the program. At the end of the day, though, this is an extremely stressful environment. And we place the leaders and the clinicians into the environment, we get them training and it is highly emotional, as you know, sir.

I mean, you have a soldier that is going through a medical process, you have a family that is in transition, it is extremely emotional. It is 24/7 for the providers and the cadre. It is tough work, but it is very rewarding.

So it is a challenge. We have instituted in the Army that a tour of duty for a cadre member is 24 months because it is so stressful. It requires such a commitment that we want to make sure that there is not a, you know, some sort of fatigue associated with a cadre member as they are going through the program.

Mr. WALZ. So there is a conscious effort to address it, and this is—it is out there.

Colonel TONER. Yeah. And so one other thing, too, if I may, Congressman, is the resiliency program that we put them through. So we have added a week of training to the cadre course that puts them through the Army's—a portion of the Army's resiliency training, shows them how to cope and also how to assess individuals that may be—that may be struggling.

We also opened up the master resiliency training course, which is a much longer course, and allows them to become trainers of that course within the formations.

Mr. WALZ. Wonderful.

Captain.

Captain BREINING. Yes, sir. I talk to each of our staff members as they come through to take their assignments, and resiliency is one of the top things I talk about because it is such a challenging assignment. It is very rewarding to be able to give back to these wounded warriors that deserve our support so well. But it takes a lot out of you, and they are putting in a lot of extra hours to provide that quality care that they believe that the wounded warriors deserve. And resiliency is definitely something we've got to look at.

My concern is we have military that come in for 3-year orders, but then I also have government civilians that do this for 7, 8 years.

Mr. WALZ. Yeah.

Captain BREINING. And they are the ones who really impress me, because they keep at it. I continually focus them on living well for themselves and just kind of assessing where they are at and talking to the other care providers to make sure that they are not internalizing these stresses.

General DOHERTY. Sir, we found that the training is incredibly invaluable to all of our recovery care teams. And we just got done with a one-week session down in San Antonio with nonmedical care managers, along with the recovery care coordinators, and the community airmen family readiness community leaders that help it along assisting families.

But we give them those resiliency skills during this week. They are a part of our master resiliency trainer program as well. And then just the socialization and the commonality of bringing our 43 regions across the globe together to share challenges, to share insights, best practices, and whatnot, we find that to be very valuable. And we are putting that into our battle rhythm.

So we are doing that once a year. And then the policy folks, the folks that have levers to—we midstream it at the summertime, and then we start it all over again for next January. We will be doing the same thing. Yes, sir.

Mr. WALZ. Mr. Williamson, I am sorry, my time cut you off. I may have to follow up with you and just ask you offline. Thank you.

Dr. HECK. Mr. Knight.

Mr. KNIGHT. Thank you, Mr. Chair.

It is always interesting to be a freshman. You get to hear all the good questions, and then you are last.

You know, some of the statements I will make, and I will leave it kind of open for how you want to answer this, but I always look at outreach. I just Googled and went onto Web sites and saw how you enroll into the program and what is needed and all of that.

How much outreach are we doing? Obviously, if someone is wounded, then we probably enroll them right away. But if someone comes home and now is starting to go through some of the issues of PTSD or some other issues by being in the combat zone, what kind of outreach are we doing so that those individuals know that

there is a place for them, there is a place where they can get treatment, there is a place where they can be treated?

And secondly, what are we doing about funding? We always—we are always talking about funding in one form or fashion. I am sure we are going to be talking about that this year quite a bit. But there is something the American people never argue about, and that is, taking care of our wounded warriors. There is never a partisanship there, there is never a question about that. It is always they should get the care, and they should get everything that they need and they deserve.

So I will just leave those both open to Colonel or Captain or General, if you want to answer any one of those?

Colonel TONER. Sir, I guess I will start. So in terms of outreach, you know, so it is a large Army issue, first of all, and so the Army has addressed this in many ways. We have embedded behavioral health now down in the combat brigades. We have medical providers in the combat formations out there. And so within the formations themselves, they have the ability to assess an individual and get them the help they need.

A soldier who is medically evacuated from theater, from some sort of deployment, so the policy that is in place right now is that soldier, when they are medically evacuated—so let me give you an example: Fort Campbell, 101st Airborne soldier medically evacuated from Africa goes back to Fort Campbell. They are attached to the Warrior Transition Unit for an evaluation period. And so the primary care managers, those clinicians within that formation and that leadership within that formation will assess the soldier and determine whether or not that soldier can proceed back to their unit and receive the care they need, or they remain in the Warrior Transition Unit.

So the other thing that units do is they do medical review boards where the clinicians of the unit will sit down, they will go through the formation, they will take a look at their folks that are in the care process, and they will make a determination to whether that individual needs to go in the Warrior Transition Unit.

From a funding perspective, we are a fully funded program, and we have been the whole time. I am fully funded for this year, and I don't see any lack in my ability to execute my mission and my mandate.

Captain BREINING. So there is a few ways. One is our proactive marketing and outreach, getting different advertising spots that are aired at base theaters, to putting local news stories in the base paper, to actually going out and meeting with leadership of unit commands at the regions to get the word out about the program.

I have done a tour around the U.S. to meet with Reserve Component commands, and all the NAS [naval air station] COs [commanding officers] to talk to them, especially on the Reserve side. It is always a challenge to let them know that our services are available to them as well.

And then finally is the personal casualty report [PCR]. So anyone who is seriously wounded, ill, or injured, the unit commander is required to do a PCR on that individual. And we track all those as they come in. And that is the primary means for us to be notified that someone needs our services.

But it is a continuing challenge to get the word out and make people understand that we are more than just combat wounded, that 80 percent of our population is for seriously ill and injured as well.

As far as resourcing, I brought the stats up at the beginning, 19 percent growth in 2013, 34 percent this past year. Basically our enrollments, because of our successful marketing and outreach, is outpacing our resources. And in a resource-constrained environment that is a challenge, but we are addressing that through the planning, programming, budgeting, and execution system and are hopeful that we will be able to catch up with the current need.

General DOHERTY. Yes, sir, as far as the outreach, it starts from the top and it comes with the profession of arms and the ethos. And so General Welsh, in his statements last week, it is a top priority. It is a sacred trust. And so from the top down through the chain of command, the way our program is organized with parent units taking care of their folks to the most extent possible, we stress that.

And so I personally at every new wing commander, crew commander that is coming on line, I personally have sessions with them in forums to talk through the program, talk through the strengths, the possible challenges and insights on keeping their eye and keeping the focus. And then we give them lists on who their wounded warriors are, who their recovery care coordinators are, phone numbers, and get them personally connected with all the people that are in charge of their programs. So once they hit the ground, they are part of the team immediately.

As far as funding goes, it is a nonstarter. I mean, that is a top priority and has not been an issue, even though we have growth as well as the other services.

Mr. KNIGHT. Thank you, Mr. Chair.

Dr. HECK. Mrs. Davis, did you want to follow up with your question?

Mrs. DAVIS. Sure. I don't know that we need to go back and go through the piece from the Air Force and the Marines, but if you wouldn't mind doing that for the record, just in terms of making sure that people—sort of the distinctions in terms of getting people into the program. That would be helpful.

[The information referred to can be found in the Appendix on page 89.]

Mrs. DAVIS. What I did want to ask you about is what you see are barriers for people being served today. Are there changes to the policies that would make a difference with the population as we see it going forward, or do you think that we pretty much need to keep things as they are?

One of the things that—we have come a long way. I mean, I just want to really applaud the effort for resiliency and taking care of the care providers, because that is very, very important.

I had the woman come to see me recently from the Heroes and Healthy Families program. I don't know if anyone is familiar with that. But what they have tried to do is, from a really experiential point of view, share the experiences that folks have had getting help and assistance.

At the beginning of all this, you know, a number of years ago, the stories of people who just were not seeking care were really right there in front of us, and it took almost our senior leaders to show up at mental health clinics, frankly, and to sit there and to suggest to the troops that they needed help as well, in order to get people to get the care that they needed.

And so I am just wondering, is there anything different now that we need to do to address those policies to make it more comfortable and less career-inhibiting to be certain that people get the help that they need in a timely fashion? You are providing it, but sometimes people are not necessarily getting in line.

Mr. RODRIGUEZ. Well, ma'am, thank you for the question. And I definitely can provide a little bit of information of that from the OSD level.

One of the things that we are consistently doing is reviewing our policies to make sure that they meet the requirements that our service members are going to need in the future. We also want to ensure that they are inclusive as possible to be able to provide the services that any service member may need as he or she feels that they may be—they may benefit, rather, from the services that are provided within the WTUs from all of the services.

One of the things that we consistently do is do, again, a quality assurance of our programs, ensuring that the programs meet the needs of our service members and that the services, again, based off of their unique way that they conduct their execution of their programs for their particular service members, I think they may be able to elaborate a little bit more on that.

However, we are consistently reviewing our policies from OSD standpoint to make sure that they do meet the requirements in the new population that we are working with.

Mrs. DAVIS. Okay. Does anybody see the problem that we have with individuals who believe, soldiers, sailors, who believe that seeking help would hurt their career in the future? Is that still an issue out there?

Colonel TONER. Yeah. So, ma'am, again, thanks for the question.

So unfortunately or fortunately, however you want to characterize it, what almost 14 years of conflict has given us is a large population of soldiers and leaders who understand PTS and behavioral health issues. And it has significantly reduced the stigma associated with it, to the point that leaders and those that they are leading out there understand it and understand the treatment and the help they can get to it and understand the fact that we have folks walking in our formations now that are dealing with it and doing just fine in terms of their ability to perform.

From an experienced perspective, you know, my own experience, you know, prior to going to combat I probably was—you know, just didn't understand it. I thought maybe I understood it; didn't understand it. Going to combat, first tour, 16 months, I get it. I understand it. And so you have this generation out there right now that understands it.

The fact that we have embedded behavioral health inside our formations—I was one of the first brigade commanders to get that, and I will tell you that is a phenomenal achievement, a leap, just an incredible leap, where I have an individual inside my formation

that I call Bob or Sue or whatever and that I can go to and talk and I can address my problem. More importantly, I have a squad leader that pushes me in that direction because they understand I am suffering, they understand I am going through that challenge.

So the big challenge is just to not lose that, is to maintain that kind of understanding, and to make sure that the new generation that is coming in that has not had that experience borne out of war understands that, and that we don't lose the funding and the policies and the procedures that we have in place. At the end of the day, we are hard on ourselves. We are going to constantly address the policy and the program and make it right.

Mrs. DAVIS. Yeah. Thank you.

Thank you, Mr. Chairman.

Dr. HECK. Well, I want to thank you all for—that was the call for votes, so I want to thank you all for taking the time to be here today.

And, more importantly, thank you for everything that you are doing to take care of our soldiers, sailors, airmen, Marines, and Coast Guardsmen that need the care that your folks are providing and that they deserve.

So there being no further business before the subcommittee, we stand adjourned.

[Whereupon, at 4:38 p.m., the subcommittee was adjourned.]

A P P E N D I X

FEBRUARY 3, 2015

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

FEBRUARY 3, 2015

**Opening Remarks – Chairman Heck
Military Personnel Subcommittee Hearing
Wounded Warrior Program Update
February 3, 2015**

I want to welcome everyone to the first hearing of the Military Personnel Subcommittee for the 114th Congress. I especially want to welcome the new members of the subcommittee. I look forward to working with each of you during the coming year.

I am very pleased that Congresswoman Susan Davis from California will continue to be the subcommittee Ranking Member. I value her years of experience on the subcommittee as Chairwoman and as Ranking Member. I look forward to working with you as we shape the work of the Subcommittee for this year.

The past several days have been very busy with the release of the Military Compensation and Retirement Modernization Commission's report and the President's Budget for fiscal year 2016. I know that the information in both of these documents are at the forefront of everyone's mind and I want to assure everyone that the Military Personnel Subcommittee will have several opportunities to thoroughly review and discuss them in the coming months.

But today, we meet to continue the subcommittee's effort to improve the care of injured and wounded troops as they recover and transition either back to duty or to civilian life.

The Department of Defense and the military services have had many years to develop the policies and programs to assist wounded, ill and injured warriors and their families through the recovery process. I recognize that this was and continues to be a tremendous effort by very dedicated and professional individuals, both military and civilian, that crosses all military communities. However, it has not been without fits and starts and it has not been without problems.

Our purpose today is to learn the current state of the wounded warrior programs. I am interested to know whether the programs still serve the needs of wounded, ill and injured service members and their families. Are they viewed by DOD and the services as enduring programs? Or are there plans to reevaluate the need for the programs in their current state as the mission in Afghanistan winds down and those deployments taper off? I am interested in hearing the witnesses' views on these questions.

Before I introduce our panel, let me offer Congresswoman Davis an opportunity to make her opening remarks.

Prepared Statement

of

James D. Rodriguez

Deputy Assistant Secretary of Defense for Warrior Care Policy

DEPARTMENT OF DEFENSE AND MILITARY SERVICE

WOUNDED WARRIOR PROGRAM UPDATE

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE

MILITARY PERSONNEL SUBCOMMITTEE

February 3, 2015

Introduction

Chairman Heck, Ranking Member Davis, distinguished Members of the Subcommittee, thank you for the opportunity to appear before you today to discuss the Department of Defense's policies regarding care for our wounded, ill, and injured recovering Service members.

One of the Department of Defense's (DoD) highest priorities is ensuring the Nation's wounded, ill, and injured recovering Service members, their families, and caregivers receive the support they need for recovery, rehabilitation, and reintegration. The great success we have seen over the last thirteen years of war in saving lives on the battlefield has also driven the need for the Department to provide additional services, many directly relating to the support needed by our Service members and their families

To ensure our Recovering Service Members (RSM) receive the right services when they are needed, the Department provides concise policy parameters that allow the Services to deliver consistent, high quality care and support. As part of this mission, the Office of Warrior Care Policy (OWCP) develops specific policies for the Department and provides the oversight of those policies to ensure that execution delivers on both the intent and produces the outcome we need. The policy and oversight areas for OWCP include the Recovery Coordination Program, the Integrated Disability Evaluation System (IDES), the Military Adaptive Sports Program, Operation Warfighter, the Education and Employment Initiative, and the Caregiver Support Program. Each of these is briefly discussed in the sections that follow.

Recovery Coordination Program (RCP)

In 2008, Congress directed DoD to establish the Recovery Coordination Program to better assist Service members across the phases of their recovery process. This program, delivered by each Service using Recovery Care Coordinators (RCCs) and Comprehensive Recovery Plans (CRPs) individualized for each Service member, identifies resources for both the member and the family as they navigate the many transitions of healing and recovery. The Recovery Coordination Program is guided by policy which requires forty hours of standardized training for all non-medical case managers (NMCs) in order to improve care, management, and transition services. This training includes information on roles, responsibilities, and concepts for developing a CRP. As of October 2014, 449 RCCs are providing services at 237 locations worldwide to support approximately 14,000 Recovering Service Members and all have received the required training. In compliance with policy and verified through oversight, 100 percent of RSMs enrolled in a Wounded Warrior Program have an active CRP. Furthermore, these plans are shared with the VA to ensure a smooth transition of care and services.

Disability Evaluation

In 2007, DoD and the Department of Veterans Affairs (VA) jointly fielded IDES. The IDES became fully operational in October 2011, producing a more transparent process and reducing the gap between separation from military service and receipt of VA disability compensation. While the primary objective of IDES is to determine whether a Service member is physically and mentally fit to perform their military duties, IDES also offers a number of other benefits, including eliminating duplicate disability examinations and ratings, and sharing full medical records between DoD and VA. The Department continuously reviews the IDES process and implements change to improve performance, efficiency and transparency.

The IDES population varies each month, but as of December 2014, approximately 25,500 Service members were enrolled, with several thousand Service members coming into and leaving the system each month. The amount of time Service members wait to receive VA benefits after discharge has decreased significantly, and is currently just 46 days. The IDES process itself is more streamlined as a result of iterative improvements. Currently, the Department is meeting or exceeding all timeliness goals. Furthermore, as of September 2014, 85 percent of Service members completing the IDES process have expressed satisfaction with their IDES experience.

Oversight of RCP and DES

In February 2014, WCP began site assistance visits (SAVs) with the goal of assessing compliance with established policy, including the uniformity and effectiveness of care coordination for RSMs and their families and caregivers provided by RCCs, Army Wounded Warrior (AW2) Advocates, and Navy Non-Medical Case Managers (NMCs). These visits gauge the care, management, and transition process of RSMs, review RCC roles and responsibilities, and assess RSM and family member experiences with the support provided on each installation. Through the 27 SAVs conducted in FY 2014, WCP identified areas for improvement and best practices. In October 2014, WCP formalized a DES Quality Assurance Program (QAP) to standardize disability evaluation quality assurance requirements across the Services. The QAP is designed to assess, monitor, and improve the accuracy and consistency of determinations and decisions made by medical and physical evaluation boards, and to ensure the boards and liaison officers properly perform their duties. WCP is collecting and reporting preliminary data but continues to refine and validate the procedures for the QAP with a view toward full implementation in the fourth quarter of FY 2016. This information will be included in the next Congressional report, scheduled to be delivered in mid-2015.

Military Adaptive Sports Program

MASP provides recreational activities and competitive opportunities to all RSMs to improve their physical and mental quality of life throughout recovery and transition. Participation in adaptive sports and activities helps RSMs realize their new physical capabilities, which may be beyond what they might have previously thought possible. This experience can build confidence that helps RSMs in other parts of their recovery.

RSMs in MASP participate in activities such as wheelchair basketball, cycling, track & field, yoga, strength conditioning, swimming, golf, sitting volleyball, and archery. In FY 2014, the Services held 79 camps and clinics with approximately 1,500 RSMs participating.

DoD provides subject matter expertise, equipment, and policy guidance to the Services, and works with community-based organizations, non-governmental organizations, and the VA adaptive sports programs. Leaders from the MASP and the VA National Sports Program Office established a monthly working group to share best practices and collaborate on adaptive sports issues affecting our populations. The working group strives to create competitive events for new Veterans who have participated in MASP, incorporate non-traditional adaptive sports or activities such as art, music, and writing, increase VA involvement in MASP events, and increase the use of social media to better promote both programs to participants in both Departments.

Operation Warfighter

OWF assists RSMs' recovery process by placing them in supportive work settings as part of their rehabilitation. Through internship opportunities in the Federal government, the program provides opportunities for resume building, exploring employment interests, and developing job

skills. OWF has worked with the Services to increase RSM participation, resulting in an increase in the number of participants by 14 percent between 2013 and 2014.

Education and Employment Initiative (E2I)

As RSMs begin considering their separation from service, E2I assists them by identifying areas of expertise, matching them to related career or educational opportunities, and supporting successful transitions to education and employment. The Department's strategic partnerships with academic institutions and employers provide a resource for RSMs to hone their skills even if they are unable to perform their regular military duties. Between 2013 and 2014, E2I experienced a 52 percent increase in participation.

Conclusion

The Department continuously evaluates our wounded warrior programs and implements improvements that yield concrete results for wounded, ill, and injured Service members and their families. We are incorporating lessons-learned and best practices to update policies and programs to improve support for RSM and their families. This is an ongoing commitment of the Department and a promise to all those who serve.

Thank you for your support of the brave men and women who serve our Nation, and your dedication to ensuring DoD has the most efficient systems in place to care for wounded, ill, or injured Service members.



James Rodriguez

Deputy Assistant Secretary of Defense, Office of Warrior Care Policy

Mr. James Rodriguez is the Deputy Assistant Secretary of Defense, Office of Warrior Care Policy, Office of the Secretary of Defense. In this role, Mr. Rodriguez serves as the principal advisor on the coordination of recovery, rehabilitation, and reintegration for wounded, ill, and injured Service members across the military departments.

Prior to his selection as Deputy Assistant Secretary of Defense, Mr. Rodriguez was the Director for Veteran and Wounded Warrior programs at BAE Systems. In that capacity, he acted as the Corporate Liaison for the White House Joining Forces initiative, to senior military leaders, government officials, and nonprofit organizations, increasing the footprint of our nation's wounded, ill, and injured across all spectrums.

Mr. Rodriguez served twenty-one years in the United States Marine Corps in numerous leadership and management positions. He deployed to over 11 countries around the world and served in Operations Desert Shield/Desert Storm, Operation Eastern Exit-Somalia, and Operation Enduring Freedom. During his final duty assignment at Balboa Naval Hospital, he was the Senior Enlisted Advisor to the Officer in Charge of the Wounded Warrior Battalion, where he was responsible for the transition, development, and education of Service members with service-connected disabilities.

Mr. Rodriguez holds a Bachelor's Degree in Political Science from the University of Maryland, University College and a Masters of Arts Degree in International Commerce and Policy from the George Mason University School of Public Policy. He is married to Mrs. Vanessa Rodriguez. They have two college-age daughters Courtney and Casey.

39

RECORD VERSION

**STATEMENT BY
COLONEL CHRIS R. TONER
COMMANDER WARRIOR TRANSITION COMMAND
OFFICE OF THE SURGEON GENERAL
UNITED STATES ARMY**

BEFORE THE

**HOUSE ARMED SERVICES COMMITTEE
SUBCOMMITTEE ON MILITARY PERSONNEL**

FIRST SESSION, 114TH CONGRESS

**DEPARTMENT OF DEFENSE AND MILITARY SERVICE WOUNDED WARRIOR
PROGRAM UPDATE**

FEBRUARY 3, 2015

**NOT FOR PUBLICATION UNTIL RELEASED BY THE
HOUSE ARMED SERVICES COMMITTEE**

Chairman Heck, Ranking Member Davis, and Distinguished Members of this Committee – thank you for the opportunity to appear before you to discuss our Warrior Care and Transition Program (WCTP) and some of Army's initiatives to address the needs of our Soldiers; specifically as they relate to wounded, ill, and injured Soldiers and their Families.

HISTORY AND MISSION.

Warrior Transition Command (WTC) was established at the direction of the Chief of Staff of the Army on 1 April 2009 and replaced the U.S. Army Medical Command (MEDCOM) Warrior Transition Office, the HQDA Warrior Care and Transition Office, and the Human Resources Command Army Wounded Warrior (AW2) Program. Today, WTC is a major subordinate command of the MEDCOM. As the Army's proponent for Warrior Care and Transition, WTC provides centralized policy, oversight, guidance to Warrior Transition Units and the AW2 Program, and advocacy for our Soldiers in Transition. Through individualized, comprehensive transition plans, the WTC enables and empowers our wounded, ill, and injured Soldiers, Veterans, and Families to successfully reintegrate back into the force or community with dignity, respect and self-determination.

WTUs were developed in 2007 in response to concerns over the care and management of wounded, ill, and injured Soldiers and their Families. While WTUs resemble a traditional Army line unit, their singular mission is to provide comprehensive outpatient management that allows Soldiers to successfully heal and transition. Within the WTUs, Soldiers receive personalized support from a Triad of Care that includes a nurse case manager, a squad leader, and a primary care manager. The Triad of Care coordinates clinical and non-clinical issues to successfully transition Soldiers and their Families either back to the force or onward to successful civilian lives. Since inception, the WTUs have helped over 65,700 Soldiers to heal and transition. Of note, the WTUs have returned over 29,400 Soldiers back to duty. Today's WTU population of 4,196 (as of January 12, 2015) is down from a high of 12,451 in June 2008.

Enduring Statement. The past eight years have been a time of significant investment in the development of the WCTP. The Army Medical Action Plan was established in 2007 and the WTC stood up in 2009 as the Army's proponent for Warrior Care and Transition. The WCTP's top priority then, as it is now, is the welfare of our Soldiers and their Families: commitment to the best care and treatment of wounded, ill, and injured Soldiers and commitment to their education, training and careers. Since the WCTP inception, the Army has been committed to ensuring our wounded, ill, and injured Soldiers have the best health care possible and successfully remain on active duty or successfully transition out of military service.

ORGANIZATION.

Warrior Transition Units (WTUs). Today, the WCTP consists of 25 Warrior Transition Units supported by over 3,100 cadre on Army installations throughout the United States (including Alaska and Hawaii), Puerto Rico and Germany. As the WCTP moves forward, it will continue to evolve to meet the changing needs of its population as well as the Army.

Mission Command. The Warrior Transition Command (WTC) serves as the single focal point and strategic focus for the Army's WCTP. A Triad of Leadership is comprised of the senior leaders at the installation, military treatment facility (MTF), and the WTU. The Senior Commanders and Command Sergeants Major at each of these levels have command and control over the local WTU to develop a balanced WTU structure that is enduring, scalable and responsive to the medical needs of every Soldier. Regional Medical Commanders oversee the delivery of world class clinical care to each WTU. Clinical care is embedded in the WTU (nurse case managers, primary care managers, occupational therapists, physical therapists, social workers), in the local MTFs and in external clinical settings.

Installation Management Command (IMCOM). The Army's Installation Management Command (IMCOM) plays a vital role within the WCTP by delivering and integrating base support to our Soldiers and our units.

In 2008, and with the support of Congress, we started our effort to build WTU campuses. WTU campuses are comprised of Battalion and Company Headquarters, American with Disability Act (ADA)-accessible barracks, and Soldier Family Assistance Centers (SFAC), all of which are IMCOM-provided facilities.

WTU barracks are different from any other barracks the Army has constructed. Other than these newly constructed WTU barracks, all Army barracks have been, and continue to be, designed and constructed for able-bodied Soldiers with no consideration for full ADA and Architectural Barriers Act (ABA) compliance, much less Accessibility Guidelines compliance. Congress appropriated \$1.2B of Military Construction funding over four years (FY2008 through FY2011) specifically for the design and construction of 20 healing campuses for the care and transition of wounded, ill, and injured Soldiers. As part of these campuses, the barracks have been designed and constructed to fully comply with ADA-ABA Accessibility Guidelines.

In instances where no military construction was appropriated to construct dedicated WTU campuses, IMCOM has modified existing facilities to accommodate the WTU mission and WTU Soldier population. Additionally, IMCOM has the authority to procure leased hotel or apartment space, either on- or off-post, to meet the requirement to provide the WTU Soldiers adequate housing. Currently, the average occupancy level of WTU barracks is near 50%.

The SFAC is a collection of support services created to meet the Army objective to provide integrated support for WTU Soldiers and their Families in a "one-stop shop" setting located within or near the WTU. Services provided by the SFAC equip and aid WTU Soldiers and their Families in making life-changing decisions as they transition back to duty or to a veteran status in the private sector. The SFAC provides the

following services: military personnel services; transition and employment assistance; government entitlements and benefits assistance; education services; social services; legal assistance; financial assistance; pastoral care; and child care. SFACs also provide services to the Integrated Disability Evaluation System (IDES) Soldier population.

Staffing. Every two years, the WTC conducts a manpower analysis and uses time and task analysis to ensure our staffing models and ratios best serve the needs of our Soldiers. From squad leaders and company commanders to occupational therapists and nurse case managers, our manpower studies ensure the proper cadre-to-Soldier ratios are not only appropriate and meet the needs of our Soldiers, but are standard throughout the WCTP. Our WTU organizational structure is ratio-based (e.g., 1:10 Squad Leader-to-assigned Soldiers, 1:20 Nurse Case Manager-to-assigned Soldiers, or 1:200 Primary Care Manager-to-assigned Soldiers), allowing the WCTP to expand and contract based on the total number of Soldiers within the program. The WTC will ensure the proper staffing ratios are maintained, while retaining a level of flexibility to meet the future needs of the Army.

In years past, the WCTP primarily focused on two different, but equally important, efforts: Building the right multi-disciplinary medical team to manage the Soldiers' care and selecting and training the right cadre members to serve within our WTUs. Going forward, additional emphasis will be placed on ensuring our Soldiers are ready to face the challenge outside of military service. We will continue to work to improve our staff and cadre training and ensure our Soldiers receive world-class healthcare.

Force Structure and the Strategic Posture Review (SPR). We recognize our population is changing, and must adjust to their needs and the needs of the Army. To ensure the command is servicing the needs of our Soldiers and Families consistent with guidance issued by the Department of the Army and the U.S. Army MEDCOM, the WTC performs semi-annual programmatic reviews of its force structure through SPRs. Responding to an enduring requirement and a declining "wounded warrior" population, the WTC will

continue assessments in accordance with the Army's intent that the WCTP maintains the appropriate capacity and capabilities to execute its mission. In the past 30 months, the command completed three reviews, resulting in both capacity adjustments as well as the inactivation of several units. The latest review led to the Army restructuring its WTUs beginning in October 2014 (this was the fourth time the Army adjusted the number of WTUs while still maintaining the proper staffing ratios). Beginning in October 2014, the Army established Community Care Units (CCUs) across 11 installations. These changes were made in an effort to improve the care and transition experience of our WTU population while optimizing the program's structure in alignment with Army force structure, reduce unnecessary administrative procedures, improve command oversight, standardize Soldier experience and outcomes, and better leverage available resources. As those CCUs have just recently been activated, our Organization Inspection Program will include an overview of the effectiveness of the new CCUs in support of the WTUs. Lessons learned and best practices gleaned from these reviews can then be implemented WCTP-wide.

PROGRAM.

Entry Criteria. The Senior Installation Commander (General Officer), the MTF commander and the WTU commander comprise the triad of leadership responsible for establishing processes to determine which Soldiers enter their respective WTUs. Ultimately, it is the Senior Commander's responsibility to ensure Soldiers who are approved for assignment or attachment to a WTU meet the entrance criteria specified by the WTC serving as the Army's proponent for warrior care.

For Soldiers in the active component and Active Guard Reserve (AGR) to be eligible for assignment to a WTU, they must generally have a physical profile for more than six months, with duty limitations that preclude the Soldier from training or contributing to the unit mission accomplishment, and a level of clinical complexity that requires clinical case management. If a Soldier's psychological condition is evaluated by a qualified medical or behavioral health provider and determined to pose a substantial danger to

self or others (if the Soldier remains in the unit) that Soldier also may qualify for entrance into the WTU.

For Soldiers in the reserve components (National Guard and Army Reserve) to be eligible for entry into a WTU, their medical condition must have been incurred or aggravated in the line of duty during an active duty status and their condition must require definitive care.

Cadre Training. Our cadre plays key roles in the WCTP. Therefore, cadre training is paramount to our oversight activities. Their job is very demanding and requires a wide range of leadership skills. Consequently, WTU cadre undergo additional screening processes and are required to attend supplemental training. Senior Commanders at each installation are responsible for identifying, screening, and selecting best-qualified candidates to fill WTU cadre positions. Soldiers identified for cadre positions have served successfully in leadership positions, display a strong potential for promotion, have completed all required Non Commission Officer Education System (NCOES) for their grade and completed a Sensitive Duty Assignment Eligibility Questionnaire.

Starting in July 2009, the MEDCOM required that unit cadre be trained according to their roles within the WTU. The Department of Warrior Transition (DWT), Army Medical Department Center and School serves as proponent for standardized cadre training and conduct the Cadre Training Course ten times per year. The course is designed for assigned squad leaders, platoon sergeants, company level commanders, first sergeants, and nurse case managers. Additionally, cadre attend the Comprehensive Resiliency Course (CRC) that incorporates much of the Comprehensive Soldier and Family Fitness Master Resilience Training concepts, into a resident course. The CRC was created to help meet the challenges cadre face as they manage our wounded, ill, and injured Soldiers and Families through the complexity of care and transition.

Training is not limited to those serving in first line supervisory positions. All WTU Commanders and Command Sergeants Major attend the MEDCOM Pre-Command

Course. The mandatory Senior Leader and Clinician Course, held quarterly, provides new commanders, sergeants major, and WTU clinical leaders training on WTC policies and doctrine, and current command level issues, initiatives, and guidance. Also, all nurse case managers (NCM) assigned to the WTUs attend a comprehensive distance learning course designed to provide a firm grounding in Soldier and Family care management within 60 days of assuming a NCM role. There is also a preceptor period after the course that must be completed at duty station.

Finally, many of the cadre assigned to the WTUs have the opportunity to attend the Comprehensive Soldier and Family Fitness (CSF2) Master Resilience Trainer (MRT) Course. The curriculum is designed to promote mental skill development and coping techniques through education and application. Key focus areas include instilling a sense of ownership in the Soldier's rehabilitation and transition process, maximizing abilities as opposed to disabilities, and inspiring Soldiers regarding their future. In coordination with CSF2, the WTC sponsors two MEDCOM-specific MRT courses each year. WTUs also host resilience workshops for cadre, Soldiers, Families, and caregivers on a reoccurring basis. Resilient cadre creates a more resilient environment for healing and transition. Today, our WTUs have 217 cadre who are Master Resilience Trainers.

COMPREHENSIVE TRANSITION PLAN AND TRANSITION ACTIVITIES.

Comprehensive Transition Plan (CTP). The WTC's Comprehensive Transition Plan (CTP) is the overarching methodology to support a Soldier's rehabilitation and ultimate reintegration back to the fighting force or to the community as a productive veteran. The CTP is developed by the Soldier for him/herself, and is a future-oriented, aspirational action plan that places Soldiers and their Families at the very heart of the Army's WCTP. The CTP is the core of the WCTP. It focuses on the Soldier's future and aligns with the domains of strength within the Comprehensive Soldier Fitness model of physical, emotional, social, Family, and spiritual, and includes the additional domain of career to establish goals that map a Soldier's transition plan towards self-

reliance and independence. The Soldier owns his or her CTP and it empowers him or her to take charge of his or her own transition with the support of Family and the interdisciplinary team.

A triad of care (squad leader, nurse case manager, and primary care physician) and a multi-disciplinary team of professionals support the Soldier by helping them to develop a CTP and every Soldier in a WTU begins their CTP upon assignment or attachment to a WTU. Soldiers must complete all six CTP processes: in-processing, goal-setting, transition review, rehabilitation, reintegration and post-transition.

Transition Activities. Career and Education Readiness activities are the centerpiece of effective transition from the Army for wounded, ill and injured Soldiers and include remain-in-the-Army work assignments (RIAWA), internships, or education/training. In calendar year 2014, of our Career and Education Readiness eligible population, 32% participated in RIAWA, 13.3% in internships, and 31% in education or training opportunities.

Transition Coordinators (TC) support WTU Companies. The TC implements procedural, administrative, regulatory and policy guidance of the Warrior Transition Program. The TC integrates employment, education, and internship support elements found on and off the installation to enable a successful transition plan. The TC serves as the WTU staff coordinator and point of contact for all Career and Education Readiness programs. These staff members will provide intensive career and employment preparation services to each Soldier and their Family.

The Soldier for Life (SFL) Transition Assistance Program (TAP) provides robust transition assistance as part of new Veterans Opportunity to Work entitlements for all eligible Soldiers. Soldiers complete a 12-month post-transition budget, identify any skill gaps during a "Military Occupational Specialty" crosswalk with civilian occupations, and complete career assessments in order to effectively make career decisions. WTC has nested its CTP program elements within the SFL TAP process, which blends SFL TAP

activity with additional opportunities including volunteer internships and college education.

DoD's Operation Warfighter internships and the Department of Veterans Affairs' (VA) Coming Home to Work program provide wounded, ill and injured Soldiers the opportunity to work in a desired occupational area as volunteers while still on active duty, gaining valuable civilian work experience. Such opportunities are particularly valuable as they help Soldiers overcome their apprehensions about entering the civilian workforce and provide employers with the confidence they need to be willing to hire veterans.

The VA's Vocational Rehabilitation and Employment program (VR&E) allocated 200 new vocational rehabilitation counselors for 71 separate military installations, giving Soldiers and other service members early access to VA vocational and educational counseling.

Army WTC and VA's VR&E staff conduct joint site visits to Army installations to ensure that interagency staffs collaborate effectively to provide career counseling, testing, and services to wounded, ill and injured Soldiers in support of their personal employment goals. Site visits at ten locations will occur this fiscal year.

We also work closely with the United Service Organization to provide high-tech résumé and interview workshops across the WTU enterprise to complement existing programs and prepare Soldiers and Spouses for a successful transition from the Army to the civilian workforce. In calendar year 2014, 51 workshops were conducted with 750 participants and an estimated 39 workshops will be conducted in calendar year 2015. In an effort to make certain each Soldier has an employment resource available on transition, Soldiers are provided contact information for their hometown DOL Disabled Veterans Outreach Program or Local Veterans Employment Representative prior to transitioning from the WTU. WTU Staff are also required to refer Soldiers to the DoD Education and Employment Initiative regional coordinator not later than six months prior

to the anticipated transition date for enhanced support regarding employment and education.

Army Wounded Warrior Program (AW2). Since April 2004 with the onset of the Disabled Soldier Support System, AW2 has assisted and advocated for our most severely wounded, ill, or injured Soldiers, their Families, and Veterans. Any Soldier with a disability rating of at least 30% in one or more specific categories, as well as those who have a combined rating of 50% or greater for any other combat or combat-related condition are AW2-eligible. Currently, AW2 assists and advocates for more than 22,400 severely wounded, ill, or injured Soldiers and their Families.

Exit criteria. As with entrance eligibility, exit criteria differ upon Army component. A Soldier departing the WCTP can either return to the force, or be separated or retired. Active component Soldiers wishing to return to duty can do so provided any of the following are met: their primary care manager determines the Soldier can return to duty; the Soldier is found to be fit for duty by a physical evaluation board; or the Soldier is accepted for continuation on active duty.

Active component Soldiers must separate or retire if they meet one of the following conditions: the Soldier fails to meet the Army retention standards described in AR 40-501, Standards of Medical Fitness, Chapter 3, Medical Fitness Standards for Retention and Separation, Including Retirement; or, the Soldier is eligible for, and elects to accept, a non-medical retirement.

Reserve component Soldiers will exit the WCTP by either a release from active duty or separation/retirement; upon completion of the disability evaluation system process with a finding of fit for duty or continuation on active reserve status; because they do not fulfill their medical and military responsibilities according to WCTP Policy Memo 13-009 (WTU)/Community Based Warrior Transition Unit Soldiers Medical and Military Responsibilities, dated 03 Nov 2013; or because an incarceration is expected to exceed 30 days in duration which prevents the Soldier from participating in the CTP.

A reservist, not on AGR status, can exit the WCTP through retirement or separation when one of the following are also met: completion of the disability evaluation process with a finding of not fit for duty; administrative or UCMJ actions recommending separation/discharge from the Army; or a Soldier's eligibility for, and election to accept, a non-medical retirement is met.

OVERSIGHT. This is a highly emotional mission and the stress on our Soldier's Families, cadre and caregivers is considerable. We are constantly adjusting our program to the emerging needs of our Soldiers and have robust oversight programs in place to address individual concerns and to identify policy or procedures that need modification or implementation.

Internal. Since 2009 we have implemented multiple policies and programs to address Soldier/Family care, cadre selection and training, and increase our oversight of the WCTP.

Triads Care/Leadership. Triad of Care (squad leader, nurse case manager, and primary care manager) and Triad of Leadership (senior installation commander, Military Treatment Facility, and Warrior Transition Unit) are individually focused on the WCTP Soldiers' recovery and transition. Soldiers meet with their Triad of Care every 90 days to discuss progress issues specific to their care and transition.

Ombudsman Program. One of the most important tools used by the WTC to assess and resolve individual Soldier issues is the MEDCOM Ombudsman Program. The Ombudsman program was established by MEDCOM as an outgrowth of the Army Medical Action Plan in 2009. The Ombudsman functions as a resource in support of both WTU and non-WTU Soldiers (with medical issues), as well as their Family Members. Ombudsman are DA Civilians specially selected based on their experience, determination, and passion to help Soldiers. They are located at 35 locations in the United States, Puerto Rico and Europe.

Following the airing of complaints about conditions at Walter Reed Army Medical Center and elsewhere in the media, the Army was quick to engage problem solving solutions to insure all Soldiers and Family Members that they could expect the very best healthcare. Simultaneously, steps were taken to improve infrastructure and streamline administrative actions associated with the Physical Disability System. The final pillar in the strategy was the creation of a vehicle Soldiers and Family Members can use to air grievances and obtain assistance resolving problems. Since it was established in 2007, over 54,239 Soldier and their Families have used the Ombudsman Program to help resolve their issues.

The WTC's relationship with the Ombudsman Program is paramount to it's success as it facilitates identification of issues which may not be realized through other processes. This success is based on continuous engagement. The WTC reviews daily ombudsman reports provided by MEDCOM Medical Assistance Group. These reviews enable the WTC Commander to engage with local commands or direct WTC staff to assist in resolution of select Soldier complaints, interview the Ombudsman on unit trends as part of the WTC's Organizational Inspection Program (described later in this document), and hiring of an Ombudsman Liaison Officer at the WTC HQs in the 2st quarter of FY15.

Operational Inspection Program (OIP). Another successful program used to assess and resolve both Soldier and unit issues along with ensuring compliance to WCTP polices is our Operational Inspection Program. The OIP provides Senior Commanders and Regional Medical Commanders with an assessment of the performance of the WTUs in their footprint. The OIP team conducts sensing sessions with Soldiers and their Families to identify and resolve their issues. Inspections are conducted objectively to hold our system of performance accountable. Additionally, OIPs serve to identify systemic issues that require policy or program changes. The WTC's OIP team will conduct ten separate OIP visits to WTUs this fiscal year.

Soldier Options for Redress. Soldiers have many options available to resolve issues. A Soldier's chain of command is always available to assist, and Commanders have open door policies which make them readily available to the Soldiers. Commanders at all levels are required to hold quarterly town hall meetings with their Soldiers and Family members. Additionally, Soldiers can seek assistance from Equal Opportunity Advisors, Inspector General, Chaplains, and Ombudsman.

External. Since WTUs were established, the WTC, MEDCOM, and a number of external agencies frequently inspect and visit the WTUs. These include: the Office of the Secretary of Defense - Office of Warrior Care Policy; Department of Defense (DOD) Inspector General Office; Department of the Army Inspector General Office; the Government Accountability Office; the DOD Task Force on the Care, Management and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Forces; IMCOM; and the Army Medical Command. Members of Congress periodically perform oversight visits of the WTUs and conduct sensing sessions of the cadre, staff, Soldiers and their Families. All findings brought forth by these agencies are evaluated within the WCTP, addressed locally, and when appropriate, key initiatives are implemented to address areas requiring improvement across the WTC.

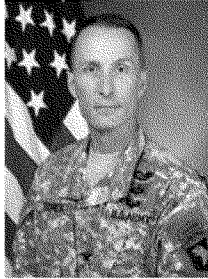
CLOSING. Since its inception in 2007, the WCTP has evolved to meet the changing needs of the Army while remaining focused on providing world class care to our Soldiers and their Families. Much has changed since the start of the program. In the midst of such change, one thing remains clear: A program centered on the idea of returning our Soldiers to the force or to a successful transition to civilian life will remain the central part of our mission. Our CTP will continue to be the foundation for our Soldier's transitions. No two are the same, yet this Soldier-centric plan is flexible enough to support rehabilitation and ultimate reintegration back to the fighting force or transition to the community as a productive veteran. The Triad of Care and the use of the multi-disciplinary team to manage the care for our Soldiers have served us well in the past and that, too, will be carried into the future.

As we move forward, we must maintain a level of scalability and flexibility within the program that allows us to meet the future needs our Soldiers and the Army. Today's WCTP population is much smaller than it was ten years ago; however, it is critical we maintain the capability to expand and contract. In years past, 50 percent of Soldiers exiting the WCTP returned to the force. This percentage is quickly changing as the number of wounded Soldiers decreases in the program. Now an increasing percentage of Soldier assigned in the WCTP are ill and injured and are less likely to return to the force due to the severity of their conditions. Just last month, of the 483 Soldiers who departed a WTU, only 24 percent returned to the force. As we focus on how best to aid our Soldiers in their transition, we must also reinforce and build upon those relationships we have already established with the Army Soldier for Life, Army G1's Transitioning Services, Operations Warfighter and the VA's Vocational Rehabilitation and Employment Service; while simultaneously increasing our efforts and resources within our Career, Education, and Readiness services as well as our Army Wounded Warrior Program transition activities. Likewise, we will continue to build partnerships with our veteran centric organizations like the Department of Labor, Department of Veterans Affairs, national and local business groups, and Veterans and Military Service Organizations.

The WCTP remains a highly effective organization with many success stories. Though the WCTP is seeing fewer wounded and more ill or injured patients, the WTU population remains complex and the need for the Army to continue to provide centralized oversight, guidance, and advocacy for this population will remain an enduring requirement. We've come a long way since the days of the medical holding company and long wait times for our injured Soldiers. We will not return to that setting. Warrior care remains an Army priority and a sacred obligation. We will not turn our backs on our Soldiers and our Families.

COL Chris Toner

Commander



Col. Chris Toner is currently serving as the Commander of the Warrior Transition Command. In this role, he oversees all aspects of the Army's Warrior Care and Transition Program (WCTP). The WCTP includes all aspects of the recovery and transition process for the Army's wounded, ill and injured Soldiers recovering at Warrior Transition Units (WTUs) and the most severely wounded, ill and injured Soldiers and Veterans enrolled in the Army Wounded Warrior Program (AW2).

Toner received his commission in 1987 as a distinguished military graduate of the ROTC program at Emporia State University, Emporia, Kansas.

Toner's first assignment was with 1st Battalion, 15th Infantry, 3rd Infantry Division where he served as a Rifle Platoon Leader and Scout Platoon Leader. In 1992, he was assigned to the 2nd Brigade, 7th Infantry Division (Light) where he served as the Brigade Plans and Operations Officer. In 1993, he was assigned to the 2nd Battalion, 187th Infantry Regiment, 101st Airborne Division (Air Assault) where he served as a Rifle Company and Headquarters Company Commander. He was then assigned as the aide to the Commanding General, 101st Airborne Division (Air Assault).

In 1999, Toner was assigned to the XVIII Airborne Corps at Fort Bragg, North Carolina, where he served as a Corps War Planner. Following this assignment, he served as the Operations Officer and Executive Officer in 2nd Battalion, 505th Parachute Infantry Regiment, 82nd Airborne Division. In 2002 he was assigned to the United States Strategic Command as a Global Missile Defense Planner.

In 2004, Toner assumed command of 2nd Battalion, 87th Infantry Regiment, 10th Mountain Division. The battalion formed Task Force Catamount, deployed to Afghanistan for 16 months in support of Operation Enduring Freedom VII-VIII, and was awarded the Valorous Unit Award. In 2007, Toner assumed command of the Second Regiment of the United States Corps of Cadets, United States Military Academy, West Point, New York.

In 2009, Toner assumed command of the 3rd Brigade, 1st Infantry Division (Provisional Headquarters – Forward) at Fort Knox, Kentucky and in September, Toner assumed command of the 3rd Brigade, 1st Infantry Division at Fort Hood, Texas. The brigade reformed, moved to Fort Knox, and was activated on October 16, 2009. In January 2011, the brigade formed Task Force Duke and deployed for 12 months in support of Operation Enduring Freedom XI-XII to Khost and Paktya Provinces, Regional Command-East, Afghanistan.

In July 2012, Toner was assigned as the Chief of Staff, 101st Airborne Division (Air Assault). In February 2013, the Division deployed as CJTF-101 in support of Operation Enduring Freedom XIV for 11 months.

Toner is a graduate of the Naval War College, School for Advanced Military Studies, Command and General Staff College, the Infantry Officer Basic and Advanced Course, the Field Artillery Officer

Advanced Course, the Air Assault Course, the Airborne Course, Jumpmaster Course, and Ranger Course.

Toner's awards and decorations include the Valorous Unit Award, Legion of Merit with Oak Leaf Cluster, Bronze Star with 2 Oak Leaf Clusters, Purple Heart, the Combat Infantryman Badge, the Expert Infantryman Badge, the Senior Parachutist Badge, the Air Assault Badge, and the Ranger Tab.

Not for Publication until released by
the House Armed Services Committee

Statement of
Captain Brent M. Breining, USN
Director, Navy Wounded Warrior-Safe Harbor
Before the
Subcommittee on Military Personnel
of the
House Armed Services Committee

Subject:
Update on the Navy Wounded Warrior-Safe Harbor
Recovery Care Program

3 February 2015

Not for Publication until released by
the House Armed Services Committee

Chairman Heck, Ranking Member Davis, distinguished members of the subcommittee – thank you for the opportunity to discuss updates on Navy Wounded Warrior-Safe Harbor (NWW-SH), the non-medical recovery care program for the Navy and Coast Guard. Since its establishment in 2005, NWW-SH has made significant progress in providing the very best in non-medical care for our seriously wounded, ill, and injured Sailors and Coast Guardsmen, their families, and caregivers. Nine years later, NWW-SH enrollments have expanded more than ten-fold, and its staff includes Non-Medical Care Managers (NMCs) and Recovery Care Coordinators (RCCs) located at Military Treatment Facilities (MTFs) and Department of Veterans Affairs (VA) Polytrauma Rehabilitation Centers at 17 locations throughout the country.

As of January 1st, 2015, NWW-SH has supported 3,283 service members across the life of the program, which includes 1,810 seriously wounded, ill, and injured Sailors and 109 Coast Guardsmen. This number also includes 1,364 less seriously ill and injured Sailors and Coast Guardsmen that have been assisted by NWW-SH. The program addresses an enduring need that will persist even after sustained combat operations conclude.

Historical Narrative

In 2005, the Military Severely Injured Center requested a Navy Liaison be assigned to support Sailors seriously wounded in combat. The Navy Liaison, a Program Director, and an Outreach Case Manager were designated as the first staff of Navy Wounded Warrior. At that time there were 20 wounded Sailors enrolled in the program.

The following year, the 2006 National Defense Authorization Act (NDAA) directed the Secretary of Defense to “prescribe a comprehensive policy for the Department of Defense on the provision of assistance to members of the Armed Forces who incur severe wounds or injuries in

the line of duty". The 2007 President's Commission on Care for America's Returning Wounded Warriors (Dole-Shalala Commission) recommended continued support be extended from September 11, 2001, onward for active and transitioning wounded warrior service members. In response to the 2008 NDAA, NWW-SH services were expanded to include seriously ill Sailors, and in 2009 the Chief of Naval Operations (CNO) and the Commandant of the Coast Guard signed a joint Memorandum of Understanding authorizing NWW-SH to provide support to seriously wounded, ill, and injured Coast Guardsmen. In 2010, NWW-SH was named a Program of Record with an enrolled population of just over 1,000.

On October 1, 2012, NWW-SH realigned from the CNO's Total Force Requirements Division under the Chief of Naval Personnel to Commander (N1) to Navy Installations Command (CNIC) under the Fleet and Family Readiness directorate (N9). The program's operations became fully regionalized across the seven Navy regions in the continental United States and Hawaii on October 1, 2013.

Enrollment Expansion

NWW-SH has experienced continuous program growth since its inception. Even as sustained combat operations in Afghanistan come to a close, the program will likely continue to grow commensurate with the average rate of incidence of serious illnesses and injuries across the Fleet. In fact, only 19 percent of NWW-SH enrollees are combat wounded while the vast majority (81 percent) are enrolled for non-combat conditions. Enrollment in NWW-SH is extended to active duty and reserve Sailors and Coast Guardsmen with a service-connected serious illness or injury sustained while in the line of duty, including shipboard or training accidents, liberty accidents, motorcycle and vehicular accidents, or diagnosis of a serious illness

such as cancer, brain disease, stroke, and post-traumatic stress disorder (PTSD). The following is a breakdown of the program enrollment demographics:

- Gender: 82% Male, 18% Female
- Rate: 89% Enlisted, 10% Officer, 1% Midshipmen
- Status: 87% Active, 13% Reserve
- Origin: 19% Combat, 81% Non-combat

To highlight the expansion in program enrollments, at the conclusion of NWW-SH regionalization on October 1, 2013, average active case management had risen to 300 per year for seriously wounded, ill, and injured Sailors and Coast Guardsmen. This number had grown to 403 cases per year by October 1, 2014. Program enrollments of seriously wounded, ill, and injured service members increased by 19 percent in FY2013 and 34 percent in FY2014. The recent growth in referrals is largely due to increased Fleet awareness through an effective marketing and outreach effort that was broadened by our new regional footprint. Additionally, a change in attitude has been observed with Navy and Coast Guard service members willing to overcome the stigma of seeking help, which indicates that these barriers are being broken down with increased awareness across the Navy and Coast Guard.

Program Structure

Regional NWW-SH non-medical care teams consisting of military, civilian, and contractor NMCs and RCCs tailor support to each enrolled service member during their recovery, rehabilitation, and reintegration phases. Responsibilities are separated into addressing initial needs (conducted by the NMC), and development and implementation of a long-term care plan bridging the three phases of recovery listed above (conducted by the RCC). Currently

NWW-SH has 53 staff members supporting 1,663 active cases consisting of 595 Recovering Service Members (RSMs) and 1,068 Transitioned Service Members (TSMs).

Support includes, but is not limited to, Comprehensive Recovery Plan development, addressing pay and personnel issues, connecting family members and caregivers to available support resources, providing adaptive sports and recreational opportunities, and linking them to education and job training benefits. NWW-SH strives to return a Sailor or Coast Guardsman to duty. When that is not possible, the program works collaboratively with federal agencies and local organizations to help them successfully reintegrate into their communities, easing their transition to civilian life and ensuring that they are cared for throughout their lifetimes.

Due to the size of its population and smaller incidence of combat exposure, the Navy has elected to establish a decentralized program for providing wounded warrior support with enrolled Sailors and Coast Guardsmen still attached to their parent command. For long-term inpatient status, enrollees are usually attached to the Military Treatment Facility (MTF) where they are receiving care. When in outpatient status, they remain with their parent unit for administrative oversight.

NWW-SH is responsible for providing strictly non-clinical support while working closely with Bureau of Medicine and Surgery (BUMED) Navy Clinical Case Managers (NCCMs) located at the MTFs to ensure that the enrolled service member's clinical needs are being addressed. The Navy Case Management team is comprised of over 220 specially trained and licensed registered nurses and licensed clinical social workers assigned to 23 MTFs. NCCMs work as part of the recovery team along with RCCs, NMCs, and/or VA federal recovery coordinators. Together these specialists help service members successfully navigate through the military medical system, which can be very complex.

Today, NCCMs remain a vital member of the care delivery team, and they continue to assist with optimal outcomes for wounded warrior patients and their family members, both at home and abroad. NCCMs work closely with their counterparts from NWW-SH on optimal care delivery. The nature of this cooperation has been a focus of renewed attention in 2014, with new programs in place to provide seamless communication. For instance, BUMED recently started to systematically track referrals from Navy Medicine to NWW-SH to ensure that they are appropriately taking place with the desired frequency.

Oversight

The Recovery Coordination Program (RCP) directive, DoDI 1300.24, mandates that the Office of the Secretary of Defense (OSD) for Warrior Care Policy (WCP) conduct formal annual RCP evaluations across the Military Departments. Additionally, they encourage the Military Departments to conduct internal evaluations. As such, NWW-SH has instituted regional Site Assist Visits (SAVs) incorporating OSD WCP areas of focus to ensure compliance with existing RCP policy. The SAV team reviews roles and responsibilities, database case management, field operations, training, outreach and awareness, enrollment guidance, and compliance with cross-functional (adaptive sports, family programs, transition support) program policy guidance. Additionally, the SAV team conducts random sampling of database records and meets with at least 8-10 recovering service members and family members or caregivers to discuss their recovery, rehabilitation, or reintegration progress to ascertain any gaps in services or resources. NWW-SH has visited each of our regional staffs in the U.S. and Hawaii over the last year.

Current InitiativesFamily Programs/Caregiver Peer-to-Peer

The Military Caregiver Peer-to-Peer Support Program is a Joining Forces supported initiative in response to the findings of a 2014 RAND Study on Caregivers commissioned by the Elizabeth Dole Foundation. The purpose is to raise awareness of challenges and assist military families and caregivers of wounded warriors. Launched in the National Capital Region in June 2014, the plan calls for nation-wide rollouts to 118 DoD installations by the end of summer 2015. This program utilizes Military Family Life Counselors to facilitate support groups at MTFs and bases consisting of military family members and caregivers, allowing them to connect with their peers, share best practices, learn about available resources, and tell their stories. To date NWW-SH has implemented this program at seven out of eight identified locations where NWW-SH staff is present.

NWW-SII has implemented Family Symposiums to provide an opportunity to spotlight the contributions of families and caregivers of seriously wounded, ill, and injured Navy and Coast Guard service members in targeted Navy regions. Families and caregivers participate in a panel forum to share their experiences and challenges in an effort to raise awareness of the various needs and services required to support their RSM as they progress through the phases of recovery, rehabilitation, and reintegration. A local resource fair is held in conjunction with the Family Symposium to highlight available military, VA, and civilian resources. NWW-SH has sponsored three Family Symposiums to date, each drawing on the successes of the previous events. The latest event at Walter Reed National Military Medical Center drew an audience of 119 to include enrollees, family members, hospital staff, and military personnel from other

branches. NWW-SH also publishes a quarterly family newsletter listing upcoming events and available resources to promote awareness to families and caregivers of RSMs and TSMs.

Education and Employment Program

NWW-SH Education and Employment Program connects transitioning wounded warriors to scholarship programs, resume writing resources, and employment and internship opportunities such as OSD WCP's Operation Warfighter (OWF), which provides wounded warriors internship opportunities in the federal workplace. NWW-SH transition coordinators also utilize the VA's Vocational Rehabilitation Program and eBenefits, OSD WCP's Education and Employment Initiative (E2I) counselors, as well as their connections with industry to identify available employment opportunities tailored to their wounded warrior's individual needs. In 2014, NWW-SH provided the following support:

- 51 TSMs were employed (20 percent increase over 2013)
- E2I Navy participation increased from 185 in 2013 to 354 in 2014 (91 percent increase over 2013)
- Navy placement in OWF internships increased from 82 in 2013 to 129 in 2014 (57 percent increase over 2013)
- 74 TSMs registered for school (50 percent increase over 2013) with over 26 participating in the Vocational Rehabilitation Program
- NWW-SH provided employment support information to 178 TSMs and tailored job assistance and referrals to 73 TSMs

The Department of the Navy Wounded Warrior Hiring and Support Conference brings together government, military, and industry leaders who brief wounded warriors on innovative

strategies for successful reintegration, career development, and long-term employment while emphasizing the importance of education and training. This annual event is sponsored by the Assistant Secretary of the Navy for Manpower and Reserve Affairs and co-hosted by Naval Air Systems Command, Naval Sea Systems Command, and Space and Naval Warfare Systems Command. NWW-SH participates in planning sessions and a resources panel as well as identifies interested Navy and Coast Guard wounded warriors for participation.

Anchor Program

The NWW-SH Anchor Program provides TSMs with a peer mentor from a local Reserve component and a senior mentor selected from a pool of community veterans and retirees to facilitate their transition and reintegration into the community during their first year as a military veteran. Of the 166 peer mentors, 160 are Navy Reservists supporting 202 wounded warrior veterans.

Adaptive Sports/Recreation

Adaptive athletic reconditioning and recreation – athletic activities that are modified to meet the abilities of seriously ill or injured individuals – are essential to the recovery and rehabilitation of wounded warriors. In 2014, 129 NWW-SH athletes participated in 11 adaptive sports camps/clinics throughout the country as well as the London Invictus Games and DoD Warrior Games in Colorado Springs, Colorado. In 2015, 344 active and transitioned enrollees have registered to participate in adaptive sports/recreation opportunities.

Benefits Administration

NWW-SH manages the Navy's Pay and Allowance Continuation (PAC) program, which facilitates the continuation of pay for up to one year during a service member's hospitalization and rehabilitation after incurring a wound, illness, or injury in a combat zone. In 2014, NWW-SH facilitated the distribution of more than \$95,884 to nearly 250 Sailors in PAC benefits. Additionally, NWW-SH administers the Navy's Special Compensation for Assistance with Activities of Daily Living (SCAADL) program, which compensates caregivers of wounded warriors who may have experienced a loss of income. More than \$509,000 in SCAADL benefits was paid to 50 NWW-SH enrollees in 2014.

NWW-SH Call Center

The call center connects people to the catalog of services provided by NWW-SH, and handled more than 1,300 incoming calls and over 700 outreach calls during calendar year 2014. Established at the start of FY2013, the call center is based in Millington, Tennessee. Representatives field telephone inquiries 24 hours a day, every day of the year, and continually work to increase program support capabilities.

Testimonials

Navy Machinist's Mate 1st Class Michael Dayton, injured in a shipboard accident:

"NWW has been really beneficial for me. Initially, I didn't consider myself a wounded warrior; I wasn't wounded in combat. But I now realize that doesn't matter. If you are a service member, and you are seriously hurt or diagnosed with a life-changing illness, NWW is there to help."

Navy Aviation Structural Mechanic 1st Class John Dusseau, recovering from cancer:

“My NWW non-medical care manager saved my life. He reminded me that I was still a Sailor; the Navy still cared about me.”

Navy Special Operator 1st Class Mark Robbins, wounded in combat:

“I could barely walk straight due to my injury, my wife had never been to the area, and we both didn’t know how to navigate the medical system. [My non-medical care management team] helped us line things up and made everything run smooth. We would call for an appointment and would be told we could be seen in three weeks; [NWW] could get us an appointment the next day, if not that very day. If there ever was an issue, she was right on top of it, which was a lifesaver.”

Coast Guard Lt. Cmdr. Anthony Owens, serious illness:

“My life is not easy, but [NWW] has really helped make it easier. They really do a lot for me, and go above and beyond.”

Way Ahead

While NWW-SH has made significant strides over the past nine years, there will always be more work to do. In the coming years the program needs to continue efforts to expand its regional footprint to keep pace with a growing wounded warrior population. Additionally, it needs to place continued emphasis on adaptive and recreational sports opportunities while taking advantage of the latest marketing trends to raise awareness of the program, the services provided, and the people supported within the medical and Fleet communities. Our wounded warriors,

their families, and caregivers have sacrificed much for this Nation, and they deserve the very best support we can offer them in return.

Chairman Heck, Ranking Member Davis, distinguished members of the subcommittee – I thank you for holding this hearing and continuing to shed light on these important issues. It has been my pleasure to testify before you today and I look forward to answering your questions.



Captain Brent Breining, USN
Director of Navy Wounded Warrior — Safe Harbor

Captain Brent Breining is the Director of Navy Wounded Warrior — Safe Harbor, where he oversees the non-medical care of more than 1,350 seriously wounded, ill, and injured Sailors and Coast Guardsmen, and provides resources and support to their families. Through proactive leadership, the program provides individually tailored assistance designed to optimize the success of enrollees' recovery, rehabilitation, and reintegration activities. Its goal is to return Sailors and Coast Guardsmen to duty and, when that is not possible, to work collaboratively with federal agencies and state and local organizations to ease them back into their communities.

A native of Naperville, Illinois, he graduated from the University of Michigan in 1990 with a Bachelor of Arts degree in Political Science. He was commissioned through the Naval Reserve Officer Training Corps, and was designated a Naval Flight Officer in October 1991.

His operational tours include assignments with the “Patriots” of Electronic Attack Squadron (VAQ) 140 deploying aboard USS George Washington (CVN 73), the “Gray Wolves” of VAQ 142 deploying to Prince Sultan Air Base in support of the 363rd Air Expeditionary Wing, and Strike Operations Officer for Carrier Group Six (CCG 6) deploying aboard USS John F Kennedy (CV 67). His command tour was with the “Black Ravens” of VAQ 135 deploying aboard USS Nimitz (CVN 68). He has supported combat Operations Deny Flight, Southern Watch, Enduring Freedom, and Iraqi Freedom.

His shore tours include instructor duty with the “Vikings” of VAQ 129; in-residence education at the Air Command and Staff College in Montgomery, Alabama; joint duty as Chief of the Flying Hour Program Office for U.S. Special Operations Command in Tampa, Florida; and assignment as the 2010 Defense Legislative Fellow for Senator Jeff Sessions (R-AL) in Washington, D.C. His most recent tour was at the Defense Intelligence Agency (DIA) in Washington, D.C., where he served as a division chief with the Defense Combating Terrorism Center and Senior DIA Liaison to the Director for Strategic Operational Planning at the National Counterterrorism Center. He is a 2011 graduate of the Joint Forces Staff College, and earned a Master of Public Administration from Auburn University Montgomery in 2002.

His personal decorations include the Defense Superior Service Medal, Defense Meritorious Service Medal, Meritorious Service Medal (two awards), Air Medal (four Strike/Flight awards), Navy Commendation Medal (two awards), Joint Service Achievement Medal, and Navy Achievement Medal (four awards). He has logged over 2,500 flight hours and 600 carrier arrested landings on six different carriers.

DEPARTMENT OF THE AIR FORCE
PRESENTATION TO THE SUBCOMMITTEE ON MILITARY PERSONNEL
COMMITTEE ON ARMED SERVICES
UNITED STATES HOUSE OF REPRESENTATIVES

SUBJECT: DEPARTMENT OF DEFENSE AND MILITARY SERVICE WOUNDED
WARRIOR PROGRAM

STATEMENT OF:

BRIGADIER GENERAL PATRICK J. DOHERTY
DIRECTOR OF SERVICES
UNITED STATES AIR FORCE

FEBRUARY 3, 2015

NOT FOR PUBLICATION UNTIL RELEASED
BY THE COMMITTEE ON ARMED SERVICES
UNITED STATES HOUSE OF REPRESENTATIVES

Thank you for the opportunity to testify before this Subcommittee on our Air Force Wounded Warrior Program. Caring for our wounded warriors remains a Secretary of the Air Force and Chief of Staff of the Air Force priority. As such, when the Office of the Secretary of Defense expanded the “Wounded Warrior” definition in 2009 to include ill and injured members, we established our support structure with a keen focus on providing a continuum of care construct that our members both need and deserve. In doing so, we currently have continuous support at all Air Force levels, and dedicated medical, personnel, and family program resources to meet the needs of our Airmen, their families and caregivers.

Since the Air Force’s last opportunity to provide Congress detailed information on our wounded warrior program, we have teamed with our members, their families, caregivers, supervisors, commanders and others, and expanded our capabilities to ensure a variety of services to meet wounded warriors’ physical, social, psychological, and family needs. Our program was developed, and continues to be enriched, based on our Air Force community. Although we provide support at all levels of the Air Force, we are convinced the strongest support for each Airman comes from their unit. To that end, we do our best to maintain our wounded, ill and injured Airmen as a part of their home unit to render an environment they are accustomed to, and allow them to continue to be as productive a member of their unit as their circumstances will allow. This approach ensures commander and first sergeant involvement and provides a structure that echoes, “You remain a valued unit member!” In those circumstances where the level of medical care an Airman requires is significant, we can assign them to an Airman

Medical Transition Unit (AMTU) to facilitate the care and treatment needed; that is the focus of AMTUs.

In 2007, we established the Air Force Wounded Warrior program to provide transition and benefit support to our Airmen with combat-related injuries. In 2009, at the direction of Congress, we established the Recovery Care Coordinator program to provide care and support to both combat wounded and non-combat ill and injured Airmen; from that point, we continued to grow and improve our programs. Based on feedback from our Airmen, the Department of Defense Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Forces, plus an Air Force commissioned study by the RAND Corporation and our own internal process reviews, we realized efficiencies could be gained by combining the Air Force Wounded Warrior and the Recovery Care Coordinator programs. Consequently, in the Fall of 2012, we consolidated the Air Force Wounded Warrior and Recovery Care Programs under the title of Air Force Wounded Warrior Program, encompassing all our seriously wounded, ill and injured Airmen, to maintain the recognized "Wounded Warrior Program" branding, and continue to provide service through an accepted and well-established system. Consolidation of the programs provides a staff of over 90 professional care managers and program managers in support of our 4,165 total force wounded, ill and injured members.

The Air Force Wounded Warrior program is our premier program for the care of our wounded, ill and injured. Our 43 Recovery Care Coordinators provide personalized support to our total force through a regional plan that supports our wounded, ill and injured, their families and caregivers throughout our Air Force communities. This regional plan enables every commander

to ensure his or her Airmen and families have the support they need, even though there may not be a Recovery Care Coordinator physically located at their installation. In addition, each base has a Community Readiness Consultant at the Airman and Family Readiness Center that provides local support to the wounded, ill and injured Airmen, their families and caregivers. Through a recovery team concept that includes the Recovery Care Coordinators, the Community Readiness Consultants, our medical personnel, unit commanders and non-medical care managers, we personalize the care and support given to each Airman enrolled in our program. This recovery team coordinates their efforts to help ensure clear understanding for the Airman and his or her family, and develops a Comprehensive Recovery Plan to help meet the needs, goals, and plans of each Airman we serve.

We also tailor our approach to care for each Airman individually. We have developed our program to be responsive and flexible to their needs because no two situations or cases are identical. Commanders at all levels understand the variation in cases and support needed, and are vital in the decision process for the overall care of Airmen. Commanders work with medical providers to understand limitations an Airman's circumstances present and how best to use the Airman in the execution of their unit's mission. We believe it is important to the psychological well-being of the Airman to ensure they feel like a contributing member of the unit. So commanders work to involve the Airman, even if it is not in the member's primary role they are accustomed to doing. Above all else, our wounded, ill and injured are still Airmen, and we want them to know we will never give up on them.

In the area of post-traumatic stress, this is obviously a challenge for our Airmen and their families and it can manifest in many ways, and may not appear for several weeks, months, or even years after the traumatic situation has occurred. Families, friends, fellow Airmen and the unit's mission are all impacted by post-traumatic stress cases. Our programs are designed to help Airmen and their commanders work through challenges and limit impacts as medical treatment and other support continue to be provided to help our members deal with this illness.

One of our more successful programs for assisting with physical, psychological, social and familial rehabilitation and recovery is our Adaptive Sports Program. In 2010, the Air Force fielded a team of 17 wounded, ill and injured Airmen to compete in the first Warrior Games where all Armed Services were represented. In 2014, we had 100 Airmen try out for the Warrior Games Team and introduced over 300 Airmen to the benefits of recreational and competitive sports. As a testament to the holistic approach to healing from this Adaptive Sports Program, one of our Airmen commented on how his daughters were finally able to be his children again because of the confidence and self-sufficiency the sporting events provided him. Adaptive sports are remarkable in that they help our wounded, ill and injured members make the best use of their current physical or mental capacity, and the program has helped countless Airmen develop a renewed sense of self-worth and inclusion as they conquer new skills, and even reach out to support one another.

We have also heard the voices of our families and caregivers and have trained our care managers that the wounds, illnesses and injuries impact the entire family. We know the pain and struggle our families have dealt with and have worked with the Office of the Secretary of Defense for

Warrior Care Policy to develop local forums for caregivers to meet and share experiences and challenges, and lean on one another for strength and support. Additionally, the Air Force developed closed social media sites for our caregivers to connect with one another across the globe in a way that ensures their privacy and allows them to discuss sensitive topics they may not otherwise be comfortable with addressing. We have designed special events for our caregivers that give them time to deal with compassion fatigue, parenting stress and the challenges of going from being a spouse to a caregiver and the head of the household. Furthermore, this year we are implementing Equine-Assisted Psychotherapy clinics for families to go to the US Air Force Academy Equine Center. Through these clinics, families can share in a common activity that supports normalization as they accept and adjust to the new lifestyle resulting from their wounds, illness or injury.

Another successful program we have in place is our Recovering Airmen Mentorship Program (RAMP). Through this program we connect Airmen-to-Airmen based on wound, injury or illness, rank, military specialty, and location. By supporting one another, our Airmen have someone that can relate to them and their circumstances. They are able to discuss treatments, challenges and expectations with someone that has experienced what they are going through. RAMP also provides mentors through our Adaptive Sports program. These mentors help Airmen just beginning in the adaptive sports program to have the courage to try. They help others determine that nothing is impossible. Anywhere Airmen can benefit from the support of one another, the RAMP connects them.

Overall our program is strong, but like any program designed to help people in need, we are constantly looking to improve at each level. While our programs were born out of the need to care for our combat wounded, we have learned that, despite how it occurs, a severe injury or illness can have devastating effects on individuals, their families, and on our Air Force. While commanders and first sergeants did their best in the past to care for Airmen under their charge, they did it without a structured program to support them. Never again. Each of our Airmen made a commitment to Integrity First, Service Before Self, and Excellence In All We Do. These are the Air Force's Core Values. They are what we expect of our Airmen...and they should expect nothing less from the Air Force when they are wounded, ill and injured. Our programs, designed to care for our wounded, ill and injured, are built around these values with the understanding their Air Force will continue to provide the level of care they need and deserve; they have earned it.

Again, thanks to the Subcommittee for the opportunity to testify before you and share information on our Air Force Wounded Warrior Program. We appreciate your continuous support and recognize it is crucial to our continued program success... Thank you!



BIOGRAPHY



UNITED STATES AIR FORCE

BRIGADIER GENERAL PATRICK J. DOHERTY

Brig. Gen. Patrick J. Doherty is the Director of Air Force Services, Headquarters U.S. Air Force, Washington, D.C. His organization's mission is to increase combat capability and improve productivity through programs promoting readiness, esprit de corps and quality of life for Airmen and their families. He provides policy, technical direction and oversight for the \$2 billion worldwide Services program, which includes Comprehensive Airman Fitness, physical fitness, peacetime and wartime troop feeding, Air Force Mortuary Affairs Operations, Armed Forces entertainment, Air Force protocol, lodging, libraries, child development centers, youth centers and a wide spectrum of recreation activities. He provides oversight for uniforms, awards and recognition, Airman and family readiness, and other commander-interest programs that contribute to military force sustainment.



General Doherty entered the Air Force in 1987 through the Air Force Reserve Officer Training Corps program at Iowa State University, Ames, where he earned a Bachelor of Science degree in aerospace engineering. He initially served as a B-52 navigator and was then selected to attend Undergraduate Pilot Training and transitioned to the F-15E. His staff experiences include serving for the J3 as the Chief of Special Technical Operations and lead crisis action planner on U.S. Forces Korea staff at Yongsan Post, Seoul, South Korea and Deputy Director, Combined Air and Space Operations Center, Southwest Asia, providing strategic and operational command and control for coalition and joint air, space, and other government agency operations. He recently served as the Commander of the 4th Fighter Wing, Seymour Johnson AFB, N.C. and Director of Assignments and Air Expeditionary Force Operations, Air Force Personnel Center, Randolph AFB, Texas.

EDUCATION

1987 Bachelor of Science degree in aerospace engineering, Iowa State University, Ames
 1992 Squadron Officer School, Maxwell AFB, Ala.
 1997 Master of Science in aerospace management, Embry-Riddle University, Daytona Beach, Fla.
 2000 Command and General Staff College, Ft. Leavenworth, Kan.
 2001 School of Advanced Military Studies, Advanced Studies Group, Fort Leavenworth, Kan.
 2001 Master of Military Art and Science, Command and General Staff College, Fort Leavenworth, Kan.
 2006 Air War College, Air University, by correspondence
 2008 Naval War College, Newport, R.I.

2008 Master of Arts in National Security and Strategic Studies, Naval War College, Newport, R.I.
 2009 U.S. Air Force Enterprise Leader Seminar, Darden School of Business, University of Virginia
 2012 National Security Studies, The Maxwell School, Syracuse University, Syracuse, N.Y.

ASSIGNMENTS

1. April 1988 - February 1989, Student, undergraduate navigator training, Mather AFB, Calif.
2. February 1989 - September 1989, Student, B-52 combat crew training school, Castle AFB, Calif.
3. October 1989 - January 1991, B-52H Navigator, 9th Bomb Squadron, Carswell AFB, Texas
4. January 1991 - January 1992, Student, undergraduate pilot training, Vance AFB, Okla.
5. February 1992 - May 1993, Plans Officer, 71st Operations Support Squadron, 71st Fighter Wing, Vance AFB, Okla.
6. May 1993 - Feb. 1994, Student, F-15E Flying Training Unit, 555th Fighter Squadron, Luke AFB, AZ
7. February 1994 - April 1997, Flight Commander/Instructor Pilot, 391st Fighter Squadron, Mountain Home AFB, Idaho
8. April 1997 - December 1998, Fighter Training Unit Instructor Pilot/Chief of Weapons, 334th Fighter Squadron, Seymour Johnson AFB, N.C.
9. December 1998 - June 1999, Chief of Courseware Development, Det .15, Air Combat Command Training Support Squadron, Seymour Johnson AFB, N.C.
10. June 1999 - June 2000, Student, Command and General Staff College, Ft. Leavenworth, Kan.
11. June 2000 - June 2001, Student School of Advanced Military Studies, Ft. Leavenworth, Kan.
12. June 2001 - June 2002, Chief, Special Technical Operations, J3 Plans, U.S. Forces Korea, Yongsan, South Korea
13. June 2002 - March 2004, Chief of Standards/Evaluation and ADO, 336th Fighter Squadron, Seymour Johnson AFB, N.C.
14. March 2004 - October 2005, Operations Officer, 335th Fighter Squadron, Seymour Johnson AFB, N.C.
15. October 2005 - June 2007, Commander, 334th Fighter Squadron, Seymour Johnson AFB, N.C.
16. July 2007 - June 2008, Student, Naval War College, Newport Naval Station, Newport, R.I.
17. August 2008 - June 2009, Combined Air and Space Operations Center Deputy Director, U.S. Air Force Central Command, Al Udeid AB, Qatar
18. July 2009 - March 2010, Vice Commander, 4th Fighter Wing, Seymour Johnson AFB, N.C.
19. April 2010 - June 2012, Commander, 4th Fighter Wing, Seymour Johnson AFB, N.C.
20. July 2012 - March 2013, Director of Assignments, Air Force Personnel Command, Randolph AFB, Texas
21. March 2013 - June 2013, Director of Assignments and Air Expeditionary Force Operations, Air Force Personnel Command, Randolph AFB, Texas
22. June 2013 - present, Director of Services, Headquarters U.S. Air Force, the Pentagon, Washington, D.C.

SUMMARY OF JOINT ASSIGNMENTS

1. June 2001 - June 2002, Chief, Special Technical Operations, J3 Plans, U.S. Forces Korea, Yongsan, South Korea
2. August 2008 - June 2009, Combined Air and Space Operations Center Deputy Director, U.S. Air Forces Central, Al Udeid AB, Qatar

FLIGHT INFORMATION

Rating: Command Pilot
 Flight hours: More than 3,800
 Aircraft flown: F-15E, T-38A, and B-52G/H

MAJOR AWARDS AND DECORATIONS

Legion of Merit
 Distinguished Flying Cross with "V" Device
 Bronze Star
 Defense Meritorious Service Medal
 Meritorious Service Medal with two oak leaf clusters
 Air Medal with one silver leaf cluster
 Aerial Achievement Medal with two leaf clusters
 Air Force Achievement Medal with oak leaf cluster
 Air Force Combat Action Medal

Joint Meritorious Unit Award
Meritorious Unit Award
Combat Readiness Medal with three oak leaf clusters
Armed Forces Expeditionary Medal
Iraq Campaign Medal
Global War on Terrorism Expeditionary Medal
Global War on Terrorism Service Medal
Korean Defense Service Medal
Armed Forces Service Medal
Honorable Order of St Barbara, U.S. Field Artillery Association-US Army/US Marine Corps

EFFECTIVE DATES OF PROMOTION

Second Lieutenant Nov. 1, 1987

First Lieutenant Nov. 1, 1989

Captain Nov. 1, 1991

Major June 1, 1999

Lieutenant Colonel Feb. 1, 2004

Colonel Sept. 1, 2008

Brigadier General Jan. 31, 2014

(Current as of February 2014)

**STATEMENT
OF
MR. PAUL D. WILLIAMSON
COMMAND ADVISOR, WOUNDED WARRIOR REGIMENT
UNITED STATES MARINE CORPS
BEFORE THE
SUBCOMMITTEE ON PERSONNEL
OF THE
HOUSE ARMED SERVICES COMMITTEE
CONCERNING
DEPARTMENT OF DEFENSE AND MILITARY SERVICE WOUNDED WARRIOR
PROGRAM UPDATE
ON
FEBRUARY 3, 2015**

NOT PUBLIC UNTIL RELEASED BY THE
HOUSE ARMED SERVICES COMMITTEE

Paul D. Williamson

Mr. Williamson began his Civil Service career in October 2001 with his appointment as President, Department of the Navy Physical Evaluation Board, Washington, DC. In December 2007 he was selected for his current position as the Command Advisor for the United States Marine Corps' Wounded Warrior Regiment.

As Command Advisor Mr. Williamson advises the Regimental Commander and other senior Marine Corps officers, to include the Commandant of the Marine Corps, on all matters related to wounded warrior and family care coordination.

Previous to his initial Civil Service appointment, Mr. Williamson completed a distinguished career of 32 years active naval service. Mr. Williamson enlisted in June 1969 and promoted to Senior Chief Petty Officer prior to his commissioning as an Ensign in April 1979 through the Navy's In-service Procurement Program. As an Administration Limited Duty Officer he held a variety of leadership and command positions at sea and ashore. Mr. Williamson retired from active duty in January 2001 as a Commander.

Mr. Williamson graduated from the University of Southern Illinois with a Bachelor's Degree.

In recognition of his outstanding performance of duty as the President, Department of the Navy Physical Evaluation Board, Mr. Williamson was awarded the Superior Civilian Service Award in 2007. In 2014 Mr. Williamson was awarded the Meritorious Civilian Service Award for his service with the Marine Corps' Wounded Warrior Regiment.

I. Introduction

Chairman Heck, Ranking Member Davis, and distinguished Members of the Subcommittee, it is my privilege to appear before you today to provide an overview on Marine Corps Warrior Care policy and procedures.

In 2007, the United States Marine Corps responded to the need for a more coordinated, thorough, and effective delivery of services for wounded, ill, and injured Marines, Sailors in units directly supporting Marines, and their families with the establishment of the Wounded Warrior Regiment. Headquartered at Marine Corps Base Quantico, the Wounded Warrior Regiment commands two battalions, located at Camp Lejeune and Camp Pendleton; 11 detachments, including overseas locations; three resource call centers, one at each battalion and one in Quantico area; and field level District Injured Support Coordinators across the nation to support reserve and transitioning Marines.

Recovery care for Marines must be enduring because the Marine Corps must always be ready at a moment's notice to care for its combat wounded during times of conflict. In addition, the Marine Corps will always have casualties as the result of wounds, injuries or illnesses incurred in service during peacetime, and it is the responsibility and moral obligation of the Marine Corps to account for their care. The Wounded Warrior Regiment maintains the expertise and resources to ensure coordinated recovery care is provided to our wounded, injured or ill. Catastrophic injuries, post-traumatic stress, traumatic brain injury, and other psychological health problems often do not present themselves until long after combat has ended and require long-term care. The need for coordinated care delivery extends beyond the impacts of combat. Historically, at any given point in time, approximately one percent of the Marine Corps' total force is in a medically-impacted duty status and referred into the Disability Evaluation System process. This

population requires ongoing case/care management to ensure they receive needed medical and non-medical care, benefits information, and transition support. We are committed to resourcing the capabilities we have established in times of war and peace. As stated in our Commandant's 2015 Planning Guidance, "Our commitment to our wounded Marines and families is unwavering."

II. Assignment / Support

Marines suffering catastrophic wounds or injuries or requiring complex care coordination for treatment of acute or chronic illnesses are typically assigned to a Wounded Warrior Regiment element during hospitalization. However, in most cases, the Marine Corps model remains that wounded, ill, or injured Marines will continue serving with their parent units so long as their commanders can ensure their medical and other recovery needs are being met. Unit commanders and medical providers of Marines requiring either acute or chronic complex care have access to a Regimental referral and assignment process. Currently, approximately 450 Marines are formally assigned to the Wounded Warrior Regiment, and approximately 475 Marines receive support while remaining with their parent units.

As with any military unit, an assigned Marine understands the primary mission - in this case, recovery from their specific illness or injury. Maintaining the structure and support of a military unit reinforces the Marine mindset that supports successful recovery and elimination of obstacles.

The Marine Corps and Regiment staff understands that an individual's physical and psychological recovery from a wound, illness, or injury is not predictable. In addition to the underlying medical conditions, many psycho-social factors must be considered by the recovery team in the development of a Marine's recovery plan. The overarching approach is a

relationship, not a process. In addition to the medical case managers, appointed by the servicing medical facility, recovering Marines joined to the Wounded Warrior Regiment are assigned a core recovery care team composed of a Recovery Care Coordinator (RCC) and Section Leader. RCCs work with the recovering Marine and family to develop a personal Comprehensive Recovery Plan following a comprehensive needs assessment. The section leader provides leadership, accountability, and motivation, which encourages a focus on ability vice disability, and helps recovering Marines manage their daily schedules to meet their recovery goals. Through the services of their recovery team, recovering Marines receive assistance with the identification of career and education opportunities; referral to other programs and federal agencies that may assist them; and advocacy as they navigate the joint DoD/VA Integrated Disability Evaluation System

Marines recovering with their parent units also have access to the resources available through the Wounded Warrior Regiment, including RCCs, mental and behavioral health counselors and Veterans Affairs professionals. Additionally, battalion call centers conduct outreach calls to those recovering Marines who are not assigned to provide assistance as necessary.

Disability retired Marines, transitioning and reserve Marines receive assistance from District Injured Support Coordinators, geographically dispersed mobilized reserve Marines. To ensure long-term care oversight, our Sergeant Merlin German Wounded Warrior Call Center provides a continuum of access by conducting an average of 9,500 outreach calls per month to Purple Heart recipients, Marines placed on the Temporary Disability Retired List, and Marine Veterans. The call center, available 24/7, also receives calls for assistance on the average of 1,200 per month.

The Marine Corps adopted this longitudinal approach to recovery care support – enabling coordinated care while on active duty as well as meaningful post-separation support – to ensure we keep faith with our Marines and meet our moral obligation to ensure necessary long-term care is provided for those who have fought in defense of our country.

III. Administration and Training

This highly effective means of providing the care and support wounded, ill, and injured Marines need requires a full team of Marines, sailors, Department of Defense civilians and contractors. The Marine Corps is dedicated to recruiting and retaining the most highly skilled and motivated Marines and civilians to serve wounded, ill, and injured Marines.

In order to facilitate timely and efficient training of warrior care staff, the Wounded Warrior Regiment developed a comprehensive training curriculum that trains our Marine staff through online modules, in-class lectures, and scenario-based discussions. The training must be completed within the first 30 days of assignment and provides an overview of the major functions and resources of the Wounded Warrior Regiment in order to ensure our cadre understands the issues affecting and resources available to wounded, ill, and injured Marines.

Additionally, Regiment leaders screen reserve Marines applying for a mobilization tour with the Wounded Warrior Regiment to ensure their personnel records and medical history do not disqualify them for mobilization as a Marine responsible for ensuring the care of recovering Marines.

A diverse work-force and complementary non-medical resources within Marine and Family Programs ensure overall success of the mission. The robust civilian force in the Marine Corps' warrior care community provides both continuity and expertise. The civilian staff includes a team of licensed clinical social workers and behavioral health specialists who are

available to advise leaders at all levels on major issues facing Marines as well as review individual case files to ensure coordinated delivery of medical and non-medical care.

IV. Assessments

The Marine Corps seeks to be a self-regulating entity; identifying issues and implementing changes that have an immediate, positive impact. Efforts to seek best practices, improved policies, and enduring resources include participation in the Recovery Warrior Task Force and Department of Defense Inspector General's Assessment of Wounded Warrior Matters. In concert with the findings of the DoD IG report, issued in August 2014, we are conducting a future requirements analysis of our Wounded Warrior Regiment's recovery care command. Results of that assessment and associated recommendations are being developed and considered. In the interim, we have developed protocols for screening personnel assigned to leadership positions within the Wounded Warrior Regiment and implemented updated training courses to address the essentials of warrior care.

The Wounded Warrior Regiment also conducts annual surveys of recovering Marines. The most recent survey, completed November 2014, included questions used to assess the overall command climate. The survey yielded highly positive responses: Section Leader Availability, 98% positive; Section Leader Frequency of Communication, 96% positive; RCC is well trained and knowledgeable, and they are sensitive to their concerns, 96% positive. Nine questions concerning the prevention of discrimination and sexual assault had favorable responses; eight of nine questions had a favorable response rate of 94% or greater.

V. Conclusion

Recovery care for our Marines must be multi-faceted and enduring. Often, the initial phase of recovery addresses physical injuries. Post-traumatic stress, traumatic brain injury, and other psychological health issues may require long-term, often acute, care. Many Marines first seek treatment for these conditions years after returning from combat when they realize they can no longer face their symptoms alone. Others transition from the Marine Corps and find themselves periodically reaching back to the Marine family who guided them through their physical recovery, in need of encouragement and focus. Warrior care resources for those wounded in combat, injured on duty, or battling a chronic illness remain consistently available. Through the Wounded Warrior Regiment, the Marine Corps offers unique capabilities in support of Marines so that an illness or injury does not preclude a meaningful career, cause the mental or emotional breakdown of a family, or worse, end a life.

To facilitate the warm hand off transition of a Marine with a permanent, severely disabling wound, illness or injury from our recovery care services and support to that provided by the Department of Veterans Affairs (VA), the Marine Corps is actively engaged with the DoD/VA Interagency Care Coordination. Embracing the two agency Secretary's vision of One Mission – One Policy – One Plan, the Marine Corps fully supports the collaborative efforts that will ensure the Marine's seamless transition to the VA.

**WITNESS RESPONSES TO QUESTIONS ASKED DURING
THE HEARING**

FEBRUARY 3, 2015

RESPONSES TO QUESTIONS SUBMITTED BY MRS. DAVIS

General DOHERTY. In 2005, we began support of our combat wounded Airmen through our Air Force Wounded Warrior Program (originally called Palace HART). In 2009, we added the Recovery Care Program to provide non-medical support to our seriously/very seriously ill and injured as well; both deployment and non-deployment related. In 2012, we combined the two programs into one, the Air Force Wounded, Ill and Injured (WII) Program, to consolidate our resources and provide standardized care.

Airmen that fall in one of the following categories are eligible for the WII Program: identified as seriously or very seriously ill or injured or combat wounded; referred to Integrated Disability Evaluation System (IDES) for Post Traumatic Stress Disorder (PTSD) or Traumatic Brain Injury (TBI); Air Reserve Component Airmen who are redeployed because of an injury or illness or who are in an active duty status and are anticipated to remain on Title 10 medical orders (serious/severe conditions) for at least six months; and Airmen assigned to a Patient Squadron and have a 9P AFSC Wounded Warrior Identifier.

Since 2005, the program has seen numerous key changes and initiatives for our Airmen and families. Our Recovery Care Coordinator (RCC) program has grown from 15 to 44 RCCs and has morphed into a regional concept to ensure all bases, including Guard and Reserve are covered by an RCC. To better serve our Airmen and their families, we developed automated case management through the Recovery Care Program–Support Solution (RCP–SS) and added technology tools (Skype, Texting, Twitter, Facetime, Facebook) to allow contact flexibility. Our Adaptive Sports program provides physical, social and psychological rehabilitative opportunities. In cooperation with OSD Office of Warrior Care Policy, our Airmen have Education and Employment support and opportunities to participate in Operation Warfighter. We also implemented programs to help alleviate financial burdens. Airmen wounded, ill or injured in support of combat operations are eligible for the Pay and Allowance Continuation program. And, to help offset a caregiver's loss of income, we have the Special Compensation for Assistance with Activities of Daily Living program. This past year, we developed special programs to support our Caregivers, focusing on peer-to-peer support, counseling, and resiliency. Annually we conduct program reviews to assess the continuum of care, validate support is on-the-mark, capture lessons learned, and continuously make improvements. [See page 23.]

Mr. WILLIAMSON. 1. The U.S. Marine Corps Wounded Warrior Regiment (WWR) was established in 2007 to provide and facilitate non-medical care to combat and non-combat wounded, ill, and injured Marines, Sailors in direct support of Marines, and their families. In 2009, Department of Defense Instruction (DODI) 1300.24 established an enduring requirement for service level recovery care coordination for all severely ill and injured service members, regardless of combat status. The WWR command is headquartered at Quantico, VA and commands two subordinate battalions and 11 detachments that provide recovery care coordination for the Marine Total Force.

2. The Marine Corps model is for Marines to recover with their parent units as long as the unit can support their recovery and return to full duty status or transition to civilian status. Marines requiring complex care coordination are joined to a WWR element either during hospitalization or through a referral made by a medical provider via the Marine's unit commander. A WWR board, composed of medical and non-medical subject matter experts evaluates each commander-endorsed referral and makes a determination based on several criteria, including: a. The Marine has injuries that will require more than 90 days of medical treatment or rehabilitation per Marine Corps Order 6320.2, Administration and Processing of Injured/Ill/Hospitalized Marines. b. The Marine has three or more appointments of complex nature per week. c. The parent command cannot support transportation requirements to the medical treatment facility. d. The Marine cannot serve a function in the parent command due to their injuries or illnesses.

As of February 2015, 501 Marines were joined to the WWR, with an additional 46 Marine in-patients and their families receiving service and support from a Regiment on-site staff.

3. Marines not rising to the level support required to be joined to a WWR element will remain with their parent units and may, based on a comprehensive needs assessment, receive external support from WWR. Support comes through Recovery Care Coordinators (RCC), battalion level contact center outreach, pay and entitlements audits and assistance, Disability Evaluation System (DES) advocacy, and transition support. As of February 2015, 374 Marines remained with their parent units while receiving, at a minimum, RCC support from the WWR.

4. The combined joined and external WWR population has shifted in recent years, with combat wounded Marines dropping by more than half since December 2012. Of the recovering service members (RSMs) currently supported by RCCs, 68% became ill or injured outside a combat zone; 13% were ill or injured in a combat zone; and 19% were combat wounded as the result of direct armed conflict with the enemy. The number of combat wounded is expected to continue to decline through FY17; the remaining population needing services will be severely ill and injured.

5. Current referral and acceptance policies for assignment to the WWR for recovery allow the commander to evaluate each case individually. Using the criteria previously set forth, the WWR is able to join each Marine whose medical/non-medical needs require complex care, regardless of the type or timing of the illness or injury, including those Marines receiving treatment for post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI). As the warrior care community gains a better understanding of PTSD and TBI, the WWR continually trains staff and cadre to recognize and support recovery from these conditions. Should the current operating policy be found inadequate in the future, the WWR will take necessary measures to ensure Marines in need and their families have access to the best possible care and resources.

6. In addition to the joined and external RCC supported Marines, there are other specific populations of WII Marines receiving support through the Regiment. The Regiment's Wounded Warrior Operations Center (WWOC) reviews every Personnel Casualty Report (PCR) and Serious Incident Report (SIR) generated by field level commanders, across the Marine Corps, to identify Marines who may require WWR assistance. If the WWOC deems appropriate, a deeper dive into the particulars of a case may be directed and may result in a direct engagement with the Marine's unit commander or the individual Marine who was the subject of those reports. Through our Battalion level contact cells and the Regiment's Sgt. Merlin German Resource and Outreach Call Center, more than 30,446 reserve Marines and Marine veterans who were disability separated or retired, and 3,338 WII Marines currently on active duty receive periodic contact to ensure their recovery needs are being properly addressed or they are receiving information on benefits and services available to them and their families. The outreach facilities generate more than 120,000 outreach and receive 14,000 incoming calls. Additionally, 741 reserve and medically retired Marines currently receive recovery care coordinator-like services through one of the Regiment's 31 field level District Injured Support Coordinators who are geographically dispersed across the nation and most often embedded within a VA Integrated Service Network (VISN) facility.

7. POC is Mr. Paul Williamson, Command Advisor, Wounded Warrior Regiment, at 703-432-1857. [See page 23.]

RESPONSES TO QUESTIONS SUBMITTED BY MR. COFFMAN

Colonel TONER. Of the 29,463 Soldiers who returned to the force, 2,056 Soldiers from all components (7%) were diagnosed with Post Traumatic Stress Disorder. Further 1,112 Soldiers of 29,463 (4%) had Post Traumatic Stress Disorder as a "primary condition". By comparison, 4,633 Soldiers (16%) had a Behavioral Health diagnosis (non-Post Traumatic Stress Disorder), and 2,833 Soldiers (10%) had a Behavioral Health diagnosis as a primary condition. [See page 11.]

Captain BREINING. As of 3 February 2015, 495 enrollees in Navy Wounded Warrior-Safe Harbor have a primary or secondary diagnosis of Posttraumatic Stress Disorder (PTSD) out of a total population size of 3,310. This equates to 15 percent of all enrollment conditions and 33 percent of illnesses. [See page 12.]

Captain BREINING. Of the 495 Navy Wounded Warrior-Safe Harbor (NWW-SH) enrollees that have a primary or secondary diagnosis of Post-Traumatic Stress Disorder (PTSD), 21 are presently in a return to duty status (4 percent).

It should be noted, however, that this return-to-duty percentage is not representative of the entire population of Navy personnel who have been diagnosed with

PTSD. Many of these personnel are enrolled in NWW-SH for serious disorders in addition to PTSD, and it is these disorders, rather than PTSD, that are preventing them from returning to duty. In addition, those personnel enrolled in NWW-SH typically suffer from more severe conditions than other patients. The vast majority of PTSD patients in the Navy are effectively treated through routine outpatient care and are never referred to NWW-SH. In the majority of cases, a diagnosis of PTSD does not necessitate separation from the service. [See page 12.]

General DOHERTY. Since the Air Force Wounded, Ill and Injured (WII) program inception in 2005, 4,246 members have been enrolled in the program (RegAF, Guard, Reserve). 45% (1,916) of the WII have PTSD, and 13% (258) of those with PTSD are still on Active Duty (RegAF, Guard, and Reserve).

Since 2005, 2.8% (54) of those with PTSD have been returned to duty. [See page 12.]

General DOHERTY. There are 1,049 Airmen on Active Duty (RegAF, Guard, and Reserve) in the Wounded, Ill or Injured program. 258 of those Airmen have PTSD; 124 combat related, and 134 non-combat related.

During verbal testimony the Army reported having 4,196 Soldiers in the Warrior Transition Unit (WTU). That number reflects those Soldiers currently assigned to the WTUs as of the date of the testimony. The Army reported that since program inception in 2007, they have provided recovery and transition support to 65,700 Soldiers. The current Army number of 4,196 Soldiers should be compared to the 1,049 Airmen still on active duty currently in our program, not the 4,246 total Airmen. [See page 13.]

RESPONSES TO QUESTIONS SUBMITTED BY MR. JONES

Colonel TONER. Of the 6,248 Soldiers previously deployed Army Active Duty Service Members assigned to the Wounded Warrior Program between October 1, 2013 to September 30, 2014, and diagnosed between October 1, 2011 to September 30, 2014, with at least one post-traumatic stress and/or traumatic brain injury condition, 6,147 (98.38%) were prescribed at least one medication, and 6,045 (96.75%) were prescribed at least one chronic maintenance medication for any medical condition at any time from October 1, 2013 to September 30, 2014. [See page 18.]

General DOHERTY. There are 1,049 Airmen on Active Duty (RegAF, Guard, and Reserve) in the Wounded, Ill or Injured program. 258 of those Airmen have PTSD; 124 combat related, and 134 non-combat related.

During verbal testimony the Army reported having 4,196 Soldiers in the Warrior Transition Unit (WTU). That number reflects those Soldiers currently assigned to the WTUs as of the date of the testimony. The Army reported that since program inception in 2007, they have provided recovery and transition support to 65,700 Soldiers. The current Army number of 4,196 Soldiers should be compared to the 1,049 Airmen still on active duty currently in our program, not the 4,246 total Airmen.

There are 1,049 Airmen on Active Duty (RegAF, Guard, and Reserve) in the Wounded, Ill or Injured program. 258 of those Airmen have PTSD; 124 combat related, and 134 non-combat related.

During verbal testimony the Army reported having 4,196 Soldiers in the Warrior Transition Unit (WTU). That number reflects those Soldiers currently assigned to the WTUs as of the date of the testimony. The Army reported that since program inception in 2007, they have provided recovery and transition support to 65,700 Soldiers. The current Army number of 4,196 Soldiers should be compared to the 1,049 Airmen still on active duty currently in our program, not the 4,246 total Airmen. [See page 19.]

QUESTIONS SUBMITTED BY MEMBERS POST HEARING

FEBRUARY 3, 2015

QUESTIONS SUBMITTED BY MR. JONES

Mr. JONES. How many service members that are in the WTUs still being medicated, in percentages?

Captain BREINING. There are currently 125 Sailors assigned to Navy Wounded Warrior-Safe Harbor (NWW-SH) who have served in Iraq or Afghanistan and were diagnosed with Posttraumatic Stress Disorder (PTSD) or Traumatic Brain Injury (TBI).

Within all of Navy Medicine, 75% of individuals diagnosed with PTSD are prescribed medications for the treatment of this diagnosed condition. Of these, 93% receive medications in accordance with DOD/VA Clinical Practice Guidelines (CPGs). A review of personnel assigned to NWW-SH indicates that their treatment is consistent with these overall numbers.

Navy Medicine closely tracks the extent to which our PTSD patients are prescribed medication, and the extent to which these prescription patterns are consistent with CPGs. Specifically, Navy Medicine conducts quarterly metrics reviews using data from the Military Health System Management Analysis and Reporting Tool (M2), as well as detailed reviews of a representative sample of medical records from multiple facilities. Our findings related to medication have been consistent each quarter. Among those seen in our Medical Treatment Facilities (MTFs), between 93 and 94% of those prescribed medication are prescribed those medications specifically recommended by CPGs. In the 5-7% of cases in which alternative medications are prescribed, these are typically used only in the short term for sleep, or to provide rapid alleviation of symptoms for a patient in acute distress.

Mr. JONES. How many service members that are in the WTUs still being medicated, in percentages?

General DOHERTY. The Air Force does not have Warrior Transition Units. Most Air Force Wounded Warriors, including those with PTSD or TBI, remain at their duty station for treatment and care at their local Air Force Military Treatment Facility (MTF) or a civilian hospital in the community. If the care Airmen require is unavailable at their duty station or if they are stationed overseas and require treatment for more than six months, they are assigned to a Patient Squadron in an Air Force MTF that provides the specialties required for their treatment.

There are approximately 2,100 Active Duty, and active Reserve and Guard members with a PTSD diagnosis. Of those, 124 are Wounded Warriors and 105 (84.7%) have had a PTSD-associated medication prescribed since 1-Jan-14. Only 11 of the Wounded Warrior Airmen with PTSD are in a Patient Squadron. These Wounded Warriors are treated under the supervision of providers at the local MTF, which monitors medications and other therapies. All Airmen with PTSD have access to medicine and psychotherapies as outlined in nationally recognized DOD/VA Clinical Practice Guidelines for the treatment of PTSD.

Mr. JONES. How many service members that are in the WTUs still being medicated, in percentages?

Mr. RODRIGUEZ. [No answer was available at the time of printing.]

Mr. JONES. How many service members that are in the WTUs still being medicated? He would like this answer in percentages

Colonel TONER. Of the 11,829 Army Active Duty Service Members assigned to the Wounded Warrior Program between October 1, 2013 to September 30, 2014, 11,519 (97.38%) were prescribed at least one medication, and 11,171 (94.44%) were prescribed at least one chronic maintenance medication for any medical condition at any time from October 1, 2013 to September 30, 2014

Mr. JONES. How many service members that are in the WTUs still being medicated, in percentages?

Mr. WILLIAMSON. As of February 2015, there were 155 Marines assigned to the USMC Wounded Warrior Regiment (WWR) who had served in Iraq or Afghanistan and were diagnosed with PTSD or TBI.

Within all of Navy Medicine, 75% of individuals diagnosed with PTSD are prescribed medications for the treatment of this diagnosed condition. Of these, approximately 93% receive medications in accordance with DOD/VA Clinical Practice Guidelines (CPGs). In the approximately 7% of remaining cases, alternative medica-

tions are prescribed, primarily for short-term sleep issues or rapid alleviation of acute symptoms. A review of personnel assigned to WWR indicates that their treatment is consistent with these overall numbers.

Navy Medicine closely tracks the extent to which our PTSD patients are prescribed medication, and the extent to which these prescription patterns are consistent with CPGs. Specifically, Navy Medicine conducts quarterly metrics reviews using data from the Military Health System Management Analysis and Reporting Tool (M2), as well as detailed reviews of a representative sample of medical records from multiple facilities. Our findings related to medication have been consistent each quarter.

