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INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
4800 MARK CENTER DRIVE
ALEXANDRIA, VIRGINIA 22350-1500

August 22, 2012

MEMORANDUM FOR DISTRIBUTION

SUBJECT: Assessment of DoD Wounded Warrior Matters – Wounded Warrior Battalion-West Headquarters and Southern California Units (Report No. DODIG-2012-120)

This report discusses the U.S. Marine Corp's Warrior Care and Transition Programs at Camp Pendleton and Twenty Nine Palms, California and is the fourth in a series of site reports that will discuss the care, management, and transition of recovering Service members.

We are providing this report for review and comment. We considered management comments on a draft of this report when preparing the final report. Some of these comments were partially responsive and require additional comments.

We request additional comments on recommendations by September 28, 2012 as follows:

- Secretary of the Navy: We request additional comments on Recommendations C.1.1., C.3.1.
- Undersecretary of Defense for Personnel and Readiness: We request additional comments on Recommendations C.9., D.1.1.
- Office of the Secretary of Defense Health Affairs: We request notification be provided as progress is made towards updates in Recommendation D.4.1.
- Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery and Navy Medicine West: We request additional comments on Recommendations D.1.2., D.1.3, D.2.1., D.2.2, D.3., and D.4.2. (a) (b).
- Commandant of the Marine Corps: We request additional comments on Recommendations A.1.2., C.2., C.3.2., C.3.3., C.4., and C.5.1.
- Deputy Commandant for Manpower and Reserve Affairs: We request additional comments on Recommendation C.6.

DOD Directive 7650.3 requires that recommendations be resolved promptly. If possible, send a .pdf file containing your comments in electronic format (Adobe Acrobat file only) to spo@dodig.mil. Copies of your comments must have the actual signature of the authorizing official for your organization. We are unable to accept the /Signed/ symbol in place of the actual signature. If you arrange to send classified comments electronically, you must send them over the SECRET Internet Protocol Router Network (SIPRNET).

We appreciate the courtesies extended to our staff during the conduct of this project. Please



A handwritten signature in cursive script that reads "K P Moorefield".

Ambassador Kenneth P. Moorefield
Deputy Inspector General
Special Plans and Operations

DISTRIBUTION:

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DEPUTY UNDERSECRETARY OF DEFENSE FOR WOUNDED WARRIOR CARE AND
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HOUSE COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

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Results in Brief: Assessment of DoD Wounded Warrior Matters – Wounded Warrior Battalion – West Headquarters and Southern California Units

What We Did

We assessed whether the Wounded Warrior Battalion-West (hereafter, WWBn-West) and appropriate supporting organizations' programs responsible for the care, management, and transition of Wounded Warriors (who include Wounded, Ill, or Injured Marines, hereafter, Warriors) located at Marine Corps Base Camp Pendleton (hereafter Camp Pendleton), Marine Corps Base Camp Twentynine Palms (hereafter Twentynine Palms), and Naval Medical Center San Diego were managed effectively and efficiently. Specifically, we evaluated the missions, policies, and processes in place to assist Warriors in their recovery and return to duty status or transition to civilian life, and the specific programs for Wounded Warriors with Traumatic Brain Injury and Post Traumatic Stress Disorder.

What We Found

We identified several initiatives implemented by WWBn-West and other identified organizations that we believed to be noteworthy practices for supporting the comprehensive care, healing, and transition of Warriors. Further, we observed that the WWBn-West leadership and staff and other identified organizations were fully dedicated to providing the best available care and services for helping Warriors heal and transition.

We also identified a number of significant challenges that we recommend the WWBn-West leadership and staff as well as other identified organizations address. Resolving these challenges will increase program effectiveness in providing quality and timely care and services in support of the Warriors' healing and transition.

Finally, we recognized as a result of this assessment, that it was important to give a voice

to the Warriors themselves. We recommend that the WWBn-West leadership and staff, as well as other identified organizations, consider Warriors' comments as discussed in this report so they are cognizant of Warriors' views and concerns and can take appropriate action.

What We Recommended

We recommend that the appropriately identified organizations:

- Implement processes to reduce lengthy Warrior transition times.
- Establish a dedicated medical officer, battalion aid station, or appropriate equivalent for WWBn-West.
- Implement policy prohibiting Warriors from serving as WWBn-West staff.
- Implement policy that appropriately accommodates Warriors' transition location preferences.
- Implement programs that enable support persons to effectively contribute to Warrior's healing and transition.
- Ensure that computer systems used to facilitate Warriors' healing and transition interface appropriately.
- Properly resource Warrior transportation requirements at Twentynine Palms.
- Ensure End of Active Duty Service Dates requirements do not interfere with Warrior healing and transition.
- Identify Warriors eligible and ineligible to transfer Post 9-11 G.I. Bill benefits.
- Develop policies and procedures for determining effective medical case manager patient loads.
- Improve policies and procedures for medication management, poly pharmacy and medication reconciliation.
- Ensure access to medical care is within established standards.

Management Comments and Our Response

Those offices listed on the recommendations table below either concurred or non-concurred with comments to our recommendations. Responses to 20 recommendations were either responsive, or partially responsive, all requiring additional comments. Therefore, we request additional comments on recommendations by September 28, 2012.

Recommendations Table

Management	Recommendations Requiring Comment	No Additional Comments Required
Undersecretary of Defense for Personnel and Readiness	C.9., D.1.1.	
Office of the Assistant Secretary of Defense, Health Affairs	D.4.1.	
Secretary of the Navy	C.1.1, C.3.1.	
Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery and Commander, Navy Medicine West	D.2.1., C.4., D.1.2., D.1.3., D.2.2, D.3., D.4.2a., D.4.2.b.	
Commandant of the Marine Corps and Commander, Wounded Warrior Regiment	A.1.2., C.2., C.3.2., C.3.3, C.4., C.5.1.	A.1.1., B.1., C.5.2. C.7.1., C.7.2., C.8.
Deputy Commandant for Manpower and Reserve Affairs	C.6	
Commander, Marine Corps Installations-West		C.8.

Please provide comments by September 28, 2012

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Introduction

Objectives

The broad objective of this ongoing assessment is to determine whether the DoD programs for the care, management, and transition of recovering Service members wounded during deployment in Operation Iraqi Freedom or Operation Enduring Freedom were managed effectively and efficiently.¹

Specific Objectives

Our specific objectives were to evaluate the missions, the policies, and processes of:

- Military units, specifically the Army and Marine Corps, established to support the recovery of Service members and their transition to duty status in Active or Reserve Components² or to civilian life; and
- DOD programs for Service members affected with Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD).

Assessment Approach

We conducted this assessment in response to a request to DoDIG made by Congressman Walter B. Jones (R-NC) in February 2010. Congressman Jones had received complaints from constituents about incidents that allegedly occurred at the Wounded Warrior Battalion-East (WWBn-East) at Camp Lejeune, North Carolina. As a result of meetings with Congressman Jones and his staff, we agreed to systematically assess Army and Marine Corps Wounded Warrior matters.

This is the fourth of six scheduled site assessments that will be conducted at Army and Marine Corps Warrior transition units. To obtain unbiased data, not unduly reflecting the views of either the supporters or detractors of the program, we used a two-pronged approach to select our respondents. First, we determined how many Service members were required to be interviewed, then we applied a simple random sample approach to determine the Service members we should interview, as described in Appendix A. For the purposes of the WWBn-West assessment we performed 68 individual and five group Warrior interviews.

Second, during our two-week Camp Pendleton visit, we spoke with all available members of the key groups responsible for the Warriors care, including unit commanders, staff officers, and WWBn-West military staff, as well as civilian staff and contractors. A list of the meetings and

¹ The Marines referred to in this assessment were wounded, ill and injured personnel who were under the responsibility of the Wounded Warrior Battalion-West in Camp Pendleton, California. The Wounded Warrior Regiment estimates that approximately 60 percent of Marines in the Wounded Warrior Battalions were combat wounded.

² The Marine Corps is a component of the United States Department of the Navy and is comprised of Active Duty Marines and Reserve Marines. The Army is comprised of two distinct and equally important components, the Regular Army (the Active Component), and the Army National Guard and the Reserve (the Reserve Components).

interviews conducted at WWBn-West, Naval Medical Center San Diego, Naval Medical Center Camp Pendleton and Naval Medical Center Twentynine Palms, along with the scope, methodology, and acronyms of this assessment are listed in Appendix A. The prior coverage of this subject area is discussed in Appendix B.

We focused our observations and corresponding recommendations on what we learned at Camp Pendleton and corresponding sites at Twentynine Palms and Naval Medical Center San Diego. However, they may have implications for other Wounded Warrior units and should be called to the attention of higher headquarters responsible for these programs.

It is important to give a “voice” to the Warriors assigned to WWBn-West and including their comments helps to illustrate our observations, discussions, conclusions and recommendations. Refer to Part III for Warriors’ remarks that amplify our observations, discussions, conclusions and recommendations.

Additional reports and/or assessments may be subsequently performed by the DoD Office of the Inspector General on DoD Wounded Warrior matters or other related issues as they are identified. A current list of specific issues, concerns, and challenges that we identified at the WWBn-West that may be addressed in future assessments and/or reports to organizations other than those located at the Army and Marine Corps installations we visited are discussed in Appendix C.

Background

U.S. Marine Corps Wounded Warrior Regiment

The 34th Commandant of the Marine Corps, Gen. James T. Conway, in his 2006 Planning Guidance, highlighted his vision of taking care of Wounded Warriors and their families. As a result, 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, and Sailors attached to or in direct support of Marine units and their family members in order to assist them to return to active duty or transition successfully to civilian life.

The Regimental Headquarters element, located in Quantico, Virginia, maintains administrative and operational control of two Wounded Warrior Battalions located at Marine Corps Base Camp Pendleton, California (WWBn-West) and Marine Corps Base Camp Lejeune, North Carolina (WWBn-East). The Regimental Headquarters provides unity of command and unity of effort through a single Commander who provides guidance, direction, and oversight to the Marine Corps Warriors non-medical care process and ensures continuous improvements to care management and the seamless transition of recovering Marines.

The mission of the WWR, according to their Promulgation Statement, is the following:

The Wounded Warrior Regiment will provide and facilitate assistance to wounded, ill, and injured Marines, Sailors attached to or in support of Marine units, and their family members, throughout the phases of recovery.

The WWR’s motto is “Still in the fight” which helps to focus a recovering Marine on “ability” vs. “disability.” The WWR strives to focus the mindset of these Warriors on their ability to overcome their disabilities and personal challenges to thrive in all areas of their lives. The WWR considers focusing on ability provides the psychological and emotional support to encourage healing and a quicker adaptation to injury and leads to an increased ability for these Warriors to thrive within their new “normal.”

Since the WWR stood up in April 2007 it has provided support to nearly 27, 377 wounded, ill, and injured Marines. This support included Call Center contact, administrative support (benefits and compensation), healthcare referral, and family support, among others. Approximately 60 percent of these Marines were wounded in combat, and 40 percent had suffered injuries not associated with combat.

As stated in the United States Marine Corps, Wounded Warrior Regiment Handbook: “Once a Marine, always a Marine” is an enduring commitment the WWR upholds. Whether Marines are wounded in combat, fall ill, or are injured in the line of duty, the WWR mission is to serve the total wounded, ill and injured force: Active Duty, Reserves, retired, and Veteran Marines.

Wounded Warrior Battalions

The Wounded Warrior Battalion-West is located at Marine Corps Base Camp Pendleton, California, while the Wounded Warrior Battalion-East is located at Marine Base Camp Lejeune, North Carolina. These battalions have Detachments located at Military Treatment Facilities (MTFs) and at Department of Veterans Affairs (VA) Polytrauma³ Rehabilitation Centers.

Table 1. Wounded Warrior Battalion Locations

Wounded Warrior Battalion - West Sites	Wounded Warrior Battalion - East Sites
Naval Medical Center San Diego, CA	Naval Hospital Camp Lejeune, NC
Naval Hospital Camp Pendleton, CA	Naval Hospital Portsmouth, VA
Naval Hospital Twentynine Palms, CA	Walter Reed National Military Medical Center, Bethesda, MD ⁴
VA Polytrauma Center, Palo Alto, CA	Andrews Air Force Base, MD
Tripler Army Medical Center, Honolulu, HI	San Antonio Military Medical Center, San Antonio, TX
Naval Hospital Okinawa, Japan	VA Polytrauma Center, Minneapolis, MN
	VA Polytrauma Center, Tampa Bay, FL
	Landstuhl Regional Medical Center, GE

³ “Polytrauma” is termed by the VA to describe injuries to multiple body parts and organs occurring as a result of blast-related wounds experienced in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Traumatic brain injury (TBI) frequently occurs as part of poly-trauma in combination with other disabilities, such as amputations, auditory and visual impairments, spinal cord injury (SCI), post-traumatic stress disorder (PTSD), and other medical conditions. Due to the severity and complexity of their injuries, Veterans and Service members with polytrauma can require an extraordinary level of coordinated and integrated clinical and other support services.

⁴ The 2005 Defense Base Realignment and Closure Commission recommended that DoD establish a new Walter Reed National Medical Center on the site of the current National Navy Medical Center in Bethesda, Maryland. The last patients at Walter Reed Army Medical Center were transported August 27, 2011 to the new location at Walter Reed National Military Medical Center.

Active and Reserve Marines and other support personnel working for the Wounded Warrior Regiment at the detachment sites are the primary interface with Warriors and their families. Specifically, through ongoing and personal interactions, they assist families with non-medical issues (e.g. pay, entitlements, travel and transportation, temporary lodging, etc.) allowing families to focus on their Warriors' recovery. Additionally, they coordinate care and resources provided by governmental agencies and non-governmental benevolent organizations including the scheduling of special event and educational opportunities.

Each detachment commander reports directly to their respective battalion commander (e.g. WWBn - East or West.) The battalion commander reports to the Wounded Warrior Regiment commander. The U.S. Marine Corps relies on the other military services, the VA, or the civilian healthcare network to provide for the medical needs of Warriors. Specifically, the healthcare provided to each Warrior is coordinated by the closest MTF or VA. These MTF or VA care teams consist of, but are not limited to, military personnel, physicians, nurses, medics/corpsmen, medical case managers, and specialty providers such as TBI and behavioral health specialists (e.g. psychiatrists, psychologists, social workers, and family counselors) and a myriad of outside organizations offering resources to the Warriors.

The WWBn detachments and MTFs provide this critical support to Warriors who are referred and meet the eligibility criteria for entrance in the WWBn. Eligibility criteria generally require that a wounded, ill, or injured Marine has a medical condition that will require 90 or more days of medical treatment and/or rehabilitation. Other considerations a commander can use to determine whether a Marine should be referred to a WWBn include the following: 1) Three or more medical appointments required per week; 2) Command cannot support transportation to and from appointments; and 3) the Marine cannot serve a function in their parent command due to his or her injuries or illness.

Personnel Support of the Wounded Warrior Battalions

There are several members of the team that support individual Warrior recovery and transition including, among others, the Warrior's Section Leader, Medical Case Manager, Primary Care Manager and Recovery Care Coordinator.

Specifically, the following is a brief description of each member's roles and responsibilities.

- **Section Leader** – is a military Service member (senior non-commissioned officer)⁵ who plays a key leadership role in supporting the Marine through the recovery process and helps them complete actions necessary to meet their transition goals as outlined in their Comprehensive Transition Plan (CTP)⁶. The Section Leader combines the discipline and standards of the Marine Corps with an understanding of the obstacles Warrior

⁵ A senior non-commissioned officer is an enlisted member of the armed forces, appointed to a rank conferring leadership over lower-ranking personnel.

⁶ The primary tool used to coordinate a recovering Marine's and their family's care is the Comprehensive Transition Plan (CTP). This plan is based on information from the Marine's recovering needs assessment, which takes into consideration various components such as employment, housing, financing, counseling, family support, disability evaluation process, among others. The CTP is referred to as a "life map" for the recovering Marine and their family and reflects their medical and non-medical goals and milestones from recovery and rehabilitation to community reintegration.

Marines face while serving as their advocate to ensure coordinated medical and non-medical recovery efforts. WWR guidelines state that the objective is for Section Leaders to support their wounded, ill and injured Marines on a 1:10 ratio. *Note: The Wounded Warrior Regiment subsequent to our visit renamed the CTP to the Comprehensive Recovery Plan (CRP) which is a framework addressing a Wounded, Ill, and Injured Marine's and family's needs through the phases of recovery, rehabilitation, and reintegration. The Wounded Warrior Regiment requested that we incorporate this new terminology, see page 133.*

- **Medical Case Manager** – is usually a civilian employee who “assesses, plans, implements, coordinates, monitors and evaluates options and services” to meet the Warriors’ complex health needs. The medical case manager helps to coordinate medical appointment schedules and other medical related activities.
- **Primary Care Manager (PCM)** – is either a military or civilian healthcare provider (e.g. physician, physician’s assistant, or nurse practitioner) who is the medical point of contact and healthcare advocate for the Warrior. Primary Care Managers provide primary oversight and continuity of healthcare and are to ensure the level of care provided is of the highest quality. They are the gateway to all specialty care (such as behavioral health specialists or orthopedic surgeons) and they coordinate with other physicians to ensure that the Warriors are getting the treatment that they need.
- **Recovery Care Coordinator (RCC)** – is usually a civilian who serves as the Warrior’s primary point of contact to help them define their individual goals for recovery, rehabilitation, and community reintegration. Additionally, the RCC identifies the services and resources needed to achieve these goals and develops the CTP (now CRP) that guides the Warrior during their transition.

Marine Corps Base Camp Pendleton, California

The mission of Camp Pendleton is to operate a training base that promotes the combat readiness of the Operating Forces and the mission of other tenant commands by providing training opportunities, facilities, services and support responsive to the needs of Marines, Sailors and their families. Camp Pendleton is the home base for the 1st Marine Expeditionary Force which comprises the 1st Marine Division, 1st Marine Logistics Group and elements of the 3rd Marine Air Wing. Camp Pendleton is also home to many tenant units, including Marine Corps Installation-West, 1st Marine Special Operations Battalion, Wounded Warrior Battalion-West, Marine Corps Air Station at Munn Field, Marine Corps Tactical Systems Support Activity, Marine Corps Recruit Depot, San Diego Weapons & Field Training Battalion, Marine Corps and Army Reserve Forces, the Navy's Assault Craft Unit Five, Naval Hospital and 1st Dental Battalion. The Naval Hospital provides primary medical care to service members and their families stationed at Camp Pendleton. The Naval Hospital Commander does not exercise command and control over the Wounded Warrior Battalion-West. Rather, the Naval Hospital Commander provides direct medical support to the Wounded Warrior Battalion-West as he does for all other units at Camp Pendleton. The Wounded Warrior Battalion-West organizational structure that supported the Warriors in the battalion is shown in Figure 1, page 6.

As of early April, 2011, the WWBn-West had approximately 166 Marines, Sailors and civilian professionals dedicated to ensuring the health, welfare, and morale of 368 Warriors assigned to WWBn-West. At the time of our assessment, 170 of these Warriors were assigned to Camp Pendleton, 131 were assigned to Naval Medical Center San Diego, 40 were assigned to Detachment Hawaii, 21 were assigned to Detachment Twentynine Palms, and six were assigned to Detachment Palo Alto. WWBn-West also tracked an additional approximately 3,229 Warriors.

WWBn-West contained an Operations Section with a Call Cell staff, Non-Medical Case Managers, and Recovery Care Coordinators (RCCs) which supported wounded, ill and injured Marines who were attached to WWBN-West but physically remained with their parent commands.

The Regiment's nerve center is the Wounded Warrior Operations Center, which serves as the central point of contact for all non-medical care management issues. The Operations Section enables the Battalion to extend support to wounded, ill or injured Marines and their families throughout the phases of recovery with a variety of services to include advocacy, resource identification, and referral into the Battalion, information distribution, and care coordination. The Call Center and Non-medical Managers reach out and support active duty Warriors who are not attached to WWBN-West and remain with their parent commands. The staff provides them with assistance on a wide variety of issues, including but not limited to: benefits and entitlements, Social Security Disability Insurance (SSDI) and TSGLI claims, GI Bill, transition assistance, charitable organization resources, and mental health outreach. The mission of the Wounded Warrior Battalion West Call Center is to support the Marine Corps Wounded Warrior Regiment's efforts in providing customer care services for marines and their families through qualitative support from an 8 hour, 5 days a week Call Center. The Call Center conducts outreach calls to active duty Warriors who remained with their parent commands or returned to their parent commands from the WWBn, receives calls for assistance, and engages in follow-on monitoring to ensure issue resolution. The Call Center's purpose is to provide customer service while ensuring the ongoing well-being of wounded, ill, and injured Marines and their families. Wounded, ill, and injured Marines and their families may contact the Call Center for advice and/or support for many issues, including:

- Benefits
- TSGLI
- Pay and Entitlements
- SSDI
- Awards (Purple Hearts)
- Veterans Administration
- GI Bill
- Employment/Education
- Psychological Health Concerns
- Traumatic Brain Injury Concerns
- Post-Traumatic Stress Disorder Concerns
- Counseling support on a variety of issues

The geographic spread of Wounded Warrior Battalion-West is greater than any other Wounded Warrior unit encountered during this project because the bulk of the Battalion is split between three separate Southern California locations. We visited the Naval Medical Center San Diego detachment of WWBn-West April 4-8, 2011 then continued with WWBn-West organization and Naval Hospital Camp Pendleton located at Camp Pendleton April 11-22, 2011. While we were at Camp Pendleton, we sent a two person team to Twentynine Palms to conduct interviews at the Naval Hospital Twentynine Palms and the WWBn-West detachment located there. During our site visits, we observed WWBn-West operations and formations, visited Warrior living quarters and WWBn-West and Camp Pendleton medical facilities, surveyed certain operations at the medical facilities, and examined pertinent documentation. We also had meetings and interviews, ranging from unit commanders and staff officers to civilian staff and contractors.

WWBn-West had a very limited number of medical personnel that directly supported the battalion. The majority of the Warriors’ medical care was provided by U.S. Navy hospitals located at Naval Medical Center San Diego, Naval Hospital Camp Pendleton and Naval Hospital Twentynine Palms, with the remainder of the needed services being coordinated by the TRICARE healthcare contractor utilizing off-base civilian healthcare providers and facilities.

Of the Warriors assigned to WWBn-West as of April 22, 2011, approximately 60 percent were combat wounded in the Iraq or Afghanistan theaters of operations.

Between April 2007 and the completion of our site visit on April 22, 2011, WWBn-West had a total of 416 Marines either currently assigned or already transitioned. Table 2 shows the status of those Warriors.

Table 2. Status of Warriors Who Transitioned through WWBn-West

Return to Duty	36
Transitioned from the U.S. Marine Corps to Civilian Life	180
Deceased	5
Discharged for Administrative or Adverse Action	3
Remain Assigned	192

NOTE: These numbers include three Marine Reservists who had transitioned through WWBn-West. All three Reservist Marines returned to duty with their Reserve Unit.

Naval Medical Center San Diego

There are approximately 250,000 people in San Diego County eligible to receive care at Naval Medical Center San Diego (NMCS), the largest academic medical center in Navy Medicine. Over 95,000 beneficiaries are enrolled for primary care and many thousands more receive specialty care. This care is provided by more than 6,600 military and civilian staff. To augment that staff and to expand the scope of services available to its patient population, Naval Medical Center San Diego has taken the lead in introducing many innovative partnership and resource sharing programs with the Veteran’s Administration and other civilian health systems and providers.

Naval Medical Center San Diego is first and foremost a military command. The center has five medical mobilization teams including the hospital ship USNS Mercy. These teams deploy to the Western Pacific and Southeast Asia at various times during the year. It is the center's mission to deliver top-quality, patient centered health care; prepare and deploy military personnel in support of combatant commander requirements; and shape the future of military medicine through education, training, and research.

Naval Hospital Camp Pendleton

Camp Pendleton is a large base comprising approximately 250 square miles located on federal land, approximately 35 miles north of San Diego and 100 miles south of Los Angeles. Naval Hospital Camp Pendleton is a 72 bed facility.

Naval Hospital Twentynine Palms

The hospital contains 22 beds but has room to expand to 37. The hospital has an Emergency Medical Department, four operating rooms, a seven-bed *Desert Beginnings* Labor Delivery Recovery and Postpartum Unit, a 15-bed Multi-Service Ward for inpatient care, and a modern full-service pharmacy, laboratory, radiology departments and physical therapy clinic.

Traumatic Brain Injury and Post Traumatic Stress Disorder

Two increasingly common diagnoses for recovering Service members were TBI⁷ and PTSD.⁸ TBI occurs when someone receives a direct blow or a jolt to their head that may disrupt the function of the brain. Service members may sustain TBIs when exposed to a blast or explosion (sometimes on multiple occasions), which may lead to serious symptoms that may not be immediately apparent. There are three different levels of TBI (mild, moderate, and severe) based on the severity of damage to the brain.

PTSD is an anxiety disorder or condition that develops after someone has experienced or witnessed a life-threatening or traumatic event, which may include a combat event. PTSD symptoms often begin immediately after the traumatic event but may not be evident until years later. A traumatic event leading to PTSD is one that most likely causes an intense emotional reaction of fear, hopelessness, or horror.

The Defense and Veterans Brain Injury Centers (DVBIC) at Naval Medical Center San Diego and Camp Pendleton typically serve service members from all branches who are stationed on the west coast to include Arizona, Southern California, Hawaii, and Nevada. Outreach services from Camp Pendleton extend to Twentynine Palms CA, Alaska, Nevada, and Fort Irwin, CA for mass TBI screenings and provider education. The DVBIC provides optimal care and treatment for service members with TBI. Service members referred to the DVBIC receive specialized TBI consultations, a comprehensive evaluation, and an individualized treatment plan. Additional services include: coordination of other specialty services, duty status determination,

⁷ The definition of TBI is from multiple sources, including "Types of Brain Injury," Brain Injury Association of America, October 15, 2008; and "Force Health Protection and Readiness Quick TBI and PTSD Facts," Force Health Protection and Readiness, October 15, 2008.

⁸ The definition of PTSD is from multiple sources, including "Force Health Protection and Readiness Quick TBI and PTSD Facts," October 15, 2008; and Jessica Hamblen, PhD, "What is PTSD?" National Center for PTSD, U.S. Department of Veterans Affairs, October 15, 2008.

and recommendations to medical boards. Additionally, Warriors suffering with a TBI are offered a wide range of classes and training to educate them about their conditions in order to facilitate their rehabilitation. Service members also have the opportunity to participate in TBI research.

The Naval Medical Center San Diego offers the Overcoming Adversity and Stress Injury Support (OASIS) program for service members who required treatment when their combat PTSD has not improved with outpatient treatment, as well as the Post Traumatic Stress Disorder Intensive Outpatient Program (PTSD IOP) program. Refer to Observation B.3., page 29.

Part I - Noteworthy Practices

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Observation A. Noteworthy Practices for Wounded Warrior Battalion - West

We observed two noteworthy practices that the Wounded Warrior Battalion-West leadership instituted with respect to providing quality services for Warriors.

A.1. Use of Free, Publicly Available Online Calendars

A.2. Internships and Educational Opportunities

These noteworthy practices may be applicable for utilization at other U.S. Marine Corps or Army Wounded Warrior locations, as well as Army Warrior Transition Units, and should be considered for implementation.

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A.1. Use of the Free, Publicly Available Online Calendars

Wounded Warrior Battalion – West integrated use of free publicly available online calendars to keep Warriors informed of medical appointments, meetings, and other Warrior transition activities. As a result, support staff and Warriors avoided potential conflicts with scheduled appointments and meetings and, in addition, Warriors had easier access to leadership guidance and other useful information regarding resources.

A.1. Background

It was recognized that internet based capabilities are integral to operations across the Department of Defense.⁹ Free publicly available online calendars are internet based capabilities in the form of time-management web applications that allow events to be stored online. Calendars can be viewed from any location that has internet access. Multiple calendars can be added and shared, allowing various levels of permissions for the users. This enables collaboration and sharing of schedules between individuals and groups.

It is required to guarantee that all wireless electronic communication transmissions of Warriors' health information¹⁰ containing individual identifiable health information,¹¹ protected health information, or electronic protected health information,¹² are in compliance with the Health Insurance Portability and Accountability Act (HIPAA).¹³ This includes each time Warriors are reminded of medical appointments by using free publicly available, internet based online calendars.

⁹ Directive-Type Memorandum (DTM) 09-026, "Responsible and Effective Use of Internet-based Capabilities" Change 3, January 9, 2012.

¹⁰ Health Information is any information, whether oral or recorded in any form or medium, that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual.

¹¹ Individually Identifiable Health Information is a subset of health information, including demographic information collected from an individual, and is created or received by a healthcare provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual; and that identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

¹² Protected Health Information is defined as individually identifiable health information, held or maintained by a covered entity or its business associates acting for the covered entity that is transmitted or maintained in any form or medium (including the individually identifiable health information of non-U.S. citizens). This includes identifiable demographic and other information relating to the past, present, or future physical or mental health or condition of an individual, or the provision or payment of healthcare to an individual that is created or received by a healthcare provider, health plan, employer, or health care clearinghouse. Electronic Protected Health Information is individually identifiable health information transmitted by electronic media and/or maintained in electronic media.

¹³The Health Insurance Portability and Accountability Act is a US law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers. Developed by the Department of Health and Human Services, these standards provide patients with access to their medical records and more control over how their personal health information is used and disclosed. They represent a uniform, federal floor of privacy protections for consumers across the country. HIPAA took effect on April 14, 2003.

The HIPAA Privacy Rule safeguards the privacy of protected health information. The HIPAA Security Rule, a subset of the HIPAA Privacy rule, safeguards electronic protected health information, which is individually identifiable health information created, received, maintained or transmitted in electronic media form by a covered entity.¹⁴

The Department of Health and Human Services issued the HIPAA Privacy Rule and subset Security Rule and has been given authority to implement and enforce both rules.¹⁵ According to this Department, the HIPAA Security Rule does not prohibit communication of individual identifiable health information or protected health information by e-mail or other electronic means. Information can be sent over wireless electronic communications as long as it is adequately protected. In general, the U.S. Department of Health and Human Services allows e-mailing information such as appointment reminders. The U.S. Department of Health and Human Services asserts that all efforts should be made to ensure e-mails containing an individual's health information:

- Only contain the minimum amount of information needed
- Are only e-mailed to confirmed addresses
- Are only e-mailed to persons who consent

The U.S. Department of Health and Human Services also has recommended that appointment reminders should include appropriate privacy notices.

A.1. Discussion

During this assessment, we observed that WWBn-West used GOOGLE, one of many free publicly available online calendars to keep Warriors, staff and support personnel informed of Warriors' medical appointments, meetings, and other activities. The Wounded Warrior Regiment explained that no policy existed that mandated the use of internet-based calendars for Warriors or staff. The Wounded Warrior Regiment stated however that the use of internet-based calendars was found to be a solid organizational tool for Wounded Warriors as well as staff at WWBN-West and was adopted as a best practice.

Regarding the proper handling of Warriors' medical information posted on internet based, online calendars, in accordance with DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 2003 and NAVMEDCENINST 6025.1, (Navy Medical Center Instruction) all Wounded Warrior staff members were held to the same Health Insurance Portability and Accountability Act requirements as Naval Medical Center and Naval Hospital Staff and the appropriate training was required for all staff members.

¹⁴ A Covered Entity is a health plan, a health care clearinghouse, or a health care provider who transmits health information in electronic form in connection with a transaction for which Health and Human Services has adopted a standard.

¹⁵ NIH Publication Number 03-5388, "Protecting Personal Health Information in Research: Understanding the HIPAA Privacy Rule," Page i.

The Wounded Warrior Battalion-West Commander stated that in regards to the use of GOOGLE calendar, Warriors posting their schedule on GOOGLE calendar was for him a “best practice.”

Additionally, one WWBn-West Company First Sergeant (E-8) explained that the use of GOOGLE calendar enabled WWBn-West staff to follow what each Warrior was doing to achieve medical recovery and facilitate transition to civilian life, when appropriate. He described GOOGLE calendar as user-friendly because it could be tracked without use of a government computer. He concluded that the use of GOOGLE calendar had been very helpful because most of the young Marines used smart-phones to maintain their schedules.

The Active Duty NCO Warriors (E-5 thru E-7) also explained that all Warriors have g-mail accounts on which they can use the GOOGLE calendar function.

Furthermore, the Recovery Care Coordinators conveyed their conviction that the use of Personal Digital Assistants had been beneficial for some Warriors and the use of its GOOGLE calendar function had enabled Warriors to effectively track and attend appointments. The Recovery Care Coordinators noted that the use of GOOGLE calendar especially helped Warriors with TBI-related memory problems to stay on schedule.

A.1. Conclusion

During our assessment, we observed that the Wounded Warrior Battalion-West had integrated the use of a free publicly available online calendar as a mechanism to keep Warriors informed of medical appointments, meetings, and other key activities. This had allowed support staff and Warriors to avoid potential conflicts with their various scheduled appointments and meetings. It also enabled easier access to leadership guidance regarding resources being made available to Warriors intended to facilitate their healing and transition.

We observed that guidance was in place that held Wounded Warrior staff members to the same Health Insurance Portability and Accountability Act (HIPAA) requirements as Naval Medical Center and Naval Hospital staff and that the appropriate training was required for all Wounded Warrior staff members. However, if the scope of the use of internet based, online applications to manage Wounded Warrior transitions increases beyond medical appointments, meetings, and other Warrior transition activities, the policies for handling electronic protected health information and compliance with the HIPAA Privacy Rule and Security Rule need to be adjusted appropriately.

A.1. Warrior Speak

Refer to Part III, A.1 for Warriors’ remarks that amplify our observations, discussions, conclusions and recommendations.

A.1 Recommendations, Management Comments, and Our Response

A.1.1. We recommend the Commander, Wounded Warrior Regiment ensure all procedures for handling electronic protected health information are compliant with HIPAA requirements.

Commandant of the Marine Corps Comments

The Commandant of the Marine Corps concurred with comment to our recommendation. The Commandant explained that the Wounded Warrior Regiment ensures HIPAA compliance to include annual personnel training requirements.

Our Response

The Commandant of the Marine Corps comments are responsive and the actions meet the intent of the recommendation. No further action is required.

A.1.2. We recommend the Commander, Wounded Warrior Regiment implement policy that ensures the use of HIPAA compliant, wireless electronic communications to notify Warriors of medical appointments is only done with the consent of the Warrior, and that the notifications contain applicable privacy notices, the minimum amount of information needed, and are only e-mailed to confirmed addresses.

Commandant of the Marine Corps Comments

The Commandant of the Marine Corps concurred with comment to our recommendation. The Commandant stated that the Wounded Warrior Regiment will implement the recommended policy regarding the handling of wireless electronic communications within 90 days.

Our Response

The Commandant's comments are responsive and the actions meet the intent of the recommendation. However, in response to the final report, we request that the Commander, Wounded Warrior Regiment provide a copy of the signed policy regarding the handling of wireless electronic communications.

A.2. Internships and Educational Opportunities

WWBn-West staff identified internships and educational opportunities for Warriors based on “end-state transition desires” and future job potential. As a result, Warriors were linked to internships and/or educational activities appropriate for their healing and transition.

A.2. Background

The current guidance for attendance in an internship, educational endeavor, or employment was established in the Wounded Warrior Regiment’s Handbook. The handbook articulated that the Wounded Warrior Regiment’s Lines of Operation Programs are: Mind, Body, Spirit, and Family. Mind encompassed internships, education, and employment. WWBn-West’s observed practice was that Marines were encouraged to participate in internships through OPERATION WAR FIGHTER, sponsored by the Department of Defense. For education, Marines were encouraged to participate in off-duty education initiatives using applicable Veterans Affairs (VA) education benefit programs, including the GI Bill, Tuition Assistance and Veterans Educational Assistance. In addition, Marines were offered opportunities to undergo vocational training utilizing on-base assets. Internships and educational opportunities were acquired and developed by the Internal Transition Office.

A.2. Discussion

During this assessment, we observed that WWBn-West made a concerted effort to have Warriors engaged in work internships and educational opportunities that were based upon Warriors’ desires and needs, but also ensured these activities were committed to a productive use of Warrior’s time in support of their recovery and their transition.

The WWBn-West Commander explained that, in regards to internships and education, all Warriors were required to submit a mandatory 30-hour workweek schedule which included internships and classes. He went on to explain that since the implementation of the 30-hour workweek schedule program, Warriors were no longer reported to be spending excessive time sitting around the barracks watching TV or playing video games.

The Active Duty Staff Sergeant Warriors (E-6) indicated in interviews that internships and educational opportunities had been based upon their professional interests and needs. The consensus of the group was that their definition of a successful transition was to “finish school so we can get a job.” Two of the Warriors in the group interview had already attended “Troops-to-Truckers”, a vocational program, and another Warrior had taken some college classes in support of his transition to civilian life.

The Active Duty Junior Enlisted Warriors (E-1 thru E-3) explained that their daily routine included 5 hours of productive time which included involvement in internships and schooling.

Furthermore, the Recovery Care Coordinators explained that most Warriors utilized their time to their best advantage with educational pursuits and internships.

A.2. Conclusion

During our assessment, we observed that the Wounded Warrior Battalion-West identified internships and educational opportunities for Warriors based on “end-state transition desires” and future job interests and potential. Warriors were linked to internships and/or educational activities appropriate for their recovery and transition. We determined that overall Warriors believed that the internships and educational opportunities available were productive.

A.2. Warrior Speak

Refer to Part III, A.2. for “Warrior Speak” that amplifies this observation.

A.2. Recommendation

This noteworthy practice may be applicable for utilization at other Wounded Warrior Battalions as well as Army Warrior Transition Units, and should be considered for prompt implementation, where appropriate.

Observation B. Noteworthy Practices for Navy Medicine Supporting Wounded Warrior Battalion-West

We observed three noteworthy practices that the leadership of Navy Medicine units supporting Wounded Warrior-West instituted with respect to providing quality services for Warriors.

B.1. Equal Access to Medical Care

B.2. Consolidation of Warrior Services

B.3. Post-Traumatic Stress Disorder Services

These noteworthy practices may be applicable for utilization at other U.S. Marine Corps Wounded Warrior locations, as well as Army Warrior Transition Units, and should be considered for implementation.

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B.1. Equal Access to Medical Care

Warriors and support staff did not report any difference in access to medical care for Active Duty and Reservists. As a result, we found no indication that medical care delivery was provided unequally between Active Duty and Reserve Wounded Warriors.

B.1. Background

In May 2010 United States Senator Ron Wyden and Congressman Kurt Schrader contacted the Inspector General, Department of Defense, concerning medical treatment entitlements available to the returning soldiers of the Oregon National Guard. They requested we investigate this issue as well as the medical treatment entitlements for Guard and Reserve soldiers at all Warrior Transition Units and mobilization and demobilization.

B.1. Discussion

During this assessment we did not find any evidence that access to medical care or medical care delivery was provided unequally to Active Duty and Reservists. Note that between April 2007 and April 2011 WWBn-West had a total of three Reservists either assigned or attached.

One Primary Care Manager (PCM) at Naval Medical Center San Diego stated there was no difference in access to medical care between Reserve and Active Duty personnel. The PCM acknowledged that there have been complaints in the past that Reservists were not getting the same quality care. In her opinion, this resulted in a lot of outside interest. She concluded by stating how she felt that Reservists' access to medical care is very good now.

The WWBn-West PCM at Naval Hospital Camp Pendleton indicated there were no differences in access to medical care services received by Active Duty and Reservists. The PCM explained that the challenges with Reservists, in regards to medical care, were primarily greater with administrative paperwork, not medical care access or delivery.

The PCMs at Naval Hospital Twentynine Palms stated that all recovering service members, regardless of status (Active Duty or a Reservist) received the same quality medical care. These PCMs also felt that there were no differences in the access to medical care between those serving in Active Duty and the Reserves.

The Nurse Case Managers at Naval Medical Center San Diego all indicated that there was no difference in access to medical care between the Active Duty and Reservist Warriors. They commented that every Warrior received any surgery they needed.

The Nurse Case Managers at Naval Medical Camp Pendleton also expressed that there was no difference in access to medical care between the Active Duty and Reservist Warriors. They explained that in reference to access for Reservists, there was effective coordination with Utilization Management to ensure everyone received required appointments.¹⁶

The Nurse Case Managers at Naval Hospital Twentynine Palms expressed that there was no difference in access to medical care between the Reservist and Active Duty Warriors. They explained that it was more difficult to manage Reservist Warriors due to requirements but assured us that the care provided was not different.

Furthermore, the Recovery Care Coordinators (RCCs) at Naval Medical Center San Diego reiterated that there was no difference in access to medical care services provided to the Active Duty and Reservist Warriors.

The Camp Pendleton RCCs also stated that there was no difference in access to medical care between the Active Duty and Reservist Warriors. The RCCs commented though, that the Reservist Warriors often had problems with their administrative paperwork.

The Naval Hospital Camp Pendleton, Traumatic Brain Injury (TBI) Clinic staff also believed that there was no difference in Active Duty and Reserve Personnel access to medical care. They added, however, that the Reservists were always challenged with more administrative paperwork as compared to Active Duty Warriors.

The WWBn-West Detachment-Twentynine Palms Medical Administration Staff Non-Commissioned Officer-in-Charge (NCOIC) and section leaders explained they had additional administrative paperwork that applied specifically to Reservist Warriors. This section tracks and manages the non-medical and medical care of wounded, ill and injured Reservist Marines. This section usually only extends Reserve Marine Warriors' orders for short periods so that they require regular renewal. Sometimes the administrative renewal process is not done correctly and a Reservist Marine will not get paid.

B.1. Conclusion

The medical and administrative personnel that we interviewed indicated equitable access to medical care was provided for Active Duty and Reservist Warriors. However, we did note that some Reservist Warriors experienced unique administrative difficulties, although there were no indications that these administrative difficulties significantly disrupted Reservists' healthcare.

B.1. Warrior Speak

Refer to Part III, B.1. for "Warrior Speak" that amplifies this observation.

¹⁶ The key elements of an effective Utilization Management process (utilization review, case management, and discharge planning) provide a basic foundation for evaluation of care and services, and development of best clinical practices such as practice guidelines, critical pathways, and clinical outcomes studies. Utilization review is a systematic evaluation of the necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. It includes reviews and evaluations of the following: 1) Prospective: Proposed admission or course of treatment. 2) Concurrent: Care while it is being provided. 3) Retrospective: Care after it is provided.

B.1. Recommendation, Management Comments, and Our Response

B.1. We recommend the Commander, Wounded Warrior Regiment ensure relevant battalion staff and administration personnel who support Reservist Warriors receive adequate training so that Reservist Warriors' recovery and transitions are not delayed or negatively affected by administrative procedures.

Commandant of the Marine Corps Comments

The Commandant of the Marine Corps concurred with comment to our recommendation. The Commandant agreed that all personnel within the Wounded Warrior Regiment and WWBn-West staff should have adequate knowledge of the unique administrative requirements of the Reservists on Medical Hold and in the Integrated Disability Evaluation System process. The Commandant explained that there is no difference between how a mobilized Reserve Marine is administratively handled in comparison to an Active Duty Marine at the end of enlistments or officer's contracts. He further explained that the Wounded Warrior Regiment provides staff reserve-specific computer-based training modules and the Regiment's virtual resource center includes information on reserve-specific issues.

Our Response

The Commandant's comments are responsive and the actions meet the intent of the recommendation. No further action is required.

B.2. Consolidation of Warrior Transition Services

Naval Hospital Camp Pendleton developed a mechanism for consolidating services vital to Warrior transition processes. As a result, key resources were co-located to advocate for and deliver Warriors services in a unified engagement to promote and expedite the Warriors' transition to civilian life.

B.2. Background

One key resource assisting Warrior recovery and transition was the Disability Evaluation System (DES)¹⁷ Attorney. The DES Attorney, per the Integrated Disability Evaluation System (IDES), ensured legal counsel was available to the Wounded Warrior at no cost.¹⁸ The DES Attorney's office supported the entire base and was not specific to the Wounded Warrior battalion even though a large number of clients were from WWBn-West.

Another key resource was the Veterans Affairs Military Service Coordinator (VA MSC). The VA MSC counsels Warriors on the VA's portion of the IDES process, help Warriors with their claim development, including the completion of VA Form 21-0819 (Parts II-IV), and determine what specific examinations and consults will be required to fully examine and document the referred and claimed medical condition(s). The MSC, depending on local arrangements, will schedule the appointments for the necessary VA Compensation and Pension examinations.

A third key resource was the Limited Duty (LIMDU) coordinator. The LIMDU coordinator was appointed by the Marine commander and serves as the command's point of contact during the IDES processing.

¹⁷ According to DoD regulations, the Disability Evaluation System should include a medical evaluation board (MEB), a physical evaluation board (PEB), an appellate review process and a final disposition. The services should assign each member a PEB liaison officer to help navigate the system. The MEB is an informal process initiated by the medical treatment facility. The MEB includes at least two active duty physicians who compile, assess and evaluate the medical history of a service member and decide whether the individual should return to duty. If the MEB determines that the member has a medical condition that is incompatible with continued military service, the case is referred to a PEB. The PEB is a formal fitness-for-duty and disability determination that may recommend one of the following four outcomes: 1) Return the member to duty; 2) Place the member on the temporary disability retired list (TDRL); 3) Separate the member from active duty, or 4) Medically retire the member. Balancing the significance of the member's condition against the requirements and duties that the service member is expected to perform determines the PEB outcome.

¹⁸ Directive-Type Memorandum (DTM) 11-015, "Integrated Disability Evaluation System (IDES)", 19 December 2011, establishes procedures for the respective Military Departments to ensure legal counsel is available to the Service Member during the IDES in accordance with the standards for legal support. In accordance with Military Department regulations, uniformed or civilian legal counsel of the Military Department concerned may, at no cost to a member, represent the member before DoD at all steps of the PEB determinations. Uniformed or civilian legal counsel of the Military Department concerned may represent a member before the VA during the pre-separation portion of the IDES process if the representative complies with part 14 of title 38, Code of Federal Regulations.

A fourth key resource important to Warrior recovery and transition was the Navy Hospital Medical Board staff. The Navy Hospital Medical Board staff was responsible for Temporary Limited Duty Boards, Medical Evaluation Boards, and Temporary Disability Retired Lists.¹⁹

A fifth key resource was the Physical Evaluations Board²⁰ Liaison Officer (PEBLO), who was responsible for evaluating all cases of potential physical disability.

In November, 2011, the Naval Hospital Camp Pendleton's Integrated Disability Evaluation System (IDES) office moved to a building less than 100 yards from the current WWBn-West barracks. The building consolidated the entire IDES team to include: the PEBLOS; both the military personnel and civilians who initiate the IDES process and the military personnel who advise service members on their ratings; the Veterans Administration Military Service Coordinator responsible to review Service members medical records and schedules Veterans Administration clinical examinations; and the IDES attorney responsible to review board packages with Service members prior to packages being signed and sent to the Physical Evaluation Board in Washington D.C., as well as assisting Service member in the event the findings are different than expected and a reconsideration or formal board hearing is requested.

¹⁹ The Naval Medical Center San Diego, Medical Boards staff is responsible for: 1) **Temporary Limited Duty Boards** (TLD) This office monitors active duty (Navy and Marine Corps) personnel who incur a condition, illness or serious injury that temporarily limits their ability to perform their assigned duties. For Navy and Marine Corps members, the period of Temporary Limited Duty (TLD) will not exceed 16 months, cumulative, before they are either returned to Full Duty or referred to the Physical Evaluation Board (PEB) for fitness to remain on active duty determination. Reserve personnel are not eligible to be placed on TLD; their cases are forwarded to the PEB to determine whether they are physically qualified to remain in a reserve status. If initial TLD is granted for 8 months, and an extension or renewal is required, the medical treatment facility shall submit the request to service headquarters (Commander, Navy Personnel Command, Millington, TN or Commandant of the Marine Corps, Quantico, VA), as appropriate. Service headquarters may approve additional TLD or direct the medical treatment facility to refer the case to the PEB. 2) **Medical Evaluation Board** (MEB) The Medical Board office processes medical evaluation boards (MEB) which are then forwarded to the Physical Evaluation Board (PEB) located at the Washington Navy Yard, Washington, DC. It is the professional judgment of the attending physician and not the decision of the service member whether a MEB should be convened. Service personnel should know that the attending physician has a responsibility to both the service member and the military branch of service to dictate a medical board when the service member has incurred a condition, illness or serious injury that is considered unfitting for further military service. The PEB, alone, determines whether or not the service member rates a disability finding. SECNAVINST 1850.4 series governs this process. 3) **Temporary Disability Retired List** (TDRL) The Medical Board office schedules service members who receive an unfit finding from the Physical Evaluation Board of 30% or greater with a TDRL reevaluation every 18 months as service headquarters may direct. The condition is considered temporary and must be evaluated periodically over a five year period in accordance with Title 10, United States Code, Section 1210.

²⁰ The PEB is a fact-finding board that evaluates all cases of physical disability on behalf of the Marine/Sailor and the Service in accordance with the Secretary of the Navy Instruction 1850.4E (Disability Evaluation Manual). The PEB investigates the nature, cause, degree of severity, and probable permanency of the disability concerning the service member referred to the board. The board evaluates the physical condition of the service member against the physical requirements of his/her particular office, grade, rank or rating. The PEB provides a full and fair hearing as required by § 1214, Title 10, United States Code (10 U.S.C 1214), and makes findings and recommendations required by law to establish the eligibility of a service member to be retained on active duty due to fitness, or separated or retired from the service because of a physical disability.

B.2. Discussion

During our assessment, we observed that Naval Hospital Camp Pendleton had co-located five key services into one central location within the hospital for ease of Warrior access, continuity, and communication. The Camp Pendleton VA MSC, Physical Evaluations Board Liaison Officer, Medical Transcription Supervisor, all considered the co-location of these services into one central location as exemplary.

The DES Attorney Advisor explained that their office and staff are co-located with the medical board office in the hospital and the co-location has turned out to be a key enabler for the Warriors. Because of the co-location, the DES attorney could establish positive working relationships with all those involved. Reportedly, this co-location has accelerated the disability process as well as improved the quality of medical board administrative packages.

Furthermore, the Nurse Case Managers initially responsible for making all appointments for Warriors explained that it had been made easier since most services were offered in a single location.

B.2. Conclusion

Co-locating five key services vital to Warriors' recovery and transition into one central location at Naval Hospital Camp Pendleton was reported to be a positive initiative. The co-location of services whose processes depended upon each other to support Warriors has enhanced their recovery and transition.

B.2. Warrior Speak

Refer to Part III, B.2. for "Warrior Speak" that amplifies this observation.

B.2 Recommendation

This noteworthy practice may be applicable for utilization at other Wounded Warrior Battalions, as well as Army Warrior Transition Units, and should be considered for prompt implementation, where appropriate.

B.3. Post-Traumatic Stress Disorder Services

Naval Medical Center San Diego offered two Post-Traumatic Stress Disorder treatment programs to assist Warriors in their recovery and transition.

B.3. Background

The Naval Medical Center San Diego implemented two programs that assisted Warriors with Post-Traumatic Stress Disorder.

One program was the *Overcoming Adversity & Stress Injury Support (OASIS)*. OASIS was a 10-week residential treatment program designed to assist Active Duty service members and Guard and Reserve service members on activated status when their combat Post Traumatic Stress Disorder (PTSD) had not improved with outpatient treatment. The program began with a comprehensive 2- week intensive stabilization process providing treatment focused solely on developing coping skills. Additionally, the program offered medication management, cognitive behavioral therapies, and intensive focus on sleep problems, group and individual therapy, vocational rehabilitation, integrative treatment approaches such as yoga and meditation, and weekly opportunities for community outreach. The goal of community outreach was interaction between Warriors and members of the local community and representatives of institutions within the local community.

The second program was the *Post Traumatic Stress Disorder Intensive Outpatient Program (PTSD IOP)*. PTSD IOP was an evidence-based 8-week therapeutic curriculum designed to help Wounded Warriors struggling with combat stress symptoms. The program began in February 2010 and was based upon research into the effects of traumatic stress. The program mirrored successful programs at Walter Reed Army Medical Center, the Department of Veterans Affairs, and Landstuhl Regional Medical Center. It emphasized the development of adaptive coping skills to include anger management, relaxation training, effective communication, parenting, and relationship skills. A family support and education group was offered each week for spouse and family members.

B.3. Discussion

The OASIS program staff explained that the program assisted Warriors with recovery from PTSD. After Warriors were discharged from OASIS, they continued with after-care meetings twice a month and received ongoing support from Armed Services YMCA and Veterans Village of San Diego, as well as collaboration with Veterans Affairs (VA) in support of vocational development.

Furthermore, the Nurse Case Managers at Naval Hospital San Diego described how the PTSD IOP program had assisted Warriors with PTSD. They explained that the PTSD IOP program was started locally by a psychologist based on a similar program at the Army hospital in Landstuhl Germany. It was a volunteer program. The program was initiated because the available Mental Health resources could not keep up with the demand for mental health services. The Defense and Veterans Brain Injury Center headquartered in Washington DC, with an office at Camp Pendleton, provided significant support.

B.3. Conclusion

During our assessment, we observed that Naval Medical Center San Diego Hospital instituted the OASIS and PTSD IOP programs for Warriors to address their PTSD issues, which has had a beneficial impact on the recovery of some Warriors.

B.3. Warrior Speak

Refer to Part III, B.3. for “Warrior Speak” that amplifies this observation.

B.3. Recommendation

This noteworthy practice may be applicable for utilization at other Wounded Warrior Battalions, as well as Army Warrior Transition Units, and should be considered for prompt implementation wherever needed.

Part II - Challenges

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Observation C. Challenges for Wounded Warrior Battalion- West

We identified nine challenges that need to be addressed by WWBn-West’s leadership and staff to help ensure the most successful and effective support for the care, healing, and transition of Warriors. These challenges are identified as follows:

- C.1. Lengthy Transition Times
- C.2. Lack of Dedicated Primary Medical Care Management for Camp Pendleton Warriors
- C.3. Use of Warriors for Battalion Staff Duties
- C.4. Consideration of Warriors Recovery and Transition Location Preferences
- C.5. Lack of Sufficient Support for Warriors Family Members and Support Persons
- C.6. Lack of Adequate Computer System Interfaces Used to Track Warrior Recovery and Transition Progress
- C.7. Travel Challenges for Warriors at Twentynine Palms
- C.8. End of Active Duty Service Dates Impact on US Government Military Identification Cards and Base Pass/Vehicle Decals Expiration Dates
- C.9. Ineligibility to Transfer Unused Post 9-11 G.I. Bill Benefits

We believe that addressing these challenges will increase the effectiveness of WWBn-West’s management and staff in providing quality and timely care and services in support of the recovering Marines and their transition.

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C.1. Lengthy Transition Time

Warriors' healing and transition was comprised of treatment, a medical board, a physical evaluation board, a transition phase, and reintegration back to military duty or to civilian status. WWBn-West Warriors spent an average of 24 months healing and transitioning which was longer than the length of time established by the Integrated Disability Evaluation System. As a result, the prolonged transition period had potential negative effects on some Warrior's healing and transition.

C.1. Background

Transition Timeline (Reference Figure 2, page 36)

The first step in the transition process is to treat the Warrior until it is determined that the Warrior has reached Optimal Medical Benefit. Optimal Medical Benefit is defined by DoD Instruction 1332.38, "Physical Disability Evaluation," November 14, 1996, as the point of hospitalization or treatment when a member's progress appears to be stabilized; or when, following administration of essential initial medical treatment, the patient's medical prognosis for being capable of performing further duty can be determined.

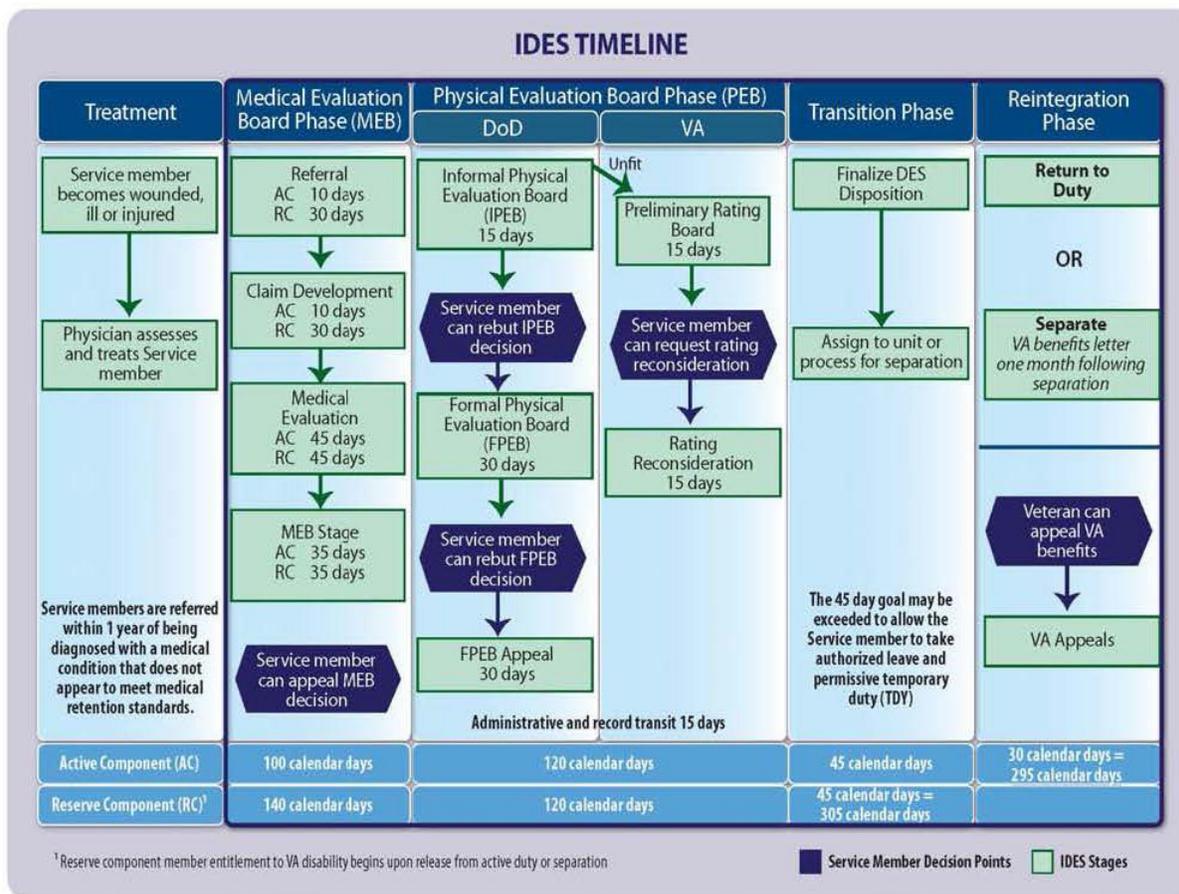
The Integrated Disability Evaluation System begins at the point it is determined a Warrior has reached Optimal Medical Benefit. The goal to complete the Integrated Disability Evaluation System is 295 calendar days for the Active Component and 305 days for the Reserve Component. To accomplish this goal the IDES is scheduled in four phases:

- Medical Evaluation Board Phase: Active Component- 100 calendar days
Reserve Component- 140 calendar days
- Physical Evaluation Board Phase: Active Component: 120 calendar days
Reserve Component: 120 calendar days
- Transition Phase: 45 calendar days (may be exceeded to allow service member to take authorized leave and/or permissive temporary duty)
- Reintegration Phase: 30 calendar days (Active Duty Only)

If at the point of Optimal Medical Care, it is determined that a Warrior cannot be returned to full duty status and his or her ability to continue military duty, even in a medically restricted status, remains in question, it is the responsibility of the medical community to refer that Warrior to a Medical Evaluation Board (MEB). On the basis of medical examinations and the Warrior's medical records, the MEB identifies and documents any conditions that may limit the Warrior's ability to serve in the military.

The Warrior's case is then evaluated by a Physical Evaluation Board (PEB) to make a determination of fitness or unfitness for duty. If the Warrior is found to be unfit due to medical conditions incurred in the line of duty, the PEB assigns a percentage rating for those unfit conditions and the Warrior is discharged.

Figure 2. Integrated Disability Evaluation System



C.1. Discussion

According to the Wounded Warrior Regiment, the average number of days a Warrior spent from the time they entered WWBn-West until they transitioned out of WWBn-West was approximately 24 months. For comparison, the average number of days a Warrior spent from the time they entered WWBn-East (the other Marine Corps transition battalion) until they transitioned out of WWBn-East was also approximately 24 months. Furthermore, the average number of days the Medical Evaluation Board took for a Warrior in WWBn-West was 197 days. For comparison, the average number of days the Medical Evaluation Board took for a Warrior in WWBn-East was 245 days. Additionally, a data review from September 2010 indicated that for 22% of all Warriors, over 3 years had passed since their original injuries with no referral to a Medical Evaluation Board or a return to duty.

In September, 2011, WWBn-West organized an Operational Planning Team to assess best-practices and shortfalls across the battalion. As a result, in February, 2012, WWBn-West Order 3010.1, “Campaign Plan,” was published in order to focus the battalion efforts and standardize processes across all five Lines of Operation, (Medical, Mind, Body, Spirit, and Family). The standardization of these processes allowed the battalion’s main effort, the Recovery Team, to

accurately track individual Warriors through the four phases of their medical recovery as well as focus all approved assets and resources on the individual Marine at the appropriate time.

In November, 2011, the Naval Hospital Camp Pendleton's Integrated Disability Evaluation System (IDES) office moved to a building less than 100 yards from the current WWBn-West barracks. The building consolidated the entire IDES team to include: the PEBLOS; both the military personnel and civilians who initiate the IDES process and the military personnel who advise service members on their ratings; the Veterans Administration Military Service Coordinator responsible to review Service members medical records and schedules Veterans Administration clinical examinations; and the IDES attorney responsible to review board packages with Service members prior to packages being signed and sent to the Physical Evaluation Board in Washington D.C., as well as assisting Service member in the event the findings are different than expected and a reconsideration or formal board hearing is requested. Additionally more leadership and administrative support was identified and hired. These actions, in conjunction with WWBn-West's diligence in ensuring that necessary documentation for the IDES process was submitted in a timely manner resulted in Camp Pendleton advancing from one of the poorest IDES performing military treatment facilities to one of the top performers within the Department of the Navy. As of May, 2012, the number of WWBn-West, Camp Pendleton Marines who have been in the MEB Phase beyond the 100 day goal is less than 5 percent.

During our assessment, we observed that the Warriors, WWBn-West staff, medical personnel and other Warrior support personnel perceived that the length of the medical board process attributed to lengthy transition times.

The Wounded Warrior Bn-West commander commented that the "long pole in the tent" is the medical board. He explained that the average time a Warrior was in his battalion was approximately 15 to 16 months. In his opinion, the ideal goal for a Warrior to heal and transition in the Warrior battalion would be 12 months.

A WWBn-West Company First Sergeant (E-8) explained that many Warriors going through the medical board process complained that the medical board process took too long.

During a group interview with the Staff Sergeant Warriors (E-6), one Warrior explained that he had to work with his Medical Board Liaison Officer (similar to a PEBLO) in San Diego for over 1 year before his medical package finally was sent in to start his medical board.

A Warrior Primary Care Manager explained that the current medical board process had to change because the requirements were too intense. She specifically cited the requirements for computed tomography scans and neuro-psychiatric testing. She went on to explain that the primary focus should be on transitioning Warriors more quickly than the current process.

The Behavioral Health team at the Camp Pendleton Deployment Health Center also referred to the medical board process as "too long."

Two Warrior Battalion volunteers with experience working with Vietnam Veterans, homeless veterans, and veterans of Iraq and Afghanistan deployments acknowledged that there were too many “trappings” in the current transition process that made it difficult for Warriors to transition.

More importantly, during our assessment we also observed that Warriors, WWBn-West staff, assigned medical personnel, and other Warrior support personnel perceived that the lengthy transition times in the Warrior battalion negatively affected some Warriors’ recovery and transition.

A Warrior Company First Sergeant (E-8) was concerned about the length of time Warriors were in the battalion. He described that his biggest challenge was how to keep the Warriors motivated during the prolonged periods they had to wait for their medical boards.

A Warrior Primary Care Manager explained that it was important to figure out how to transition Warriors in a timelier manner because, in her opinion, the longer a Warrior stayed in the Warrior battalion, the more likely a Warrior would abuse alcohol or take risks that would ultimately get them into trouble.

The TBI Clinic staff at the Naval Hospital Camp Pendleton noted that the more time Warriors spent in the “man cave” environment at the Warrior battalion, the less productive and more frustrated the Warriors became. The TBI Clinic staff said that the Warriors with whom they dealt at the Warrior battalion barracks often felt useless. The staff went on to discuss how they needed more administrative help with tracking the progress of Warriors’ paperwork, obtaining Warriors’ records, and assisting Warriors with their medical and physical evaluation boards.

It was also the opinion of the Camp Pendleton Deployment Health Center, Behavioral Health team that staying in the Warrior battalion for an extended period of time actually put Warriors at risk of having something negative happening.

According to the Recovery Care Coordinators at Camp Pendleton, free time for a Warrior with Traumatic Brain Injuries (TBI) was helpful when the Warrior was initially assigned to the Warrior battalion. They went on to explain that too much free time, which usually occurred the longer a Warrior was in transition, had negative consequences for Warriors. The Camp Pendleton Family Readiness Officer offered that she thought the longer the Warriors remained in the battalion, the sicker they became.

Two Warrior battalion volunteers with experience working with Vietnam Veterans, homeless veterans, and veterans of Iraq and Afghanistan deployments stated that they felt the current recovery and transition processes “almost enticed the Warriors to stay sick.”

C.1. Conclusion

We acknowledge the ongoing work that is conducted by the DoD, Department of Veterans Affairs, and others to rectify the multitude of issues and concerns facing the length of time it takes for processing the boards, evaluations, and paperwork required for Warriors to transition. We also acknowledge the proactive work by the WWBn-West to ensure Warriors stay engaged

in activities that enhance transition, focus on Warriors' abilities and build "Espirit de Corps" throughout the lengthy transition times. However, based on information gathered during this assessment at all levels, there was a strong belief that the lengthy transition times caused by the prolonged processing of boards, evaluations, and paperwork was contributing to a negative and even counterproductive environment for the Warriors which was not conducive to their recovery and transition.

After our assessment of Camp Lejeune, Wounded Warrior Battalion-East, we recommended that the Commander, Wounded Warrior Regiment, track each separate phase of the Integrated Disability Evaluation System (IDES) process and report each time a Warrior exceeded the prescribed timeline of an IDES phase to Deputy Commandant, Manpower and Reserve Affairs for action.

The Commanding Officer, Wounded Warrior Regiment concurred with this recommendation. The Commanding Officer explained that the Wounded Warrior Regiment currently generated a weekly brief for the Deputy Commandant, Manpower and Reserve Affairs that captured the status of Warriors in the Medical Board Evaluation and Physical Evaluation Board phases. By-name rosters of Warrior cases exceeding phase processing goals were provided bi-weekly to the Bureau of Medicine and Surgery (BUMED). The Commander further explained that there were ongoing efforts to improve IDES performance. He noted that in addition to hosting regular BUMED teleconferences with IDES stakeholders, the Deputy Commandant, Manpower and Reserve Affairs provided Marine Corps leadership with detailed IDES information, which has resulted in their ability to work closer with the Regional Medical Commanders on specific issues impacting IDES performance.

C.1. Warrior Speak

Refer to Part III, C.1. for "Warrior Speak" that amplifies this observation.

C.1. Recommendations, Management Comments, and Our Response

C.1.1. We recommend that the Secretary of the Navy take action to ensure that each phase of the Integrated Disability Evaluation System process is accomplished within the established timelines for every Warrior assigned or attached to the Wounded Warrior Battalions.

Secretary of the Navy Comments

The Secretary of the Navy provided comment to our recommendation. The Secretary explained that he is committed to ensuring the fair and timely disability evaluation of Recovering Warriors. Under the current Integrated Disability Evaluation System (IDES) structure, 295 days appears to be an unrealistic goal. The Department of the Navy (DoN) is continually reviewing staffing, procedures, and technology to implement the seamless transition of its Marines and Sailors within the IDES and reduce the average number of days to complete the processing. Recognizing portions of the IDES process are dependent on processing outside of their control, the DoN notes important accomplishments in the areas within our control.

Furthermore, the Secretary explained the IDES timeline goal of 295 days was established to reduce the legacy joint DoD/VA DES processing of 540 days. In April 2012, processing time

for USMC was 316 days and 355 days for Navy. Within the 295 day goal, there are four phases: Medical Evaluation Board (MEB) Phase (100 days); Physical Evaluation Board (PEB) Phase (120 days); Transition Phase (45 days); and VA Benefits Phase (30 days). Although DoN is meeting the MEB and PEB phase goals, they are exceeding the Transition Phase and VA Benefits Phase by an average of 22 days and 31 days respectively.

Finally, the Secretary commented that to come closer to the 295 day overall IDES goal in a fair and timely manner, the DoN has implemented the following major actions:

- Convened monthly Video Teleconferencing (VTC) involving key IDES personnel from BUMED, PEB, VA, and Service Headquarters;
- Improved staffing at MEBs in FY11 by hiring 10 doctors and 37 additional case managers for those locations needing additional, targeted support and hiring 23 additional MEB doctors in FY13 will complete resource requirements;
- Increased PEB staffing by 47 percent and leveraged a point-to-point case file transfer methodology. DoN is currently moving 75 percent of Navy and 69 percent of USMC PEB cases through the PEB Phase in less than 120 days;
- Significantly reduced average time spent in MEB Phase by leveraging existing technology to streamline development of the Narrative Summary (NARSUM). Currently, 86 percent of Navy and 73 percent of USMC cases are meeting the 100-day goal;
- Leveraged existing technologies by instituting the Electronic File transfer of all IDES cases and desk-top IT applications to build operational reporting capabilities at the MTF using the Veteran's Tracking Application (VTA);
- Presently developing a technology solution and/or process improvement between the VA and Service Headquarters regarding the DD-214 transfer to reduce Transition Phase and VA Benefits Phase time; and
- Senior leadership participation and collaboration across the DoN, within the OSD, and with the VA

More detailed information regarding the major actions being implemented are found at Appendix E, pages 138-139.

Our Response

The Secretary of the Navy's comments are responsive and meet the intent of the recommendation. However, in response to the final report, we request that the Secretary provide an update to determine if the implemented actions have made an overall improvement to the processing of Marines and Sailors in a fair and timely manner within the IDES process.

C.1.2. We recommend the Commander, Wounded Warrior Regiment implement processes to determine when Warriors' conditions improve to the point they can be released from the Wounded Warrior Battalion and complete their transition at an alternate location, as appropriate.

Commandant of the Marine Corps Comments

The Commandant of the Marine Corps non-concurred with comment to our recommendation. The Commandant explained that the Wounded Warrior Regiment has primary oversight on the non-medical care of wounded, ill, and injured Marines. This care includes transition and discharge. The Commandant further explained that generally, only the most acute cases are joined to the Wounded Warrior Regiment. Transferring a wounded, ill, or injured Marine from a Wounded Warrior Regiment to an “alternate location,” presumably another unit, would defeat the purpose of having a single unit with oversight and potentially place the wounded, ill, or injured Marine in a position of being served by a unit less prepared to assist with his or her non-medical needs.

Our Response

We acknowledge that Marine Corps Order 6320.2E, “Administrative and Processing of Hospitalized Marines,” November 1, 2007, addresses providing prompt and complete administrative assistance to injured/ill/hospitalized Marines. Furthermore, Wounded Warrior Regiment Order 6300.1A, “Administrative Procedures for Acceptance of Wounded, Ill, Injured, or Hospitalized Personnel to the Wounded Warrior Regiment,” July 27, 2011, identifies the Wounded Warrior Regiment as having primary oversight on the non-medical care of wounded, ill, and injured Marines. We consider the Commandant’s comments to be responsive and meet the intent of the recommendation. No further action is required.

C.2. Lack of Dedicated Primary Medical Care Manager for Camp Pendleton Warriors

Wounded Warriors assigned to Camp Pendleton did not have a dedicated Battalion Surgeon, Medical Officer, Battalion Aid Station or appropriate equivalent. As a result, these Warriors were assigned to a Primary Care Manager at Naval Hospital Camp Pendleton where they had to compete with other beneficiaries for access to care.

C.2. Background

A brief description of a Battalion Aid Station, Battalion Surgeon and/or Medical Officer, Primary Care Manager, and Internist are provided to clarify the operational environment in which Observation C.2. is made.

Battalion Aid Station

The mission of the Battalion Aid Station is to serve as the primary medical treatment facility for the unit, conducting sick-call and primary health services support for the battalion. The Battalion Aid Station is the focal point for all medical administrative matters for the battalion to include all Medical Boards. The Battalion Aid Station is under the direction of the Battalion Surgeon. There are usually two Medical Officers within a Battalion Aid Station, the Battalion Surgeon and the Assistant Battalion Surgeon, as well as the appropriate number of independent duty and general duty corpsmen.²¹

Battalion Surgeon and/or Medical Officer

The Battalion Surgeon or Medical Officer is a special staff officer who advises the battalion commander on matters pertaining to the medical and healthcare support of battalion personnel and supervises patient treatment, planning, and organization.²²

Primary Care Manager (PCM)

A Primary Care Manager performs routine medical duties of a general practitioner and maintains the medical welfare of patients. PCMs diagnose and treat patients suffering from diseases and disorders and conduct routine medical examinations for organic and functional diseases and abnormalities using standard tests and procedures as well as referring patients to specialty medical care and managing the overall integrated care of patients.²³

Internist

An Internist diagnoses and treats patients suffering from disease and disorders of internal organs.²⁴

²¹ United States Marine Corps Field Training Battalion-East, Camp Lejeune, Field Medical Service Technician 1501

²² United States Marine Corps Field Training Battalion-East, Camp Lejeune, Field Medical Service Technician 1501

²³ Manual of Navy Officer Manpower and Personnel Classifications, Volume I

²⁴ Manual of Navy Officer Manpower and Personnel Classifications, Volume I

C.2. Discussion

During our assessment we observed that the Warriors and WWBn-West staff perceived that the Camp Pendleton Warriors' recovery and transitioning was negatively affected because the battalion at Camp Pendleton did not have a dedicated Battalion Aid Station, dedicated PCM, or equivalent medical services support capability appropriate to support the Warriors physically located at Camp Pendleton.

During our group interview with the Active Duty Senior Enlisted Warriors (E-7 and E-8) at Camp Pendleton, they all agreed that the battalion needed a Battalion Aid Station.

Likewise, the Active Duty Staff Sergeant Warriors (E-6) at Camp Pendleton all agreed that the battalion needed its own medical officer.

The Active Duty Sergeant Warriors (E-5) at Camp Pendleton explained that the battalion needed its own medical officer and the correct number of corpsmen. They explained that because they did not have these, it took up to 3 weeks to medically in-process into the battalion and they had problems getting prescriptions filled and medical appointment referrals.

The Active Duty Corporal Warriors (E-4) at Camp Pendleton explained that the battalion needed a doctor or medical officer. One Warrior described how their current medical officer saw a lot of other base personnel so there were only two or three appointments a day for the Warriors. Another Warrior stated they got more timely care when they were back in the fleet and competed with five times as many people for appointments.

The Junior Enlisted Warriors (E-1 thru E-3) at Camp Pendleton described how they did not understand why they did not have a medical officer in the Warrior battalion.

Furthermore, one WWBn Company First Sergeant (E-8) explained that the Camp Pendleton's Warrior battalion PCM was assigned to the Navy hospital so only approximately six Warriors could be seen per week. He was concerned that there was no sick-call for the Warriors because they had no battalion surgeon and indicated that this was a problem. Another senior ranking member of the WWBn-West Command Staff stated he believed the Warrior battalion needed its own Battalion Aid Station.

Finally, the WWBn-West Commander stated that the Warrior battalion at Camp Pendleton needed its own medical officer.

According to the one PCM at Naval Hospital Camp Pendleton, he was the only PCM responsible for every one of the WWBn-West's approximately 160 Warriors at the time of the interview. He explained that he was an Internist assigned to the Naval Hospital Camp Pendleton and was responsible for the primary care for approximately 650 internal medicine patients in addition to the Warriors. Because of his patient load, he normally allotted three to four daily appointments to the Warriors. He also normally conducted four WWBn-West appointments per week to admit Warriors to the battalion.

Besides managing the Warriors' primary care and his internal medicine patients, he was responsible for covering the inpatient ward at the Naval Hospital Camp Pendleton once every 4 weeks; it used to be only once every 6 weeks but that had changed due to a decrease in the number of providers. His ward rounds averaged caring for 4 to 5 internal medicine patients as well as another 5 family practice patients. His other responsibilities required him to conduct patient rounds with the family practice providers and have indirect oversight over family practice residents. Additionally he oversaw up to six sick call appointments per day for emergencies, medication refills, and other medical needs.

During our assessment, this PCM recommended that someone other than an internal medicine provider serve as the PCM manager for the Warriors at Camp Pendleton. He explained that only ten percent of the Warriors had true internal medicine needs. He further explained that the Warriors needed their own dedicated PCM, not someone who was responsible for an entirely separate patient population besides the Warriors. He recommended that a family practice physician, physician assistant or nurse practitioner could be utilized. A "collateral" internal medicine physician, which was the current situation, was not the answer. He also suggested that having two dedicated Navy corpsman along with a dedicated physician would be sufficient to manage the primary care needs of the Warriors at Camp Pendleton.

Additionally, during our group interview with the Camp Pendleton Nurse Case Managers and Call Center staff, they agreed that if the Warriors had their own dedicated doctor (Primary Care Manager), the Nurse Case Managers would have the required access to Warriors records that they required and would have one central person with whom to coordinate Warriors' Service Members Group Life Insurance Traumatic Injury Protection Program forms. Their concern was that the current PCM worked for the Navy hospital and not the battalion. The Nurse Case Managers agreed that there needed to be a full-time PCM for the Warriors at Camp Pendleton instead of a collateral PCM which was the current arrangement. They stated that the battalion at Camp Pendleton also needs an Independent Duty Corpsman, family nurse practitioner or physician assistant, in addition. The Nurse Case Managers also said that having a dedicated PCM with support staff for the Warriors at Camp Pendleton was essential.

One Nurse Case Manager explained that it was noted by several Nurse Case Managers that there was a problem with access to care for Warriors caused by not having a dedicated PCM and offered these as typical examples:

- A Warrior had elevated blood pressure readings but it took him 2 months to see a Primary Care Manager
- A Warrior had significant sleep difficulties and it took him one and a half weeks to see a Primary Care Manager
- A Warrior had bad dermatological problems with his feet and it took him 3 weeks to see his Primary Care Manager.

Furthermore, the WWBn-West Recovery Care Coordinators at Camp Pendleton explained that the bottleneck to Warriors' access to acute and specialty care was caused by not being able to see a PCM for the referral required to obtain an acute and specialty medical care appointment. They also expressed the need for a dedicated PCM for the Camp Pendleton Warriors. They went on to describe that the Camp Pendleton's current PCM was an internal medicine doctor who had over 160 Warriors assigned during our site visit, plus an additional patient load of over 500 patients at the Navy hospital.

Also, it was the opinion of a WWBn-West Navy Corpsman that there was a problem because the Warriors did not have a dedicated PCM. In his opinion, the Warriors needed "their own guy." He further explained that the current situation was that the Warriors' current PCM at Camp Pendleton had to see other patients at the hospital. Consequently Warriors could only get three appointments per day and only two appointments per day on Tuesdays.

C.2. Conclusion

We acknowledge that Navy Medicine and Naval Hospital Camp Pendleton have made concerted efforts to provide the best possible medical care for Warriors at Camp Pendleton so they may successfully transition. However, during our assessment, we observed that the Warrior battalion at Camp Pendleton did not have the dedicated Battalion Surgeon, Medical Officer, Battalion Aid Station or other appropriate medical personnel to exclusively support the Warriors. As a result, all Warriors at Camp Pendleton were assigned to a PCM who had competing priorities at the Naval Hospital Camp Pendleton. This resulted in Warriors having to compete with other beneficiaries for access to care, caused excessive wait times for primary care appointments and reduced the time and attention available for the PCM to focus on Warrior care, thus negatively affecting Warrior healing and transitioning.

C.2. Warrior Speak

Refer to Part III, C.2. for "Warrior Speak" that amplifies this observation.

C.2. Recommendation, Management Comments, and Our Response

C.2. We recommend the Medical Officer of the Marine Corps (Health Services) identify the correct configuration for a Battalion Surgeon, Medical Officer, Battalion Aid Station or other appropriate equivalent medical services to provide dedicated Primary Care Management (PCM) support for Warriors at Camp Pendleton.

Commandant of the Marine Corps Comments

The Commandant of the Marine Corps concurred with comment to our recommendation. The Commandant explained that the Medical Officer of the Marine Corps (Health Services) will work with the Wounded Warrior Regiment, Navy Bureau of Medicine and Surgery (responsible for the in-garrison medical care missions), and other stakeholders to identify health service support manning requirements to provide health service staff functions, dedicated primary care management, and coordination of health services for Marines and Sailors at Wounded Warrior Battalion-West, as well as other Wounded Warrior units. The Commandant concluded that a proposed health services manning solution will be formulated by June 1, 2012.

Additionally, the Commander, Wounded Warrior Regiment concurred with comments in which he stated they strongly support the recommendation and will work with the Medical Officer of the Marine Corps and Navy Medicine to address the recommendation.

Navy Medicine West Comments

The Chief of Staff, Navy Medicine West non-concurred with comment to our recommendation. The Chief explained that in September 2011, the Naval Hospital Camp Pendleton embedded a Navy Primary Care Manager within WWBn-West. This Primary Care Manager's sole patient empanelment is the 220 Warriors assigned at Camp Pendleton. This contrasts with a typical civilian 'concierge' panel of 850 to 900 patients, a typical civilian empanelment of 2400 patients, or a typical military empanelment of 1300 patients. With this dedicated Naval Hospital Camp Pendleton, Primary Care Manger in the military treatment facility, the Warriors reap the benefits of enrollment within a Medical Home Port,²⁵ same-day access to primary care, secure messaging capabilities with their healthcare team, and active management of their healthcare.

Furthermore, the Chief, Navy Medicine West explained that Warriors' primary care management provided by Marine Corps Health Services personnel vice Navy Medicine and Naval Hospital Camp Pendleton would result in risk of fragmented medical care and communications challenges as the Warriors accessed specialty care within the military treatment facilities.

Our Comments

The Commandant of the Marine Corps and the Commander, Wounded Warrior Regiment's comments are responsive. However, Navy Medicine West comments are partly responsive, in that they based their non-concurrence on who would provide the dedicated primary care management for the Warriors, not how. The intent of the recommendation was to ensure provisions were considered for dedicated primary care management support for the Warriors regardless of which service provided the care (Marine vs. Navy). In response to the final report, we request that the Commandant of the Marine Corps provide a synopsis of the June 1, 2012 manning solution for health services staff functions as mentioned in his comments.

²⁵ Medical Home Port provides primary care in a way that best meets the needs of beneficiaries Medical Home Port ensures that care is all-inclusive and integrated with all other care provided within the health care system. Care delivered through Medical Home Port includes, but is not limited to, readiness, prevention, wellness, behavioral health, and disease management.

C.3. Use of Warriors for Battalion Staff Duties

The WWBn-West utilized Warriors assigned to recover and transition as Battalion staff. As a result, some of these Warriors had to partition their time between recovering, transitioning, and performing staff duties. Therefore, these Warriors risked having their recovery and transition delayed or otherwise negatively affected because they missed recovery and transition appointments and did not have adequate time to address all medical conditions.

C.3. Background

In a follow-up with the Wounded Warrior Regiment concerning its policy utilizing Warriors as staff, the Regiment's response stated that Wounded Warriors were not to be used as official battalion staff though they were permitted to perform some staff functions when those staff duties complemented their recoveries. The Regiment emphasized that Commanders know through guidance that a Warrior's recovery was his or her number one mission and staff duties are not permitted to interfere with recovery. It is the opinion of the Regiment that utilizing Warriors to augment staff was a way to enable the Warrior to assist other Warriors and to gain a sense of self-worth, as well as to ensure they were ready to transition back to duty or to civilian life.

According to the Regiment, Warriors were used to augment battalion staffs but were not identified in the Table of Organization Line Numbers (the document which prescribes the organizing, staffing, and equipping of the Warrior battalion). Warriors augmented sections in billets commensurate with their rank and abilities. Pursuant to a follow up of this assessment, the Regiment informed our team that WWBn-East and West had Warriors serving in positions such as: section leader; assistant section leader; deputy family readiness officer; assistant operations chief; operations clerk; company first sergeant; company clerk; Warrior Athletic Reconditioning Program officer-in-charge and staff-noncommissioned officer; battalion aid station corpsman; and company corpsman.

In May, 2012, the Commandant of the Marine Corps informed our team that WWBn-West had significantly improved manpower strength, most notably in the Section-Leader-to-Warrior ratio.

C.3. Discussion

While the mission of Warriors assigned to the WWBn is to heal and transition, we observed instances where Warriors were also assigned WWBn-West staff duties. There was a concern that could create a situation that made it difficult for a Warrior to successfully and timely complete his or her own recovery and transition while being responsible for other Warriors. There was also the concern that this could negatively affect Warriors when other Warriors by virtue of positions of authority had access to subordinate Warriors' medical information.

Of particular concern:

- WWBn-West utilized Warriors as First Sergeants.²⁶ These Warriors had command responsibilities as senior enlisted persons. These Warriors' responsibilities were to advise officers and discipline enlisted Marines/Warriors.
- WWBn-West utilized Warriors as Section Leaders.
 - As Section Leaders these Warriors were expected to:
 - Demonstrate the Marine Corps' core values of Honor, Courage and Commitment
 - Demonstrate integrity and sound judgment
 - Lead by example and uphold the reputation of the Marine Corps
 - Hold others accountable to Marine Corps standards 24 hours a day, seven days a week
 - Show enthusiasm in being a Marine and inspire others
 - Perform in an unsupervised capacity
 - Demonstrate situational awareness and sound judgment
 - Seek and accept responsibility for the success / failures of Warriors under their supervision
 - Take ownership of and seek assistance in dealing with difficult situations
 - Effectively communicate with and favorably relate to the Warrior population
 - Maintain a high level of mental development, emotional stability, physical readiness, and spiritual strength
 - Successfully perform in a high stress environment with Warriors who may be physically and / or mentally compromised
 - Demonstrate ability to manage personal affairs (family and marital relationships, personal finances, etc.) with maturity and judgment
 - Feel comfortable and be personable among strangers and military and civilian personnel of varying ranks and pay grades²⁷

²⁶ US Marine Corp Military Occupation Code (MOS 8999) First Sergeant: Assists the commander as senior enlisted Marine in the unit. Acts as principal enlisted assistant to the commander. Keeps apprised of all policies of the commander. Disseminates information to the unit's enlisted personnel regarding such policies. Reports to the commander on the status of matters pertaining to the efficient operation of the command. Counsels subordinate unit noncommissioned officers as required to improve the general effectiveness of the command. Interviews and counsels enlisted personnel on pertinent professional and personal matters that may affect the efficiency of the command. Assists the commander in the conduct of office hours, requests mast, and meritorious mast. Participates in ceremonies, briefings, confer commander. Assists in supervision of clerical and administrative matters; training functions and the employment of the command in garrison and in the field; logistic functions such as billeting, transportation, and messing; inspections and investigations; personnel management; and daily routine. Assumes other duties designated by the commander. Duties: (a) Communicates ideas effectively at all levels. (b) Possesses to the highest degree the faculty for working in harmony with officers, other noncommissioned officers, and civilians. (c) Possesses a comprehensive understanding of Marine Corps organization, missions, and staff procedures in units of company level. Related Classifications: Human Resources, Training, and Labor Relations Specialists.

²⁷ United States Marine Corps Wounded Warrior Regiment Handbook

- As Section Leaders, these Warriors were responsible for:
 - Providing accountability and tracking of other Warriors' progress through the Lines of Operation; Medical, Mind, Body, Spirit, Family
 - Serving as mentors and advocates for Warriors under their supervision
 - Providing small unit leadership and discipline required to help Warriors under their supervision heal mentally, physically, and emotionally²⁸
- WWBn-West utilized Warriors as corpsman. These Warriors were responsible for:
 - Conducting battalion Town Hall Meetings every Tuesday
 - Conducting battalion Post Traumatic Stress Disorder (PTSD) group sessions every Wednesday
 - Conducting Warrior administration requirements for:
 - Warrior/Patient Intakes
 - Daily Medical Records Updates
 - Medical Record Reviews
 - Conducting medical reconciliation for newly assigned Warriors with Primary Care Managers (PCMs) and pharmacists
 - Conducting quarterly Warrior medical reconciliation
 - Consulting the battalion referral board on attaching or assigning Marines to WWBn-West
 - Acting as Warrior Medical Liaison (responsibilities similar to a Nurse Case Manager)
 - Managing the Warrior Underwater Treadmill program
 - Managing the Warrior Strength program and the Comprehensive Combat Resolution program

Both Warriors and WWBn-West staff stated that it was their opinions that Warriors assigned to Warrior battalions to recover and transition should not be assigned staff duties.

The WWBn-West Commander stated that his battalion needed its own Active Duty First Sergeants who were not Warriors.

Also, Active Duty Senior Enlisted Warriors (E-7 and E-8) held the position that Warriors should not be staff because it caused problems; but they would not elaborate on the types of problems encountered.

Just as important, during our assessment we observed that the medical staff supporting the Warriors felt that Warriors assigned to Warrior battalions to recover and transition should not be diverted by being assigned staff duties.

The Wounded Warrior PCM explained that one Warrior platoon corpsman was kept busy screening sick call, other medical-related activities, driving patients, and making appointments

²⁸ United States Marine Corps Wounded Warrior Regiment Handbook

for other Warriors. He believed that using this Warrior corpsman as battalion staff was not a good practice but had resulted from a staffing shortage in the WWBn.

Additionally, the Chief Hospital Corpsman (a Master Chief Petty Officer, E-9) vehemently stated “Do not use Warrior corpsman as staff; it takes away from the corpsman’s own transition.” He went on to explain that if the battalion continued to use Warrior corpsman for staff, every effort had to be made to make sure the Warrior corpsman was stable both mentally and physically to handle the position.

One Warrior Company corpsman was asked if WWBn-West was the best place for him to recover and transition. He replied...“not both as a patient and a corpsman.” He went on to explain that he had undiagnosed problems that he had not had time to address because there were almost 200 Warriors in the battalion and as one of the only corpsmen to provide assistance to these Warriors, he was running around “like a chicken.” He went on to describe how he has missed a lot of his medical and other transition appointments because he was responsible for scheduling Warriors initial intake appointments with the PCM; performing as a Leading Petty Officer; ensuring all Warrior medical history was correct; and maintaining the monthly status report to track:

- Limited Duty Paperwork
- Physical Evaluation Board Paperwork
- Dates of Injury
- Points of Contact at last command
- Medications

He was also responsible for maintaining the weekly missed appointment sheet for all WWBn-West Warriors. The corpsman expressed that he did not like the stipulation of “must do additional duties” for corpsmen assigned to WWBn-West. He believed that this had resulted since the Navy would not make corpsman billets available for WWBn-West so the corpsmen assigned as Warriors would continue to be staff as well. At the time of the assessment there were four corpsmen Warriors in WWBn-West. Three of the four were leaving so the remaining corpsman risked having to handle the corpsmen responsibilities for the entire WWBn-West. The corpsman’s concern was that one corpsman could not handle everyone. He also explained that he believed WWBn-West overall ran a good program when it came to internships but that he worked too much and did not have enough time to take advantage of any internship opportunities.

It was the position of the Transition Center staff at the Naval Medical Center San Diego that Warriors should not be used as staff.

The WWBn-West Recovery Care Coordinators also stated that they believed that Warriors should not be staff.

C.3. Conclusion

We acknowledge that the Wounded Warrior Regiment focuses its efforts on the successful recovery and transition of its Warriors. The Regiment utilized Warriors to augment staff, believing that it enhanced Warrior transition. The Regiment gave local Commanders leeway in their authority to maintain this practice. Our observations demonstrated, however, that local opinion by WWBn-West leadership, support staff, medical personnel, and the Warriors themselves contended that this practice should not occur since it actually interfered with recovery and transition.

C.3. Warrior Speak

Refer to Part III, C.3. for “Warrior Speak” that amplifies this observation.

C.3. Recommendations, Management Comments, and Our Response

C.3.1. We recommend that the Secretary of the Navy fully staff Wounded Warrior Battalions with non-Warrior Marine Corps and Navy personnel.

Deputy Assistant Secretary of the Navy, Military Manpower and Personnel Comments

The Deputy Assistant Secretary of the Navy, Military Manpower and Personnel concurred with comment to our recommendation. The Assistant Secretary explained that staffing the Wounded Warrior Battalions is supported by existing resourcing and programming processes. He further explained that the management of the Wounded Warrior population should leverage Marine and Sailor assignment to staff positions where appropriate, particularly in support of Marines who intend to return to dull duty.

Our Response

While not agreeing to prohibit Warriors from ever serving on staff, the Deputy Assistant Secretary of the Navy, Military Manpower and Personnel comments are responsive and meet the intent of the recommendation. However, in response to the final report, and as noted in C.3.2., and C.3.3., we request that the Commandant of the Marine Corps provide the signed policy which addresses assignment of Warriors to staff positions.

C.3.2. We recommend the Commander, Wounded Warrior Regiment implement policy that Warriors assigned to Warrior battalions to recover and transition will not be assigned staff positions that require Warriors to lead or have authority over other Warriors.

C.3.3. We recommend that the Commander, Wounded Warrior Regiment implement policy that Corpsman Warriors assigned to Warrior battalions to recover and transition will not be assigned corpsman responsibilities.

Deputy Assistant Secretary of the Navy, Military Manpower and Personnel Comments

The Deputy Assistant Secretary of the Navy, Military Manpower and Personnel concurred with comment to recommendations C.3.2. and C.3.3. The Assistant Secretary explained that the Wounded Warrior Battalion will establish policy within 90 days to address this matter and allow for wounded, ill, and injured Marines to serve in staff positions only on a case-by-case basis. Depending upon the overall comprehensive transition plan of a wounded, ill, and injured Marine, as well as his/her compliance with the five Lines of Operation programs, we have established that some Marines flourish in staff positions. Staff positions provide certain wounded, ill, and injured Marines a feeling of self-worth, especially those Marines who wish to return to full duty.

Our Comments

The Deputy Assistant Secretary of the Navy, Military Manpower and Personnel comments are responsive and meet the intent of the recommendation. However, in response to the final report, we request that Commandant of the Marine Corps provide the signed policy which addresses assignment of Warriors to staff positions.

C.4. Consideration for Warriors’ Recovery and Transition Location Preferences

Warriors’ requests for alternative locations to recover and transition were not always approved. As a result, some Warriors had to recover and transition at Camp Pendleton when they felt another location either closer to home, families, and support persons or closer to future locations for residence, work and/or education would be more beneficial. Therefore, some Warriors felt they had to delay constructive, meaningful transition activities until they either transferred from Camp Pendleton to another location or separated from the Marine Corps.

C.4. Background

During a follow-up for this assessment with the Wounded Warrior Regiment, the Wounded Warrior Regiment informed our team that there was no official policy concerning where a Warrior would heal and transition. According to the Wounded Warrior Regiment, each Warrior was examined by medical doctors and Command on a case-by-case basis to determine the best location for the Warrior’s recovery and transition. The factors taken into consideration included: medical care needed, availability of treatment facilities, transition plans and goals, family location, Warrior conduct, and whether the Warrior needed a structured and/or supervised environment.

C.4. Discussion

During this assessment, Warriors expressed that their preference for alternative locations to heal and transition were not always approved.

An Active Duty Gunnery Sergeant Warrior (E-7) explained that he felt that being at the Palo Alto Veterans Affairs Poly-Trauma Center was better for him than being at Camp Pendleton. He went on to explain that he stayed at the Palo Alto medical facility for one year before being assigned to Camp Pendleton but still does most of his follow-up at Palo Alto. He was concerned that he could not stay at Palo Alto indefinitely and that it was not right that he had no choice where he got his care. He understood that the military wanted to “take care of their own” but they needed to “let go” and do what is best for the Marine.

Additionally, a Reservist Staff Sergeant Warrior (E-6) described how his family was in Phoenix, Arizona, and every time he wanted to see them he needed to spend money to travel home. He was trying to get assigned to Yuma, Arizona, so he could be closer to home. His request was to either send his whole family to Camp Pendleton or send him home. He went on to describe that during a visit home 2 weeks prior to our assessment, his wife was struggling to take care of the children and household alone while maintaining her job. He described that it felt like he was “dumping a sack of potatoes” on his wife because he could not be at home. (NOTE: Yuma Arizona is the home of Marine Corp Air Station Yuma and US Army Yuma Proving Grounds. The nearest Warrior Transition Unit is the US Army’s Fort Huachuca Warrior Transition Unit-Separate Company, which is approximately four hours from Yuma).

An Active Duty Sergeant (E-5) explained that his family owned a business and he wanted to get out of the Marine Corps as soon as possible and move on with his life. He recommended letting Warriors go on “Home Awaiting Orders” because they would be better off with their families rather than having to check in at the battalion all the time. He explained that Warriors who are not originally from the Camp Pendleton area would be better off at home with their families rather than at Camp Pendleton. He concluded by saying, “It will not work for everybody but I’d rather be with my family than here filling idle time.”

Another Active Duty Sergeant Warrior (E-5) expressed the belief that he would be better served if he was closer to his family because the separation was hard on everyone.

An Active Duty Corporal Warrior (E-4) explained that he was currently talking to his section leader to see if he could work with a Reserve unit back in his hometown in Montana to be able to start networking with police, colleges, and universities. He said he needed the face time where he plans to permanently transition and felt his transition would be better at home. He went on to explain that his Recovery Care Coordinator got him a lot of job offers from local companies in the San Diego area but that he wants to go back home and work.

An Active Duty Lance Corporal Warrior (E-3) described how he was “pretty much setting himself up for success” and that he had a job lined up at Northrop Grumman but lost it because he was waiting for his medical board to be processed. He understood that the Marine Corps want the Warriors to heal but there are other hospitals to which the Marine Corps can transfer Warriors so Warriors can maintain their care while they move on with their lives. He further explained he would be starting school on the 21st of April, 2011 for his certification, but again, really wanted to be back in Texas to do more schooling.

C.4. Conclusion

We acknowledge that the Wounded Warrior Regiment strives to consider each Warrior’s situation on a case-by-case basis to determine the best location for the Warrior to recover and transition. However, we observed that there was no official policy that identified where a Warrior could heal and transition, and that practices in place were not supportive of transition for a number of Warriors who wished to be closer to home, families, or areas where they planned to work.

C.4. Warrior Speak

Refer to Part III, C.4. for “Warrior Speak” that amplifies this observation.

C.4. Recommendation, Management Comments, and Our Response

C.4. We recommend the Commander, Wounded Warrior Regiment, implement official policy that determines the location of Warriors’ recovery and transition based on factors that include Warriors’ preferences.

Commandant of the Marine Corps Comments

The Commandant of the Marine Corps non-concurred with comment to our recommendation. The Commandant explained that Marine Corps Order 6320.2D, “Administrative and Processing of Hospitalized Marines,” and Wounded Warrior Regiment Order 6300.1A, “Administrative Procedures for Acceptance of Wounded, Ill, Injured, or Hospitalized Personnel to the Wounded Warrior Regiment,” adequately address the location preference for Warrior’s recovery and transition and that additional policy is not required to satisfy the DoD IG’s recommendation.

Our Comments

The Commandant’s comments are responsive. We acknowledge that Marine Corps Order 6320.2E, “Administrative and Processing of Hospitalized Marines,” November 1, 2007, addresses providing prompt and complete administrative assistance to injured/ill/hospitalized Marines. Additionally, enclosure (2) of that order does take into consideration whether a medical facility is close to the Marine’s parent command. Furthermore, Wounded Warrior Regiment Order 6300.1A, “Administrative Procedures for Acceptance of Wounded, Ill, Injured, or Hospitalized Personnel to the Wounded Warrior Regiment,” July 27, 2011, Section 4.c (4) (b), page 4, states that “certain considerations must be addressed prior to assignment or transferring a Marine, specifically, what is the geographic location of the family support system for the Marine.” However, in response to the final report, we request the Commandant provide any updates or additional guidance that indicates that a Marines’ preference will be taken into consideration while determining the most appropriate location for their recovery and transition.

C.5. Lack of Sufficient Support for Warriors' Family Members and Support Persons

Warrior families and other support persons did not always receive needed preparation or training to fully contribute to their Warrior's recovery and transition. Therefore, Warriors' family and support persons felt unable to fully contribute to their Warrior's healing and transition. As a result, Warriors' healing and transition risked being delayed and/or negatively affected.

C.5. Background

During this assessment we observed that agencies such as the Family Readiness Office recognized the need for more Warrior family and support person training. However, we did not observe a standardized training or support program for Warriors' families or other support persons to help assist with their Warrior's transition.

C.5. Discussion

During this assessment, we observed that Warriors and WWBn-West staff felt there were opportunities to better prepare family members and other support persons to positively contribute to their Warrior's healing and transitions.

The WWBn-West Commander noted that there was no Traumatic Brain Injury/Post-Traumatic Stress Disorder (TBI/PTSD) training for family members or other support persons. The commander recommended there be more TBI/PTSD training for family members and other support persons. The commander also recommended identifying and implementing other transition activities and opportunities for family members as well as other support persons needed to improve the Warrior healing and transition process.

An Active Duty Staff Sergeant (E-6) Warrior's spouse described how she "felt kind of lost." She described how she thought the WWBn-West needed a better orientation for the spouses because the spouses received little or no help. The Staff Sergeant described that his orientation to WWBn-West was "OK" but that there was no orientation for his spouse. The Warrior's spouse further described how there was a lack of programs for the children; especially older children. The children were left out of the healing and transition process and there was a lack of family activities that particularly involved older children. She went on to express her concern that, with regard to the spouses, their Warriors have different diagnoses, and therefore need different types of support. Her concern was that spouse and support person needs were as diverse as the Warrior needs and were not being met.

The Active Duty Sergeant Warriors (E-5) specifically identified opportunities to better prepare family members and other support persons to support their Warrior's healing and transitions. They agreed that there was a specific need to offer Parenting Classes and Family Communications Classes.

Just as important, during this assessment, we observed that WWBn-West medical and other support staff also believed that there were opportunities to better prepare family members and other support persons to contribute to their Warrior's healing and transitions.

The Primary Care Managers at Twentynine Palms would like to have seen better support for Warrior families, and the Nurse Case Managers and Call Center staff at Camp Pendleton agreed that more could be done for the families.

Additionally, the Family Support Coordinator explained that Warriors' families were often overwhelmed because they did not understand what was going on or what was going to happen with their Warriors. She went on to recommend that a program needed to be put into place that assisted Warriors, particularly family members that quit their jobs to become full-time non-medical attendants.

Furthermore, the WWBn-West Family Readiness Officer explained that there were no PTSD classes for spouses. Beginning May 2011, the Family Readiness Office began holding these monthly classes.

Two WWBn-West volunteers with prior experience working with Vietnam Veterans, homeless veterans, and Iraq and Afghanistan veterans explained that they have found that Warriors' families often do not understand their Warrior's "continuum of care" and what was available so they could assist in that continuum of care. In their opinion, Warriors' families were under-prepared and often found themselves trying to control unrealistic expectations.

C.5. Conclusion

We acknowledge that the WWBn-West's efforts are targeted at providing the best recovery and transition for the Warriors. However we observed that there were opportunities to better prepare Warrior's families and other support person to contribute to their Warrior's healing and transition so they could more effectively enable the efforts of WWBn-West.

C.5. Warrior Speak

Refer to Part III, for "Warrior Speak" that amplifies this observation.

C.5. Recommendations, Management Comments, and Our Response

C.5.1. We recommend the Commander, WWBn-West, identify all necessary programs that prepare Warriors' families and other significant care givers to fully contribute to their Warrior's recovery and transition.

Commandant of the Marine Corps Comments

The Commandant of the Marine Corps concurred with comment to our recommendation. The Commandant explained that WWBn-West has established a standardized process through the published Wounded Warrior Battalion-West Order, 3030-1, "Campaign Plan," to ensure all Marines and their families receive the same information and benefits, regardless of their location. The Commandant commented that WWBn-West is in the process of establishing or has established standardized and support programs for family members which include:

- Currently, the WWBn-West is working with the Defense and Veterans Brain Injury Clinic (DVBIC) to schedule quarterly TBI/PTSD classes for spouses and family members. WWBn-West is establishing an orientation program to introduce the families to the battalion and explain both the medical process as well as the additional program provided through the five Lines of Operations programs.
- Special Compensation for Assistance with Activities of Daily Living (SCAADL) has been implemented and the Wounded Warrior Regiment is working with the Office of the Secretary of Defense-Wounded Warrior Care and Transition Policy, to provide training to caregivers of SCAADL recipients.
- The WWBn-West Family Readiness Officer plans two family events per year that are directed toward children.
- The WWBn-West Chaplain hosts quarterly weekend “get-aways,” of which two are open to children.
- The WWBn-West Spirit Line of Operation Program Manager is currently resourcing programs and events that are child-friendly, such as a recent joint effort with the San Diego Padres.
- WWBn-West utilizes programs for children offered through Marine Corps Community Services. These programs are publicized regularly. Families Overcoming Under Stress (FOCUS) is a specific program in place to help children understand how to talk about the physical and mental injuries sustained by their parents and how to deal with their feelings associated with those injuries.
- WWBn-West has established a weekly coffee meeting dedicated to wives. Different events are discussed and questions are answered. *eMarine* was established to make sure information is always available to both the Marine and his or her family.

Furthermore, the Commandant explained that in October 2011, WWBn-West opened the Warrior Hope and Care Center which provides counseling, reconditioning, and transition services for wounded, ill, or injured Marines, Sailors and their families. The center is a 30,000 square foot structure and accommodates Wounded Warrior support ranging from Family Readiness, to Mental Health Recovery, to the Recovery Care Coordinators. The center also hosts the battalion’s Warrior Athlete Reconditioning program. More specifically, the center provides transition activities, music therapy, expressive arts education, computer labs and activities for children.

Our Response

The Commandant of the Marine Corps comments are responsive and the actions meet the intent of the recommendation. However, in response to the final report, we request that the Commandant provide a copy of the Wounded Warrior Battalion Order 3030-1, “Campaign Plan.”

C.5.2. We recommend the Commander, Wounded Warrior Regiment develop the appropriate budget, and resource and staff all appropriate programs necessary to prepare Warriors’ families and other significant care givers to fully contribute to their Warrior’s recovery and transition.

Commandant of the Marine Corps Comments

The Commandant of the Marine Corps concurred with comment to our recommendation. The Commandant explained that the Wounded Warrior Regiment’s budget reflects a commitment to ensuring wounded, ill, and injured Marines’ families and other caregivers fully contribute to their Warrior’s recovery and transition. Examples include, but are not limited to: caregiver training, the Recovery Care Coordination Program, the Wounded Warrior Regiment’s Medical Cell, Hope and Care Centers, the Wounded Warrior Regiment’s family support programs, the Wounded Warrior Call Center, and the Wounded Warrior Regiment mobile/wireless device application.

Our Response

The Commandant of the Marine Corps comments are responsive and the actions meet the intent of the recommendation. No further action is required.

C.6. Lack of Adequate Computer Interfaces Used to Track Warrior Recovery and Transition Progress

Certain computer programs used to track Warriors' recovery and transition progress did not reliably interface with each other. As a result, there were instances where Warriors' information had to be manually re-entered into multiple computer systems, potentially compromising the validity of Warrior data. Therefore, Warriors' recovery and transitions were at risk because the accuracy and continuity of data required for effective decision making concerning Warriors' recovery and preparation for transition could not be ensured.

C.6. Background

We learned during our assessment that there were computer information technology programs used to manage and track Warriors' recovery and transition processes and progress. Each program needed to interface with one or more other programs so that different persons or agencies could work in a coordinated effort to best manage Warriors' recovery and transition and make sure it remained timely. The Recovery Coordination Program needed to properly interface with the Marine Corps Wounded Ill and Injured Tracking System. The Marine Corps Wounded Ill and Injured Tracking System needed to properly interface with the Medical Board Online Tri-Service Tracking System. The following is an explanation of each of the programs

Recovery Coordination Program - Support Solution (RCP-SS)

The RCP-SS empowered Recovery Care Coordinators to provide better support to wounded warriors and their families. The Office of Wounded Warrior Care and Transition Policy worked with the Military Service Wounded Warrior programs to develop the RCP-SS, an online tool that automated Comprehensive Recovery Plan workflow and reporting for Recovery Care Coordinators. It provided secure, web-based access to all the care management, comprehensive needs assessment, and comprehensive recovery plan tools of the Recovery Coordination Program. The RCP-SS also streamlined data collection to improve Recovery Coordination Program oversight and resource management to ensure the program is sufficiently staffed and the needs of wounded, ill and injured Warriors are being met effectively and efficiently. The functions of the RCP-SS are:

- Online access to all necessary care management forms.
- Elimination of duplicative, hand-written paperwork.
- Interface capability with other case management systems already in use across the military services.
- Quality control capabilities through the tracking of met and unmet recovering service member goals.
- Transparent reporting on the needs of recovering service members and families, which allows care coordinators and the Services' Wounded Warrior Programs to develop best practices.²⁹

²⁹ The Office of Wounded Warrior Care and Transition Policy

Marine Corps Wounded Ill and Injured Tracking System (MCWIITS)

The Marine Corps Wounded, Ill, and Injured Tracking System (MCWIITS) was the official record-of-actions taken to support Warriors. It was the system used to coordinate Warriors' non-medical transition efforts. MCWIITS allowed everyone supporting Warriors' non-medical transition efforts to share notes on progress. Section Leaders, Recovery Care Coordinators, Family Support Coordinators, Call Center Representatives and others contributed notes to MCWIITS and based their actions on the notes of others.

Medical Board Online TriService Tracking System (MedBolts)

The Medical Board Online Tri-Service Tracking System (MedBolts) tracked all aspects of Medical Evaluation Boards (MEBs) and Medical Evaluation Board Reports. MedBolt's Patient Administration function was responsible for maintaining longitude accuracy of the system for Physical Evaluation Board (PEBs) final findings and limited-duty cases throughout a Marine's career and across all military treatment facilities as well as returned-to-full-duty entries. MedBolts provided views of all current and historical MEBs and was vital to assisting Service headquarters and parent commands with appropriate personnel management.³⁰

For background, we have included a copy of a point paper in Figure 3, page 48, that a Limited Duty Coordinator had drafted at the time of the assessment. Although only in draft form at the time of our assessment and technical in nature, it outlines the MedBolts to MCWIITS interface problem and makes it clear that people involved with the Wounded Warriors were already taking actions to identify and remedy data collection and interface problems affecting the Warriors' recovery and transition.

³⁰ See www.med.navy.mil/bumed/CaseManagement/Pages/lesson11.aspx, "IT Systems Tools Related to Case Management, *MedBolts: Medical Board Online Tri-Service Tracking System.*"

Figure 3. Draft MedBolts to MCWIITS Interface Problem Letter

Problem:

The Limited Duty Program should be consolidated on MedBolts to allow all Unit Limited Duty Coordinators, Military Treatment Facility Medical Boards (Patient Administration), and MMSR-4 (The Disability Section, Separation and Retirement Branch, Personnel Management Division, Manpower and Reserve Affairs Department, Headquarters United States Marine Corps) to use, upload, and update necessary information through a single database.

Background:

Currently, MedBolts is updated by Patient Administration and the paperwork is supposed to be mailed to the Marine's command. The main problem is that commands do not always receive the paperwork on a timely basis. This paperwork is the required/proper source document that places Marines on Limited Duty, processes Marines through Physical Evaluation Boards, or return Marines to full duty status. If the commands do not receive this paperwork on a timely basis, then the Installation Personnel Administration Center S-1 (IPAC/S-1) (Administrative Office) cannot update the Marine's Limited Duty status. Often, this paperwork seems to get lost or misrouted, and it must be re-mailed or the Limited Duty Coordinator must physically go to Patient Administration to retrieve it. Cases requiring the approval of higher headquarters must be faxed or e-mailed by Patient Administration to MMSR-4. This system could be streamlined and made more efficient. The information regarding Limited Duty and Physical Evaluation Boards in MedBolts does not always match the information in the Marine Corps Total Force System.

Discussion:

Under the current system, commands do not always receive on a timely basis the Limited Duty paperwork they need. If the relevant Limited Duty documents were to be uploaded to MedBolts and the Unit Limited Duty Coordinators had the ability to retrieve the documents themselves, the problems listed above would be alleviated because the Unit Limited Duty Coordinator would have direct access. Moreover, this would allow all parties to directly access Limited Duty paperwork even when the Marine had come from another military treatment facility or command.

In addition, if higher headquarters' approval process was within MedBolts, the process would be streamlined, all packages could be tracked efficiently, and Unit Limited Duty Coordinators would have the ability to see where in the process the request for approval is or to upload any necessary documents directly (e.g., Non-Medical Assessment or documents pertaining to legal /administrative action). If, upon approval from MMSR-4, an approval letter was uploaded or was automatically generated in MedBolts, the command would have the ability to directly access it in MedBolts.

Finally, MedBolts should be linked to MCTFS so that duty limitation codes are automatically updated or Limited Duty Coordinators and IPAC S-1 should be able to use "official" MedBolts reports to run Limited Duty and Physical Evaluation Board statuses in MCTFS. A "Return-to-Full Duty" official MedBolts report should be added to MedBolts so that Limited Duty Coordinators and IPAC S-1 can process that information in MCTFS. This will save paper, time, and will preserve the Marine's privacy.

Conclusion:

Consolidating the Limited Duty System within MedBolts would increase both its efficiency and its effectiveness. For such a system to function, access to MedBolts would be mandatory for all Limited Duty Coordinators. Unit Limited Duty Coordinators would have better visibility on the progress and status of limited duty cases and would have more efficient communication with both Patient Administration and MMSR-4.

Observation D.4., page 89 of this report, addresses Composite Health Care System/Host interface problems and Composite Health Care System/Armed Forces Health Longitudinal Technology Application interface problems, which are the responsibility of the Office of the Assistant Secretary of Defense for Health Affairs and Commander, Navy Medicine-West.

C.6. Discussion

During our assessment the WWBn-West Commander expressed his concern that there were too many data bases and information-technology systems used to track and/or manage Warriors' recovery and transition and that many of the programs did not interface with each other. He explained that this was one reason metrics and numbers that could potentially be used to manage recovery and transition processes were not easily accessible. In his opinion, this directly affected the quality of care, continuity of care, and efficient uses of manpower.

The first interface problem that was revealed during our assessment was that the RCP-SS did not properly interface with MCWIITS. The ramifications of this interface problem were that Recovery Care Coordinators had to manually enter Warriors' information from MCWITTS into RCP-SS and make duplicate entries into the RCP-SS to ensure the status of Warrior cases were properly documented program-wide.

The Recovery Care Coordinators (RCCs) explained that the RCP-SS "needed to be tweaked." The Recovery Care Coordinators all agreed there was duplication with the RCP-SS and that it did not properly interface with MCWIITS and other important computer programs. One RCC stated that he had been involved with review of the RCP-SS web based system and had already talked with appropriate offices at the Office of the Secretary of Defense-level (OSD). There were also conversations between the RCCs on how they had to use a shell-document for resources such as Warrior contact information, and then had to "cut-and-paste" the information into different computer systems so the information was identical. This made keeping the information accurate and up-to-date in every computer system a challenge. The RCCs mentioned that the Federal Recovery Coordinators (FRCs) had a web-based program that was a good system and easier to use than RCP-SS. The RCCs agreed that it would be more effective for the Marines to use the same system as the FRCs so that there would be better continuity as the duty status of Warriors shift from a RCC as active duty members to a FRC when they are no longer active duty.

Furthermore, the WWBn-West S-1 (Administration Officer) and S-3 (Operations Officer) explained that that they did not have access to RCP-SS through their MCWIITS. They also explained that the RCCs were having issues because RCP-SS was not pulling information from MCWIITS like it was supposed to; therefore RCP-SS was not an effective tool.

The second interface problem revealed during our assessment was that the MCWITTS did not properly interface with MedBolts. MedBolts did not properly update MCWITTS when Navy Medical Patient Administrative offices entered a Marine's Limited Duty Status into MedBolts. As a result, Navy Medical Administration offices had to mail Marines' Limited Duty Statuses in paper form to the Marine's S-1/Administrative office, which risked delaying the start of the Marine's Physical Evaluation Board (PEB).

It was the opinion of the Regional Limited Duty Coordinator that the system was “messed up and nothing seemed to mesh.” The Regional Limited Duty Coordinator expressed that there were too many points in the system that could cause failure of the system as a whole. He explained that MedBolts was the system the Navy Medicine uses to track patients and it should mirror the information in the Marine Corps Total Force System, but it did not.

C.6. Conclusion

Staff members responsible for tracking and managing Warriors’ recoveries and transitions expressed concern about the timeliness, accuracy, and therefore the usefulness of the information provided by the IT applications. This may be due to the lack of direct IT interface between the applications which required data to be manually transferred between systems or to be printed and mailed between agencies. The lack of direct interface between the IT applications increased risk of data corruption through human error which, in turn, might delay Warriors’ recovery and transitions.

C.6. Warrior Speak

Refer to Part III, C.6. for “Warrior Speak” that amplifies this observation.

C.6. Recommendation, Management Comments, and Our Response

C.6. We recommend the Deputy Commandant for Manpower and Reserve Affairs determine the requirements of all necessary computer-based and web-based systems and all interfaces required to support Marine Corps Wounded Warrior processes, and program for, fund, and resource all valid computer-based and web-based systems and interfaces.

Commandant of the Marine Corps Comments

The Commandant of the Marine Corps partially concurred with our recommendation. The Commandant explained that Manpower and Reserve Affairs will continue to work systems requirements to ensure internal Marine Corps systems provide the Wounded Warrior Regiment and its subordinate battalions the functionality needed to effectively manage its Wounded Warrior population. Additionally, the Marine Corps will coordinate with external agencies at Department of Defense and Department of Navy levels to ensure interfaces are developed to allow bi-directional transfer of information.

Our Response

While the Commandant of the Marine Corps partially concurred with comments, his comments are, in fact, responsive and the actions meet the intent of the recommendation. However, in response to the final report, we request that the Deputy Commandant for Manpower and Reserve Affairs provide an update which outlines status of all necessary computer-based and web-based systems, to include all interfaces required to support Marine Corps Wounded Warrior processes, and the status of programing for, funding, and resourcing of all valid computer-based and web-based systems and interfaces.

C.7. Travel Challenges for Warriors at Twentynine Palms

The Wounded Warrior Battalion Detachment, Twentynine Palms transportation program did not effectively support Warriors based there. Warriors had to travel up to approximately 310 miles round-trip to attend recovery and transition appointments at Navy Medical Center San Diego or Camp Pendleton. Arranging for transportation was difficult and consumed Warrior and staff time and resources. As a result, sometimes Warriors drove themselves regardless of their physical, mental, or medicated state, therefore putting themselves at risk.

C.7. Background

The Wounded Warrior Regiment explained that the mission of the WWBn-West transportation section was to support the transportation requirements of Warriors and battalion staff of WWBn-West including the outlying detachments. Transportation operations included transporting Warriors and family to and from medical appointments, recreational events, drop-offs and pick-ups to and from local airports, and other critical requirements that pertained to Warriors and their families.

The WWBn-West detachment at Twentynine Palms had the following transportation assets: one golf-cart for on-base transportation, one American Disability Act (ADA) equipped bus, one sedan, and a mini-van. There were three Marines assigned to the WWBn-West transportation detachment at Twentynine Palms. The structure of the transportation section included one dispatcher and two drivers.

The WWBn-West detachment at Twentynine Palms could increase its transportation support with additional vehicle assets provided by Southwest Regional Fleet Command (SWFRT) and staff support as drivers, if required. If passenger movement of over 15 Warriors was required, SWFRT could provide a contract driver for up to 14 hours. SWFRT was a regional organization comprised of Garrison Mobile Equipment fleets located at seven Marine Corps installations in California. These installations included Marine Corps Base Camp Pendleton, Marine Corps Recruit Depot San Diego, Marine Corps Air Station Miramar San Diego, Marine Corps Air Station Camp Pendleton, Marine Corps Ground Combat Center Twentynine Palms, Marine Corps Logistics Base Barstow, and Mountain Warfare Training Center Bridgeport.

Geographic Reference

It is approximately a 155-mile drive from Twentynine Palms Marine Corps Base to Camp Pendleton. It is approximately a 195-mile drive from Twentynine Palms Marine Corps Base to Naval Medical Center San Diego. It is approximately a 40-mile drive from Camp Pendleton to Naval Medical Center San Diego.

The Nurse Case Managers at Naval Hospital Twentynine Palms explained they were looking into contracting out local medical services to provide more timely and accessible Traumatic Brain Injury (TBI) evaluations. It was their opinion that the situation in which Warriors had to drive themselves from Twentynine Palms to Naval Medical Center San Diego or Naval Hospital Camp Pendleton for multiple evaluations was difficult and inconvenient for the Warriors. The Nurse Case Managers stated that arranging transportation at Twentynine Palms was a huge problem and very time consuming. They explained that this was especially true for getting Warriors from Twentynine Palms to specialty medical care appointments which were often at Naval Medical Center San Diego or Naval Hospital Camp Pendleton. The Nurse Case Managers explained that WWBn-West takes care of their own travel within the battalion; however, there were many other Marines on base who also needed travel assistance. They further explained that Twentynine Palms used to provide a shuttle service but it was discontinued, apparently due to budget constraints. The Nurse Case Managers were concerned that the transportation situation created the risk that Warriors were driving themselves outside the base to appointments, often at Naval Medical Center San Diego or Camp Pendleton, when in fact, some of these Warriors should not be driving at all due to such things as balance issues or blurred vision due to a TBI.

The Medical Coordinator agreed that the Warriors could use a more robust transportation system.

Additionally, the Recovery Care Coordinators (RCCs) expressed that transportation was an issue for the Warriors early on in Warriors' healing and transition, especially for those that require handicapped accessible transport.

C.7. Conclusion

Transportation resources at Twentynine Palms appeared to be inadequate to accommodate transporting Warriors and their families to Naval Medical Center San Diego or Camp Pendleton for certain recovery and transition appointments. The medical staff at Twentynine Palms was concerned that the available transportation assets at Twentynine Palms did not always support the Warriors and that resulted in some Warriors driving themselves to appointments, which could exceed 390 miles round-trip, when it was unsafe for some Warriors to be driving at all.

C.7. Warrior Speak

Refer to Part III, for "Warrior Speak" that amplifies this observation.

C.7. Recommendations, Management Comments, and Our Response

C.7.1. We recommend the Commander, WWBn-West identify all requirements necessary to fully support all WWBn-West, Detachment Twentynine Palms transportation needs.

C.7.2. We recommend the Commander, Wounded Warrior Regiment program for, fund, and resource the required transportation requirements necessary to fully support all WWBn-West, Detachment Twentynine Palms transportation needs.

Commandant of the Marine Corps Comments

The Commandant of the Marine Corps concurred with comment to our recommendations. The Commandant stated that during the DoD IG visit, there was not an issue meeting the transportation requirements for Marines assigned to WWBn-West. The issue was Marines assigned to other Twentynine Palms-based units were not receiving adequate transportation support when they had appointments at Naval Hospital Camp Pendleton, Naval Medical Center San Diego, or other San Diego hospitals. The Commandant further explained that in November 2011, the Marine Corps Air Grounds Combat Center Chief of Staff and the staff at Naval Hospital Twentynine Palms met to discuss the transportation concerns. As a result of that meeting, a base shuttle was instituted two days per week and supported through Twentynine Palms base logistics section.

Our Response

The Commandant of the Marine Corps comments are responsive and meet the intent of our recommendation. We acknowledge the positive initiatives that have been implemented to reduce Warrior's travel distance for medical care. (*Reference Observation D.3., Chief of Staff, Navy Medicine West, Page 86*).

C.8. End of Active Duty Service Dates Impact on US Government Identification Cards and Base Pass/Vehicle Decal Expiration Dates

Some Warriors were required to remain on active duty beyond their End of Active Duty Service date for medical or administrative reasons. As a result, government identification cards and base pass/vehicle registration decals for these Warriors and all their dependents expired and were usually only extended in 90-day increments. Therefore, Warriors had to take time away from their recovery and transition to renew these documents which risked being detrimental to the Warrior and a burden on the Warrior's family.

C.8. Background

According to the Wounded Warrior Regiment, Warriors who were required to stay on active duty beyond their End-of-Active-Duty-Service (EAS) date, such as Warriors awaiting medical boards, had their EAS dates lined out or made a null date (e.g., 999s). The Wounded Warrior Regiment informed our team that Camp Pendleton did not have a specific policy on renewal requirements for government identification cards or base pass/vehicle registration decals for Warriors with lined out or null dated EAS dates. Renewal depended on each Warrior's circumstances. Once a Warrior's government identification card expired, he or she had to go to his or her Unit Administration office and request a letter for an extension. The extension was usually granted for an additional 90 days.

C.8. Discussion

During this assessment, we observed that some Warriors had to remain on active duty beyond their EAS date to allow for necessary medical evaluations and treatments. As a result, they had to have their personal and dependent government identification cards and base pass/vehicle registration decals renewed regularly.

The Active Duty Staff Sergeants (E-6) explained that some Warriors who had to remain on active duty beyond their EAS date no longer had an assigned EAS date or had an EAS listed as a null date. This meant that these Warriors and their dependents' government identification cards and base pass/vehicle registration decals expired. Consequently Warriors were required to regularly renew their government identification cards and base pass/vehicle registration decals, as well as their dependents', usually every 90 days.

According to the Staff Sergeants, this process usually took 3 or 4 hours for the government identification cards and another 3 to 4 hours for the base pass/vehicle registration decals. This also required Warriors with a spouse and/or dependents to arrange for the spouse and all other dependents to plan to spend time for the renewal processes. This put Warriors at risk of missing important recovery and transition time, medical treatment, or other appointments. This also created a financial burden for Warriors if working spouses had to repeatedly take time off from work and/or pay for child care in order to renew the required documents.

C.8. Conclusion

We observed that conditions existed that caused some Warriors to remain on active duty after their EAS date. This caused some Warriors to have their EAS dates lined out or made a null date, which resulted in Warriors and their dependents having to regularly renew their government identification cards and base pass/vehicle registration decals. This required Warriors and their dependents to have to regularly dedicate approximately one or two entire recovery and transition days to renew their government identification cards and base pass/vehicle registration decals. This could also incur a financial hardship in terms of dependent spouses taking time off work and/or the cost of child care.

C.8. Warrior Speak

Refer to Part III, C.8. for “Warrior” Speak that amplifies this observation.

C.8. Recommendation, Management Comments, and Our Response

C.8. We recommend the Commander, Marine Corps Installations-West implement policy and procedures that ensure Warriors and Warriors’ dependents renewal of government identification cards and base pass/vehicle registration decals does not interfere with Warriors’ recovery and transition or impose a burden on dependents.

Commandant of the Marine Corps Comments

The Commandant of the Marine Corps concurred with comment to our recommendation. The Commandant explained that contact had been made with the WWBn-West Commanding Officer, indicating that, in his view, this issue had largely been resolved. It was noted that the Commanding Officer had assigned his Executive Officer as liaison, to coordinate and/or implement solutions tailored to accommodate Wounded Warriors. He further explained that during this discourse, it was determined that the following mechanisms were in place to accommodate Wounded Warriors and were sufficient and working well. These include:

- Warriors and their dependents receive “second-in-line privileges” at each of the three Pass and ID centers at Camp Pendleton for DEERS³¹ and/or vehicle registration. Second-in-line privileges means Warriors and their dependents are the next customers following completion of the current transaction at a particular customer service window. Whenever a customer service window is open, Warriors and their dependents receive “front-of-line” privileges, meaning they do not have to wait for any other customer.
- The WWBn-West staff is aware of who to contact at Camp Pendleton Pass and ID to coordinate unusual situations that Warriors encounter. Marine Corps Installation-West explained that this includes such adjustments as dedicating one or more customer service windows at the Camp Pendleton Pass and ID centers to Wounded Warriors during or after normal working hours to include weekends whenever required.

³¹ DEERS is the worldwide, computerized database of uniformed services members, their family members, and others who are eligible for military benefits including government identification cards.

- Whenever possible, Pass and ID transactions can be conducted by proxy by WWBn-West staff and Pass and ID personnel on behalf of the Warrior and/or dependents.
- Government identification cards and vehicle registration decals are either issued per the recommendation of the WWBn-West Commander and staff or automatically for 3 years, whichever is less. If the WWBn-West cannot assess exactly how long the Warrior will remain in the unit, the Pass and ID centers at Camp Pendleton will continue to re-issue government identification cards and vehicle registration decals in 90 day increments.

Furthermore, the Commanding General, Marine Corps Installations West, provided the same response to the recommendation as provided above by the Commandant of the Marine Corps. See Appendix E for the Commanding General, Marine Corps Installations West comments.

Our Response

The Commandant of the Marine Corps and Commanding General, Marine Corps Installation-West comments are responsive and the actions meet the intent of the recommendation. No further action is required.

C9. Ineligibility to Transfer Unused Post 9-11 GI Bill Benefits

There were Warriors otherwise eligible for the Post 9-11 GI Bill education benefits but not eligible to transfer their unused benefits to their dependents because they had become wounded, ill, or injured and could not meet the years-of- service in the Armed Forces requirement or serve the required additional years. Therefore, the Warriors' spouse and children lost this benefit.

C.9. Background

The Post-9/11 GI Bill provides financial support for education and housing to military personnel with at least 90 days of aggregate service on or after September 11, 2001, or individuals discharged with a service-connected disability after 30 days. The individual must have received an honorable discharge to be eligible for the Post-9/11 GI Bill.

According to the United States Department of Veterans Affairs, the following personnel are eligible to transfer their unused Post 9-11 GI education benefits to their spouse or children: Any member of the Armed Forces (active duty or Selected Reserve, officer or enlisted) on or after August 1, 2009, who is eligible for the Post-9/11 GI Bill, and:

- Has at least 6 years of service in the Armed Forces on the date of election and agrees to serve 4 additional years in the Armed Forces from the date of electing to transfer their unused Post 9-11 GI education benefits to their spouse and/or children.
- Has at least 10 years of service in the Armed Forces (active duty and/or selected reserve) on the date of election, is precluded by either standard policy (service or DoD) or statute from committing to 4 additional years, and agrees to serve for the maximum amount of time allowed by such policy or statute, or
- Is or becomes retirement eligible during the period from August 1, 2009, through August 1, 2013. A service member is considered to be retirement eligible if he or she has completed 20 years of active duty or 20 qualifying years of reserve service.
- For those individuals eligible for retirement on August 1, 2009, no additional service is required.
- For those individuals who have an approved retirement date after August 1, 2009, and before July 1, 2010, no additional service is required.
- For those individuals eligible for retirement after August 1, 2009, and before August 1, 2010, 1 year of additional service after approval of transfer is required.
- For those individuals eligible for retirement on or after August 1, 2010, and before August 1, 2011, 2 years of additional service after approval of transfer are required.
- For those individuals eligible for retirement on or after August 1, 2011, and before August 1, 2012, 3 years of additional service after approval of transfer required.³²

³² See <http://www.gibill.va.gov/post-911/post-911-gi-bill-summary/transfer-of-benefits.html> , “United States Department of Veterans Affairs Transfer of Post-9/11 GI-Bill Benefits To Dependents (TEB).”

C.9. Discussion

During this assessment, we observed that there were Warriors eligible for the Post 9-11 GI Bill but who had to transition out of the Marine Corps for medical reasons before they had at least 6 years of service required by law and could not serve the additional years of service. As a result, these Warriors could not transfer their unused Post 9-11 GI education benefits to their spouse or children. This was especially problematic when it was unclear if a Warrior would be able to attend school and utilize his or her Post 9-11 GI Bill. Transferring the benefit to a spouse could then become an issue of becoming educationally qualified to obtain employment paying enough to support the family.

The Wounded Warrior Battalion-West Commander believed that there should be a change to the policy on the Post 9-11 GI bill that determines when a Service member is eligible to transfer the unused benefits to a spouse or child. He explained how there are Marines in his Wounded Warrior units who got “blown up” in combat their first one or two years of service. In his opinion, being eligible to transfer the unused portion of their Post 9-11 GI education benefits to their spouse would help their family tremendously if the spouse could get an education and a good job.

C.9. Conclusion

The WWBn-West Commander was deeply concerned for the economic survivability of Warriors and their families after they transitioned out of the Marine Corp for medical reasons. He raised as his top concern the current eligibility requirements to transfer unused portions of the Post 9-11 GI Bill which precluded many of his Warriors from transferring their benefits to their spouse or children. We confirmed that there were Warriors who did not meet the eligibility to transfer their unused portions of the Post 9-11 GI Bill requirements because they become wounded, ill, or injured and subsequently could not fulfill length of stay of service requirements.

C.9. Warrior Speak

Refer to Part III, C.9. for “Warrior Speak” that amplifies this observation.

C.9. Recommendation, Management Comments, and Our Response

C.9. We recommend the Undersecretary of Defense for Personnel and Readiness recommend that the Secretary of Defense consider expanding eligibility for Warriors assigned to Wounded Warrior units so that they can transfer unused Post 9-11 GI education benefits to their spouse or children when medical conditions preclude the Warrior from meeting the length-of-service eligibility requirements to transfer these benefits.

Undersecretary of Defense for Personnel and Readiness Comments

The Assistant Secretary of Defense, Health Affairs responding on behalf of the Acting Under Secretary of Defense for Personnel and Readiness concurred with comment to our recommendation. The Assistant Secretary explained that the post 9/11 GI Bill, for purposes of promoting recruitment and retention, allows members of the Armed Forces to elect to transfer all or a portion of educational entitlement to a spouse or child. Extending the existing

transferability provision for any purpose other than the promotion of recruiting or retention would not satisfy the intent of the transferability authority, absent a legislative change.

Our Response

The recommendation addressed the requirements of a small, distinct subset of potentially eligible Warriors for transfer of GI Bill benefits to their spouses or children, i.e., those junior ranking service members who become wounded, ill, or injured prior to completing their first enlistment. As an example, a Service member enlists, completes required training, and deploys to a combat zone in under 12 months. Early in their deployment they are wounded in combat. Their wounds are severe enough that they cannot take part in a GI Bill educational or vocational program. Under current rules, they are not allowed to transfer their GI Bill benefits to their spouse or child, who could become their caregiver for the rest of their life. It is this defined population that this recommendation covers.

This recommendation was originally directed to the Under Secretary of Defense for Personnel and Readiness. However, the Assistant Secretary of Defense, Health Affairs was delegated to provide comments which are partially responsive. While stating that he concurred with the objective of the recommendation, the Assistant Secretary of Defense, Health Affairs did not state whether or not he or the Under Secretary of Defense for Personnel and Readiness intends to recommend that the Secretary of Defense consider expanding eligibility for Warriors assigned to Wounded Warrior units so that they could transfer unused Post 9-11 GI Bill education benefits to their spouse or children when medical conditions preclude the Warrior from meeting the length-of-service eligibility requirements to transfer these benefits.

The Assistant Secretary of Defense, Health Affairs stated that the purpose of the Post 9-11 GI Bill was to promote recruitment and retention and noted that extending eligibility for any purpose other than promoting recruitment or retention would not satisfy the intent of the GI Bill provision without legislative change. However, he did not state whether expanding eligibility to these Wounded Warriors will promote recruitment. We maintain that providing the proposed modification to the Post 9-11 GI Bill benefit will have a positive impact on recruitment of new Service members.

Perhaps even more importantly, beyond any recruitment impact, expanding eligibility to these Wounded Warriors will redress what we believe is a limitation in the GI Bill that prevents our most seriously wounded, ill or injured service personnel who are medically unfit and unable to take advantage of the educational benefit to transfer these benefits to their spouses or children.

In response to the final report, we request that the Under Secretary of Defense for Personnel and Readiness provide a response to this recommendation. Specifically, we request that the Under Secretary of Defense for Personnel and Readiness state whether she intends to recommend to the Secretary of Defense that he consider expanding GI Bill eligibility, either in order to further promote recruitment and/or proposing an appropriate legislative change to expand the intent of the Post 9-11 GI Bill transferability authority beyond recruitment and retention to better care for this small defined population and their families.

Observation D. Challenges for Navy Medicine Supporting Wounded Warrior Battalion – West

We identified four challenges that need to be addressed by Navy Medicine’s leadership and staff to facilitate a more effective and successful management and support system for the care, healing, and transition of Warriors. These challenges are identified as follows:

D.1. Inconsistent Medical Case Manager Patient Load Guidance

D.2. Lack of Clarity in Medication Management Policies at Naval Hospital Camp
Pendleton

D.3. Non-Adherence to TRICARE Access-to-Care Standards for Specialty Medical Care
Appointments at Twentynine Palms

D.4. Lack of Adequate Medical Information Systems Computer Interfaces

We believe that addressing these issues will enhance the quality and timeliness of recovery and transition of the Marines assigned to the Wounded Warrior Battalion-West.

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D.1. Inconsistent Case Manager Patient Load Guidance

There was no single standard guidance defining medical case management patient caseloads causing uneven distributions of cases and case management overload. As a result, it was not clear how many medical case managers were required to fully support the Warriors assigned or attached to WWBn-West. Therefore, Warriors were not always receiving needed medical case management support, causing delays or other potential adverse impacts on their recovery and transition.

D.1. Background

There is no standard guidance used to determine the number of medical case managers required to adequately support patient loads. Therefore, the correct number of medical case managers required to fully support all Warriors assigned or attached to WWBn-West was not defined. The multiple sources of guidance below that determine medical case manager patient loads differed in numbers from 17 to 30 patients per medical case manager, to a range from 10 to 50 patients depending on acuity.

The Office of the Undersecretary of Defense, Directive Type Memorandum 08-033, “Interim Guidance for Clinical Case Management for the Wounded, Ill, and Injured Service Member in the Military Health System,” August 26, 2009, established that the standard number of cases to be managed by each case manager shall be no more than 30.

The DoD TRICARE Medical Management Guide, Case Management *Version 3.0*, establishes that no more than 17 Wounded Warriors in an outpatient setting will be assigned to one Medical Care Case Managers

In contrast, the Department of the Navy Bureau of Medicine Instruction 6300.17, “Navy Medicine Clinical Case Management,” November 23, 2009, established that the case load for Case Managers can range from 10 to 50 patients depending on acuity of the patients.

Assignment of a patient (or a Marine/Warrior) to a medical case manager is the responsibility of the Bureau of Navy Medicine and Navy Medical Treatment Facilities. The Wounded Warrior Regiment’s licensed clinical consultants assist the Bureau of Navy Medicine and Navy Medical Treatment Facilities to identify patients (Marines/Warriors) who may require medical case management. This partnership between Bureau of Navy Medicine, Navy Medical Treatment Facilities, and the Wounded Warrior Regiment is aimed at facilitating the assignment of medical case managers, as appropriate.

All Navy Medical Treatment facilities make assignments to medical case management based upon guidelines published by the Case Management Society of America and the Department of Defense Medical Management guidelines.

D.1. Discussion

During this assessment, we observed that there was a difference in the guidance for how many medical case managers were required to resource Wounded Warrior Battalion-West. It was

evident from the different definitions of medical case manager patient loads that it was difficult to determine, justify, request, staff, and resource/fund the correct number of medical case managers required by Navy Medicine-West to fully support all Warriors assigned or attached to WWBn-West.

It is important to note that we observed that the medical case managers at WWBn-East were assigned to the battalion and dedicated to the Warriors. In contrast, the medical case managers, referred to as Nurse Case Managers, at WWBn-West were not assigned to the battalion and had mixed patient loads of Warriors as well as patients who were not assigned or attached to WWBn-West.

The following information was provided about the medical case manager-to-patient and Warrior ratios at Naval Medical Center San Diego.

Table 3. Naval Medical Center San Diego Nurse Case Managers

NCM Interviewed	Patients Assigned*
A	38
B	22
C	29
D	31
E	36

*At the time of this assessment the five Nurse Case Managers interviewed at Naval Medical Center San Diego were assigned either to the Comprehensive Combat and Complex Causality Care program or to the Director for Health Business. Neither group specifically identified patients who were Warriors and who were not Warriors at the time of this assessment.

The following information was provided by 10 of the 23 Nurse Case Managers at Camp Pendleton, at the time of this assessment, about the medical case manager-to-patient and Warrior ratios at Naval Hospital Camp Pendleton.

Table 4. Naval Hospital Camp Pendleton Nurse Case Managers

NCM Interviewed	Non-Warrior / Warriors Assigned
A	31 / 10
B	22 / 3
C	30 / 9-10
D	23 / 6
E	31 / 10-11
F	31 / 6
G	31 / 7
H	9 / 2
I	30 / 8-9
J	7 / 4

Additionally, the following information was provided by two of the four Nurse Case Managers at Twentynine Palms, at the time of this assessment, about the medical case manager-to patient and Warrior ratios at Naval Hospital Twentynine Palms.

Table 5. Naval Hospital Twentynine Palms Case Managers

NCM Interviewed	Non-Warrior / Warriors Assigned
A	76 / 7 – 8
B	78 / 7

The Nurse Case Managers at Camp Pendleton indicated that assignments were made based on the patient’s or Warrior’s acuity as well as the number of patients the medical case manager was currently assigned. Acuity was based on the number of interventions a medical case manager may be required to perform and the frequency of follow ups with a patient or Warrior. Interventions included events such as medication counseling, arranging durable medical equipment³³, and educating family members. The Nurse Case Managers, at Camp Pendleton emphasized that there is “never enough time in the day” to adequately handle their work load.

The Nurse Case Managers at Twentynine Palms explained that they usually averaged 55 to 60 patients, but that with the shortage of Nurse Case Manager, even according to Navy Bureau of Medicine Instruction 6300.17, it seemed they only had time for crisis intervention. The Nurse Case Managers could no longer manage inpatients (both Warriors and other patients) due to time constraints caused by the number of cases assigned to each case manager. They often had to reduce the time they spent with inpatients so they could spend more time with outpatients (both Warriors and other patients). Warriors, as well as other patients, were only assigned medical case managers after they were discharged as inpatients and started to receive outpatient care.

D.1. Conclusion

The Nurse Case Managers expressed concern that because of the number of cases each had assigned, they did not have enough time to complete their duties and that the Warriors, especially inpatient Warriors, may not be getting the proper support they needed for recovery and transition. Furthermore we observed that Warriors assigned or attached to WWBn-West did not have Nurse Case Managers dedicated to the battalion or medical case managers with a Warrior-only patient load. This placed the Nurse Case Managers at potential risk of not being able to effectively support each individual Warrior’s specific medical and/or transition needs. There was no overarching guidance for medical case managers that identified patient loads based on care acuity, complexity, and evidence-based practices.³⁴

D.1. Warrior Speak

Refer to Part III, D.3. for “Warrior Speak” that amplifies this observation.

³³ Durable medical equipment has to be reusable to be considered “durable” and includes such items as wheelchairs, oxygen equipment, and crutches. This equipment also includes hospital beds, patient lifts, power scooters and nebulizers. The durable medical equipment must be considered to be necessary due to a patient’s physical and medical conditions and it must be needed in the home of the patient.

³⁴ Evidence-based practice, as defined by Nurse Case Managers at Camp Pendleton, was ‘the integration of the best research evidenced with our clinical expertise and our patient’s unique values and circumstances.’

D.1. Recommendation, Management Comments, and Our Response

D.1.1. We recommend the Undersecretary of Defense for Personnel and Readiness implement policy that establishes and requires adequate medical case management staffing ratios specific to the Wounded Warrior program based on patient acuity, complexity and evidence-based practices.

Undersecretary of Defense for Personnel and Readiness Comments

The Assistant Secretary of Defense Health Affairs, responding on behalf of the Under Secretary of Defense for Personnel and Readiness, concurred with the recommendation. The Assistant Secretary of Defense, Health Affairs explained that they are working towards establishing case manager staffing ratios that will consider variables associated with acuity and complexity of care coordination requirements. Furthermore, the Assistant Secretary explained that the case manager staffing ratios would be consistent with the statutory requirements of the National Defense Authorization Act for Fiscal Year 2008, Section 1611 (e) (3) (C), recognizing that the Secretaries of the Military Departments concerned may waive such limitation with respect to a given manager for not more than 120 days in the event of unforeseen circumstances. The expiration date for DTM 08-033 was May 31, 2012. A formal request was submitted for an additional 6-month extension. A response to this extension request has not yet been received.

Our Response

The Assistant Secretary of Defense Health Affairs comments are responsive and meet the intent of our recommendation. However, in response to the final report, we request the Assistant Secretary of Defense Health Affairs provide an update on the status of the requested extension and an estimated timeline for the DoD Instruction implementation.

D.1.2. We recommend the Commander, Navy Medicine-West implement policy to assign dedicated medical case managers to patients assigned or attached to WWBn-West Warriors.

Navy Medicine West Comments

The Chief of Staff, Navy Medicine West concurred with comment to our recommendation. The Chief explained that while Navy Medicine-West Instruction 6320.1 formally directs the following items, many of the items were in place before the instruction was promulgated on November 10, 2011. They include:

- All Wounded Warriors will initially be assigned a Clinical Case Manager. Continuing Clinical Case Manager services will be contingent upon Wounded Warrior needs.
- Clinical Case Managers will be dedicated at medical treatment facilities with a routine caseload greater than 36 Warriors, carrying a caseload of no more than 20 Wounded Warriors per Clinical Case Manager.

- Dedicated Clinical Case Managers will be embedded within the WWBn-West detachment whenever possible.
- Medical Treatment Facilities will utilize Clinical Case Manager extenders (i.e. licensed vocational nurses, licensed practical nurses, administrative staff) if unable to fill Clinical Case Manager positions. Clinical Case Manager extenders will work under the supervision of the Clinical Case Manager.

Additionally, Warriors currently checking in to WWBn-West Detachment at Camp Pendleton are assigned a dedicated Wounded Warrior Case Manager that will remain the Warrior's case manager throughout their care. Furthermore, the Chief explained that at the time of our visit, Naval Hospital Twentynine Palms had only 4 of their 8 case manager positions filled. As of April 13, 2012, they currently have 6 of the 8 their case manager positions filled with three of the case managers designated to the Twentynine WWBn-West Detachment.

Our Response

The Chief of Staff, Navy Medicine West comments are responsive and the actions meet the intent of the recommendation. However, in response to the final report, we request the Chief of Staff, Navy Medicine West provide an update to the hiring actions to ensure the full complement of clinical case managers have been placed at Twentynine Palms as indicated.

D.1.3. We recommend the Commander, Navy Medicine-West ensure enough medical case managers are assigned to prevent them from being overloaded and unable to provide all necessary support required by Warriors.

Navy Medicine West Comments

The Chief of Staff, Navy Medicine West concurred with comment to our recommendation. The Chief explained that the Navy Medicine West Instruction 6320.1, November 10, 2011 outlines the Wounded Warrior to Case Manager ratio to be no more than 20:1.

Our Response

The Chief of Staff, Navy Medicine West comments are responsive and the actions meet the intent of the recommendation. However, in response to our final report, we request that the Chief, Navy Medicine West, provide a copy of the signed Navy Medicine-West Instruction 6320.1, dated November 10, 2011 which outlines the Wounded Warrior to Case Manager ratio.

D.2. Lack of Specificity in Medication Management Policies at Naval Hospital Camp Pendleton

The Naval Hospital Camp Pendleton did not have specific medication management policies or procedures in place to manage Warriors who were prescribed multiple medications. As a result, Warriors were at risk of having an adverse reaction from these medications which could negatively affect their health, recovery and transition.

D.2. Background

“Poly-pharmacy” is the use of a number of different drugs, possibly prescribed by different doctors and filled by different pharmacies, by a patient who may have one or several health problems.³⁵

According to the Navy’s Pharmacy Consultant, Navy Bureau of Medicine and Surgery (BUMED) does not currently have a policy on poly-pharmacy. In a follow up on this issue, BUMED had requested a copy of the Army’s instruction on poly-pharmacy and planned to have Wounded Warrior and Behavioral Health subject matter experts review the instruction to see how a similar instruction may benefit Warriors transitioning through Navy medical care.

D.2. Discussion

This assessment determined that Naval Hospital Camp Pendleton did not have specific medication management policies or procedures in place to manage Warriors who were prescribed multiple medications. This was confirmed by the Wounded Warrior Pharmacist at Naval Hospital Camp Pendleton.

A member of the medical provider staff at the Naval Hospital Camp Pendleton Traumatic Brain Injury (TBI) clinic also stated the clinic was not aware of a policy or Standard Operating Procedure to reconcile the use of multiple medications. It was also not clear to the medical provider staff exactly who was responsible to delete inappropriate medications from Warriors’ medication profiles. The member further explained that Naval Hospital Camp Pendleton did have a policy for outpatient medication reconciliation, but it did not specifically state who was responsible, only that it was expected to be done. Additionally, this policy did not specify procedures to update medication profiles in the Armed Forces Health Longitudinal Technology Application Interface (AHLTA).

D.2. Conclusion

Managing medications for Warriors was challenging due to the number and types of medications that were prescribed and the fact that both military and civilian healthcare providers were prescribing these medications. We also acknowledge that Naval Hospital Camp Pendleton had policy for medication reconciliation to address this issue. However, we observed that the existing policy was for outpatients only and did not specify who was responsible to actually

³⁵ See <http://medical-dictionary.thefreedictionary.com/polypharmacy>, Mosby's Medical Dictionary, 8th edition.

execute the policy and conduct the medication reconciliation. Without specific medication management and poly-pharmacy policies that assign responsibility and identify procedures, the identification and reduction of potentially harmful Warrior medication-related incidents was difficult if not impossible.

D.2. Warrior Speak

Refer to Part III, for “Warrior Speak” that amplifies this observation.

D.2. Recommendations, Management Comments, and Our Response

D.2.1. We recommend the Surgeon General of the Navy and Chief, Navy Bureau of Medicine and Surgery update policies and procedures for overall Navy Medicine poly-pharmacy management and medical reconciliation.

Bureau of Medicine and Surgery Comments

The Bureau of Medicine and Surgery concurred with comments to our recommendation. Bureau of Medicine and Surgery explained that the specific language of this recommendation implies that there should be only one process for poly-pharmacy management and medication reconciliation throughout the Navy Medicine Enterprise. They explained that the current BUMED position is that detailed, specific guidance for poly-pharmacy management and medical reconciliation must be developed and implemented at the MTF level. BUMED also strongly concurs with the recommendation for updated policies and procedures at Naval Hospital Camp Pendleton, but maintains that developing and updating local policies under the authority of the MTF Commanding Officer would best serve patients in that it would match local policies and capabilities to the needs of the particular patient population. BUMED further explained that a detailed, centralized policy would be difficult to implement, considering the wide variation of practice settings in Navy Medicine. That being said, BUMED will continue to emphasize the requirement for effective medication management policies at the local level to promote safe and effective care.

Finally, BUMED mentioned that in support for local MTF healthcare operations, BUMED established the Navy Comprehensive Pain Management Program (NCPMP) to improve the capability and capacity of the Navy’s pain management resources, and to foster healing and reduce suffering from acute and chronic pain. Additional information shared by BUMED regarding this program, to include Telemedicine services, training, and development of future guidance can be found in Appendix E, page 143-144.

Our Response

The Bureau of Medicine and Surgery comments are partially responsive. We acknowledge the work being done to establish the Navy Comprehensive Pain Management Program and agree that developing and updating local policies under the authority of the MTF Commanding Officer is appropriate. However, in response to the final report, we request that Navy Medicine West address what is being done at the local level and provide all pertinent local policies and procedures that address poly-pharmacy management and medication reconciliations practices.

D.2.2. We recommend the Commander, Navy Medicine West implement policies and procedures for including all medications ordered in AHLTA or not ordered in AHLTA that ensure there are specified responsible personnel for poly-pharmacy management and medication reconciliation for all Warriors assigned or attached to WWBn-West.

Navy Medicine West Comments

The Chief of Staff, Navy Medicine West concurred with comment to our recommendation. The Chief explained that while Navy Medicine West Instruction 6320.1 formally directs the following items, many of the items were in place before the instruction was promulgated on November 10, 2011. They include:

- All medical treatment facilities will identify designated/dedicated clinical pharmacists to provide Warrior services.
- All Wounded Warriors will receive a deliberate medication review and reconciliation conducted by a clinical pharmacist within 3 working days of assignment to the Wounded Warrior unit/program.
- The deliberate medication review will minimally include the following elements:
 - A review of the Warrior's medication profile and medical history using electronic health record systems (CHCS and AHLTA).
 - A reconciliation of medications listed in the electronic health record compared with medications reported by the Warrior.
 - Consideration of medications appropriateness, effectiveness, dosage, and monitoring.
 - Assessment of drug-to-drug, drug-to-disease, and drug-to food/herbal interactions.
 - Warrior compliance with prescribed therapy.
 - Poly-pharmacy challenges.
 - Assessment of need for restrictive dispensing of opioid, benzodiazepine, tricyclic anti-depressant, anti-psychotic, or insomnia relieving medications.
 - Educate the Wounded Warrior about his or her medications.

Additionally, after initial evaluation, the WWBn-West Primary Care Manager at Naval Hospital Camp Pendleton is responsible for regular follow-up with the Wounded Warriors, typically once per month, to review medications. If there are any concerns, additional clinical pharmacist review is conducted.

Our Response

The Chief of Staff, Navy Medicine West comments are responsive and the actions meet the intent of the recommendation. However, in response to our final report, we request that the Chief, Navy Medicine West, provide a copy of the signed Navy Medicine West Instruction 6320.1, November 10, 2011, which outlines poly-pharmacy management and medication reconciliation.

D.3. Non-Adherence to TRICARE Access-to-Care Standards for Specialty Medical Care Appointments at Twentynine Palms

Navy Medicine’s specialty medical care appointment practices were not ensuring that Warriors at Twentynine Palms received specialty medical care appointments in accordance with prescribed TRICARE standards of distance and time traveled. Therefore, the lack of specialty medical care within standards placed Warriors at risk of potentially delayed healing and prolonged transition times.

D.3. Background

For discussion, it is important to understand the terms *Specialty Medical Care* and *Referral*.

Specialty Medical Care

Specialty Medical Care is generally defined as care that a Primary Care Manager (PCM) is not able to provide. A Primary Care Manager is either a military or civilian healthcare provider (e.g. physician, physician’s assistant, or nurse practitioner) who is the medical point of contact and healthcare advocate for the Warrior. Primary Care Managers provide primary oversight and continuity of healthcare and are to ensure the level of care provided is of the highest quality. They are the gateway to all specialty care (such as behavioral health specialists or orthopedic surgeons) and they coordinate with other physicians to ensure that the Warriors are getting the treatment that they need.

Referral

A *referral* means a patient has been sent, referred, for a second opinion or therapy to a specialist or sub-specialist because the patient has a disease or condition that the primary or referring physician cannot, or does not wish to, treat. The expectation is that the patient will continue seeing the original physician for coordination of total care. The *referral* is the formal process when a primary care provider authorizes a patient to receive care from a specialist or hospital. The Department of Defense (TRICARE) system requires patients obtain a referral from a primary care manager before seeing a specialist.³⁶

TRICARE Standards

In accordance with the most recent Office of the Assistant Secretary of Defense (Health Affairs), TRICARE Policy for Access to Care Memorandum, February 23, 2011, all eligible beneficiaries must be offered a specialty care medical appointment with an appropriately trained provider within 4 weeks (28 calendar days) or sooner, if required, and within one hour from the beneficiary’s residence.

It is important to note that a basic principle of the TRICARE program business design plan is that if a military treatment facility (MTF) does not have the capability to provide the needed care, or cannot provide the care within the required access standards, the care will be referred to

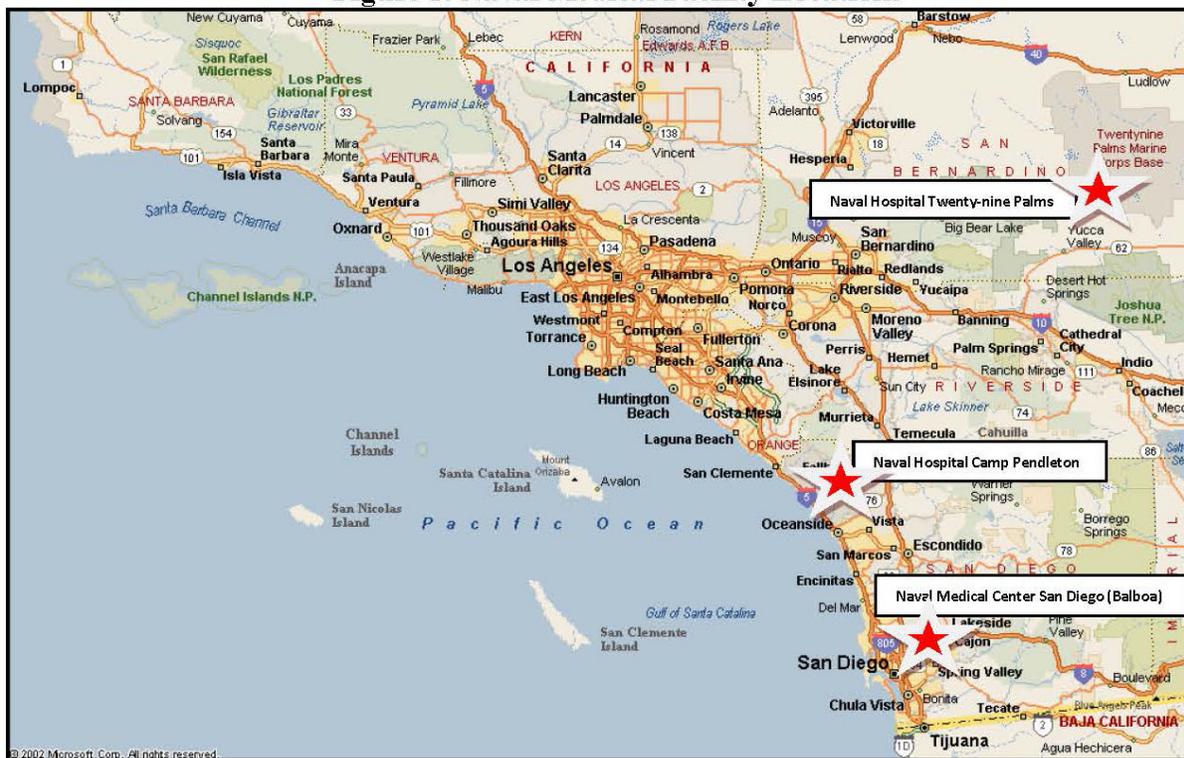
³⁶ See <http://medical-dictionary.thefreedictionary.com/referral>, “REFERRAL”

the TRICARE provider network. The determination as to whether the MTF can provide the needed care should be made by the MTF within one business day of the request.

Geographic Reference

It is approximately a 155-mile or almost 3 hour drive from Twentynine Palms to Camp Pendleton. It is approximately a 195-mile or 3 ½ hour drive from Twentynine Palms to Naval Medical Center San Diego. It is approximately a 40-mile or 45 minute drive from Camp Pendleton to Naval Medical Center San Diego. These commute times can be longer depending on traffic conditions.

Figure 5. Naval Medical Facility Locations



Observation C.7., page 65 of this report, addresses overall transportation challenges for Warriors at Twentynine Palms for which the Commander, Wounded Warrior Regiment and Commander, WWBn-West is responsible for.

D.3. Discussion

During this assessment we observed that Warriors at Twentynine Palms were not always receiving specialty medical care appointments that met the established TRICARE standard of within a one-hour drive of a beneficiary’s residence. The inability to meet this established TRICARE standard was compounded by the reliance on Naval Medical Center San Diego and Naval Hospital Camp Pendleton for specialty medical care in lieu of referring Warriors to civilian medical facilities when Naval Hospital Twentynine Palms could not meet established TRICARE access standards for specialty medical care.

A Primary Care Manager at Naval Hospital Twentynine Palms described that the Twentynine Palms area had limited access to specialty care medical resources and that Naval Medical

Center San Diego and Naval Hospital Camp Pendleton were too far away (155 to 195 miles away). Nonetheless, the Primary Care Manager recommended that the Naval Hospital Twentynine Palms needed to establish more access to specialty medical care with local specialty care medical providers. The Naval Hospital Twentynine Palms Commanding Officer acknowledged that the two primary military treatment facilities, Navy Medical Center San Diego and Naval Hospital Camp Pendleton, were beyond TRICARE driving distance standards from Twentynine Palms.

The Nurse Case Managers at Naval Hospital Twentynine Palms expressed that their challenge was making appointments for coordinated specialty care between multiple specialty care providers because the specialty care was located so far away (155 to 195 miles away) at Naval Medical Center San Diego or Naval Hospital Camp Pendleton. These Nurse Case Managers explained that access to specialty medical care appointments in the Twentynine Palms area was not as good as access at Naval Medical Center San Diego or Naval Hospital Camp Pendleton because of the geographic and isolated location of Twentynine Palms.

The Nurse Case Managers went on to explain that Navy Medicine was looking into contracting out services for more timely and accessible Traumatic Brain Injuries (TBI) evaluations close to Twentynine Palms because so many Marines at Twentynine Palms required this type of specialty medical care. This was necessary because these Marines had to travel to Naval Medical Center San Diego or Naval Hospital Camp Pendleton for TBI evaluations. Navy Medicine arranged for neuro-psychology providers to travel to Naval Hospital Twentynine Palms twice a week to increase access to this specialty medical care. The Nurse Case Managers suggested that the same type of arrangements were needed for cardiology, neurology, orthopedics, vestibular, ear-nose-and-throat surgeons, and pain management specialty medical care. Additionally, the Nurse Case Managers said that Navy Medicine seemed to be reluctant to authorize patients (Warriors) to seek civilian healthcare sources.

It appeared that the Warriors assigned to Twentynine Palms may have been required to travel farther than the prescribed TRICARE one-hour travel time for specialty medical care because of a legacy Navy Medicine-West business plan or appointing model. The Naval Hospital Twentynine Palms staff explained that under a previous Commander of Navy Medicine-West, Navy Medicine's goal was to have all specialty medical care provided in military treatment facilities regardless of distance and time-of-travel considerations.

D.3. Conclusion

Access to specialty medical appointments within the TRICARE travel time limitation was a challenge due to the location of Twentynine Palms and could also be attributed to a legacy Navy Medicine-West business plan or appointing model that strived to have all specialty medical care provided in military treatment facilities. We observed that Navy Medicine had taken some proactive measures to provide certain specialty medical care close to Twentynine Palms. However, we noted that the geographic location of Twentynine Palms, in conjunction with Navy Medicine's appointing practices and dependence on Naval Medical Center Dan Diego and Naval Hospital Camp Pendleton continued to result in some Warriors located at Twentynine

Palms receiving specialty care medical appointments outside prescribed TRICARE standards of no more than the required one hour travel time.

D.3. Warrior Speak

Refer to Part III, for “Warrior Speak” that amplifies this observation.

D.3. Recommendations, Management Comments, and Our Response

D.3. We recommend the Commander, Navy Medicine West implement procedures to ensure all TRICARE standards are met regarding WWBn-West Warriors’ access-to-care, including for referring medical care appointments.

Navy Medicine West Comments

The Chief of Staff, Navy Medicine West, concurred with comment to our recommendation. The Chief explained that since our visit, the Naval Hospital Twentynine Palms has contracted an in-house TBI program manager, which has decreased the Wounded Warrior travel requirements, including agreements/utilization of TBI/Vestibular and Occupational Therapy civilian providers at the Eisenhower Medical Center in Rancho Mirage, CA (68 miles away). Furthermore, based on demand analyses, Naval Hospital Twentynine Palms has instituted part time “circuit-rider” specialty providers from Naval Medical Center San Diego. These specialties include Podiatry (2 days per month), Neurology (2.5 days per month), and Otolaryngology (2 days every other month).

Our Response

The Chief of Staff, Navy Medicine West comments are responsive. We acknowledge the significant work that has been implemented to meet access to care for the identified medical specialty care areas. We also acknowledge that meeting prescribed TRICARE access-to-care standards could remain a challenge for Warriors at Twentynine Palms. However, in response to the final report, we request that the Chief of Staff, Navy Medicine West provide an update as to whether or not the addition of stated specialty providers has allowed Naval Hospital Twentynine Palms to meet the established TRICARE access to care standards.

D.4. Lack of Adequate Medical Information Systems Computer Interfaces

An inability to assure the accuracy of Warrior medical information in information system data bases put Warriors at risk of delayed recovery and transition and/or incorrect medication reconciliation.

D.4. Background

The Composite Health Care System (CHCS) is a Tri-Service automated medical management information system used in all Department of Defense military treatment facilities (MTFs) worldwide to support hospital administration and clinical healthcare. CHCS is the target automated information system for the clinical area of DoD's Military Health System (MHS). It is an evolutionary program that unites functionalities of over 50 different DoD and Service-unique automated information systems in varying stages of computer-based patient records for all MHS beneficiaries. CHCS integrates all patient record information clinical systems of the three Services into a single joint system, increasing access to information, taking advantage of advanced business practices, integrating civilian healthcare sector practice, and allowing MTFs to be more efficient in protecting lives and resources.

The Armed Forces Health Longitudinal Technology Application (AHLTA) is the clinical information system that generates and maintains a lifelong, computer-based outpatient record for every Soldier, Sailor, Airman and Marine, and their family members; and others entitled to DoD military care who receive care in a military treatment facility.

AHLTA provides secure online access to military health system beneficiary records. It is used by DoD medical providers in all fixed and deployed military treatment facilities. This centralized electronic health record is intended to enable healthcare personnel worldwide to access complete, accurate health data to make informed patient care decisions at the point of care. AHLTA allows for the central storage of standardized electronic health record data that is available for worldwide sharing of patient information. Many users have access to the system; however, permission to view or retrieve information is based on their particular role. AHLTA users include: physicians, nurses, corpsmen, medics, technicians, clerks and office managers.

During a follow-up with the Wounded Warrior Regiment concerning this observation, we were informed that training on the Health Insurance Portability and Accountability Act (HIPAA), which addresses the security and privacy of all health data, was required for all WWBn-West staff members, as well as the Warrior Regiment Medical Cell, regardless of their access requirements to CHCS and/or AHLTA. HIPAA training was also required for all staff assigned to Naval Medical Center San Diego, Naval Medical Hospital Camp Pendleton, and Naval Medical Hospital Twentynine Palms regardless of their level of access to CHCS and/or AHLTA.

Observation C.6., page 60 of this report addresses different computer information technology program interface problems, for which the Deputy Commandant for Manpower and Reserve Affairs is responsible.

D.4. Discussion

Composite Health Care System Host/Interface Problem

During this assessment, the first medical information system computer interface problem we observed was that the CHCS at Naval Medical Center San Diego and the CHCS at the Naval Hospital Twentynine Palms had difficulty sharing data.

A Nurse Case Manager at Twentynine Palms described multiple difficulties getting timely processing and accurate referral management requests from Naval Medical Center San Diego's CHCS. Specifically, Warriors' referral medical appointment information that was received by Naval Medical Center San Diego from Naval Medical Center Twentynine Palms had to be either re-typed or "cut-and-pasted" into Naval Medical Center San Diego's CHCS in order to make the referral-medical-appointment. The Nurse Case Manager went on to describe how sometimes not all the relevant information was copied into the Naval Medical Center San Diego's medical referral appointing system and consequently these referral medical appointments were incomplete and they were not processed in a timely fashion. The Nurse Case Manager stated that "sometimes Balboa (Naval Medical Center San Diego) is referred to as the "Black Hole" in regards to processing referrals."

Another Nurse Case Manager at Twentynine Palms stated that the non-visibility problem concerning the Naval Medical Center San Diego appointments affected the efficiency of managing medical appointments due to difficulty sharing CHCS data between Naval Medical Center San Diego and Naval Hospital Twentynine Palms.

Composite Health Care System and Armed Forces Health Longitudinal Technology Application Interface Problem

The second medical information system computer interface problem we observed was that between the Pharmacy Data Transaction Service (PDTS) and AHLTA. PDTS is a centralized drug data repository that stores patient prescription data, including Warriors' prescriptions ordered outside a military treatment facility. WWBn-West Warriors were often prescribed and/or obtained medication prescriptions from non-DoD, off-base medical providers and pharmacies. The dispensing of these medications was documented by the dispensing pharmacy into the PDTS. However, to be able to monitor Warriors' medication consumption, Warriors' medication records in PDTS had to be transferred into AHLTA. An interface was developed so that all AHLTA users could view the PDTS medication records in AHLTA to have complete awareness of all medications prescribed to patients to avoid any potential adverse medication reactions. The Defense Health Information Management System notified all users that not all medications documented into PDTS were being transferred into AHLTA which could result in the risk that the medical reconciliation of medications prescribed and taken by Warriors was inaccurate.

The Naval Hospital Camp Pendleton Traumatic Brain Injury Clinic staff explained that there was a "disconnect" between CHCS and AHLTA in describing Warriors' list of active medications. Providers used CHCS to order Warrior medications, but when reconciling Warriors' medications, those doing the reconciliation used AHLTA.

In September, 2010 the Defense Health Information Management System office sent an e-mail to all users notifying them of the interface problems and described potential mitigating actions that could be taken while their analysis of the issue continued.

In February, 2012 the TRICARE Management Agency, responding for the Office of the Secretary of Defense, Health Affairs, explained that efforts were underway to address electronic medication profile update capabilities. Two System Change Requests (SCRs) for funding have been approved for submission to the DoD Fiscal Year 2014 budget to address medication profile update capabilities. The intent of the SCRs is to upgrade electronic interfaces so that users can share medication profiles between AHLTA, CHCS, PDTS, and Veterans Affairs databases. These system upgrades will include prescription medications and over-the-counter medication status capabilities with the ability to be updated with or without a patient encounter.

D.4. Conclusion

Concerning the difficulty of sharing CHCS data, we observed that there was a risk of Warrior's medical information being incorrect or incomplete when medical treatment facilities (MTFs) shared information through CHCS. We acknowledge that the MTF staff took steps to work around the problem by "cutting-and-pasting" or re-typing Warriors information into the appropriate CHCS system. However, despite the efforts of MTF staff, Warriors will continue to be at risk of delayed recovery and transition as long as MTFs experience difficulty with the electronic interface sharing of CHCS data.

We believe it is essential that Navy Medicine-West leadership ensure that procedures are in place that guarantees the accuracy and completeness of each Warrior's medical information when that information is being shared between MTFs.

Concerning the PDTS/AHLTA interface problem, we acknowledge that the Defense Health Information Management System office acted proactively by identifying the issue and notifying users to take steps to mitigate the risk. The SCR's, DoD funding for Fiscal Year 2014 indicates that there will be no resolution of the interface issue for several more years. Until the interface problem is addressed, medical care personnel are at risk of not having complete and accurate medication profiles for Warriors.

We believe it is essential that Navy Medicine-West leadership ensure that procedures are in place that guarantee the accuracy and completeness of each Warrior's medication profile and that medication reconciliations are conducted correctly and in a timely manner.

Both the medical data sharing and the medication profile interface problems must be resolved to avoid inaccurate clinical and/or management decisions that could negatively affect Warriors' medical care.

D.4. Recommendations, Management Comments, and Our Response

D.4.1. We recommend the Office of the Assistant Secretary of Defense for Health Affairs develop and resource solutions to CHCS data sharing difficulties.

Assistant Secretary of Defense for Health Affairs Comments

The Assistant Secretary of Defense Health Affairs, concurred with comment to our recommendation. TRICARE Management Activity (TMA) addressed this recommendation previously in response to “Assessment of DoD Wounded Warrior Matters – Camp Lejeune,” Report No. DODIG-2012-067, March 30, 2012. As part of their response, they explained that efforts are underway to enhance the medical reconciliation capability within AHLTA/Composite Health Care System (CHCS). TMA stated that currently, DoD healthcare providers are able to document changes to medication orders made by DoD providers, but are unable to do so for medication orders from non-DoD providers, to include Department of Veterans Affairs and civilian providers. Two system change requests have been approved to address this, which include:

- Allow users to mark as "Taking/Not Taking" each patient's current medications, regardless of the source system. For example, the source systems include, but are not limited to, AHLTA, CHCS, VA, or the Pharmacy Data Transaction System (PDTs). This update can be done during a patient encounter or without initiating an encounter.
- Change the status of a medication to "Taking/Not Taking" when a user marks an over the counter (OTC) medication as "Taking/Not Taking."

TMA explained that currently, these enhancements are targeted for funding in Fiscal Year (FY) 2014. The program office is considering other funding options prior to the planned FY 2014 funding.

Our Response

The TRICARE Management Activity, responding on behalf of the Assistant Secretary of Defense for Health Affairs, provided comments that are responsive and the actions meet the intent of the recommendation. However, in response to the final report, we request that TMA provide updates when enhancements with respect to the medical reconciliation capability have been approved, funded, and implemented.

D.4.2.a. We recommend the Commander, Navy Medicine West ensure policy and procedures are in place to guarantee that all Warriors' medication profiles are maintained accurately and are properly reconciled.

Navy Medicine West Comments

The Chief of Staff, Navy Medicine West concurred with comment to our recommendation. The Chief explained that while Navy Medicine-West Instruction 6320.1 formally directs the following items, many of the items were in place before the instruction was promulgated on November 10, 2011. They include:

- All medical treatment facilities will identify designated/dedicated clinical pharmacists to provide Warrior services.

- All Wounded Warriors will receive a deliberate medication review and reconciliation conducted by a clinical pharmacist within 3 working days of assignment to the Wounded Warrior unit/program.
- The deliberate medication review will minimally include the following elements:
 - A review of the Warrior’s medication profile and medical history using electronic health record systems (CHCS and AHLTA)
 - A reconciliation of medications listed in the in the electronic health record with medications reported by the Warrior.
 - Consideration of medications appropriateness, effectiveness, dosage, and monitoring.
 - Assessment of drug-drug, drug-disease, and drug-food/herbal interactions.
 - Wounded Warrior compliance with prescribed therapy.
 - Poly-pharmacy challenges.
 - Assessment of need for restrictive dispensing of opioid, benzodiazepine, tricyclic anti-depressant, anti-psychotic, or insomnia relieving medications.
 - Educate Wounded Warrior about his or her medications.

Furthermore, after initial evaluation, the WWBn-West Primary Care Manager at Naval Hospital Camp Pendleton is responsible for regular follow-up with the Wounded Warriors, typically once per month, to review medications.

Our Response

The Chief of Staff, Navy Medicine West comments are responsive and the actions meet the intent of the recommendation. However, in response to our final report, we request that the Chief, Navy Medicine West, provide a copy of the signed Navy Medicine-West Instruction 6320.1, November 10, 2011 which outlines poly-pharmacy management and medication reconciliation.

D.4.2.b. We recommend the Commander, Navy Medicine-West ensure policy and procedures are in place to guarantee that all Warriors’ medical information is accurately shared between medical facilities so that Warriors receive proper medical treatment within established access-to-care standards.

Navy Medicine West Comments

The Chief of Staff, Navy Medicine West partially concurred with comment to our recommendation. The Chief explained that given the current enterprise-wide medical information programs and processes used by Navy Medicine West and other U.S. Navy, Army,

and Air Force regional commands, the DoD IG report should distinguish between those issues which require enterprise-wide action and policy from those which can be changed or impacted by a specific regional command.

The Chief further commented that Navy Medicine and the Military Health Care System, as an enterprise, has multiple safety mechanisms in place to ensure safe amounts and combinations of medications are prescribed to beneficiaries. The Chief stated one example is the Pharmacy Data Transaction Service (PDTS) Physicians and other authorized prescribers utilize. This is an extremely robust database that automatically screens prescriptions for interactions against other prescribed medications when they are entered into the computer. The PDTS captures all prescription medications that the individual received by incorporating prescription data from more than 56,000 retail pharmacies and 889 military treatment facilities, regardless of service, and all prescriptions from the TRICARE/Express Scripts mail service, making it the most extensive compilation of prescription medication in North America.

The Chief also explained an additional safety mechanism to ensure safe amounts and combinations of medications are prescribed to beneficiaries, that being the medication reconciliation performed by the physician, nurse, medical assistant or hospital corpsman at every visit. A list of medications is generated from the records system and the patient is asked if the list is what they are actually taking and if they are taking any supplements or medication that are not on the list.

Furthermore, the Chief included that the Multi-Service Market Office and Naval Medical Center San Diego, Naval Hospital Twentynine Palms has obtained Naval Medical Center San Diego CHCS access. This access now provides Naval Hospital Twentynine Palms Case Managers and Referral Management staff to view appointments at Naval Medical Center San Diego, ensuring Warriors obtain specialty treatment within access-to-care-standards.

Lastly, the Chief of Staff, Navy Medicine West provided additional comments on several other aspects of the PDTS, to include prescription interactions and duplicates, and warning overrides, among others. These comments can be found in Appendix E, page 149-150.

Our Response

The Chief of Staff, Navy Medicine West comments are non-responsive. While the Chief focused on issues that require enterprise-wide action and policy, it is unclear how these issues are related to specific command level treatment. In response to the final report, we request that the Chief of Staff, Navy Medicine West provide additional comments to policies and procedures which are currently in place or being developed that guarantee that all Warriors receiving medical care in facilities under the responsibility of Commander, Navy Medicine-West have their medical information accurately shared between medical facilities.

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Part III - Warrior Speak

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Warrior Speak: Comments from Wounded Warriors

We believe that it is important to give a “voice” to the Warriors assigned to WWBn-West. The team interviewed 57 individual Wounded Warriors and five Wounded Warrior cohort groups assigned to WWBn-West. The following comments are included to further illustrate our previously made observations, discussions, conclusions and recommendations. These comments represent a broad sampling of all Warriors interviewed.

A.1. Use of the GOOGLE Calendar

A Reservist Gunnery Sergeant Warrior (E-7) said that: “The use of the GOOGLE calendar is a really good idea.”

An Active Duty Staff Sergeant Warrior (E-6) also said: “I was not issued Personal Digital Assistant for tracking my appointments because I have a personal iPhone that I use.”

An Active Duty Sergeant Warrior (E-5) explained that: “The WWBn set everyone up with a g-mail account and all Warriors are required to post their schedule to their g-mail calendar so staff has access. Plus, the staff uses g-mail to keep the Warriors informed.”

A.2. Internships and Educational Opportunities

A Reservist Gunnery Sergeant Warrior (E-7) stated that “I am going to medically retire and want a job with Immigration and Customs Enforcement and will be doing an internship with the regional Immigration and Customs Enforcement office. I am not required to go to formation. I go straight to my internship at the regional Immigration and Customs Enforcement office for four to six hours each morning. I feel that I am definitely filling my days appropriately, especially since I began my internship.”

A Reservist Gunnery Sergeant Warrior (E-7) indicated: “I have seen a lot more internships and the pursuit of education than in the past. (NOTE: In order to give a time-reference to the word “past”; the Gunnery Sergeant had been assigned to the WWBn-West since October 2009.”

An Active Duty Sergeant Warrior (E-5) expressed: “The staff is talking to me about vocational rehabilitation and they are helping me put together a resume and find a job. I am also looking into an internship.”

An Active Duty Sergeant Warrior (E-5) expressed the view that: “Every day they push school and internships; I definitely want to look into school.”

An Active Duty Sergeant Warrior (E-5) said “I will be doing some schooling to get my Associates degree before I leave the WWBn.”

An Active Duty Sergeant Warrior (E-5) explained: “I started school the end of July (2011) to get a certification for the police academy and am starting an internship with the FBI. I got the “green-light” from the First Sergeant to go to the police academy and that the WWBn will cut

orders to go to school...which is awesome because when you are back in a regular unit you have to go to school on your own.”

An Active Duty Sergeant Warrior (E-5) stated: “I am at school at National University and want to go to seminary to become a youth pastor. I am also in an internship at “Gangland Ministry” working with “gang members.”

An Active Duty Sergeant Warrior (E-5) explained “I am trying to come up with the best solutions with the doctors to stay in the Marine Corps but I am also taking steps in case this does not happen. I am involved with college, internships and meetings with companies and corporations to “keep my foot in the door.”

An Active Duty Corporal Warrior (E-4) expressed: “I had planned to take a six month break after I separated from the Marine Corps but now that I have a wife and a child on the way, I am taking general education classes to get me on the right track with my schooling.”

An Active Duty Corporal Warrior (E-4) explained: “I do “ride-alongs” with the Border Patrol and Police Department and I am discussing my artwork with a mentor in Laguna Beach CA. The WWBn has good resources; I am aware of all the opportunities through the local colleges. I feel all opportunities are advertised well and that here are plenty of ways to get tapped in.”

An Active Duty Corporal Warrior (E-4) expressed the view that: “They have internships and all kinds of resources to help.”

An Active Duty Corporal Warrior (E-4) expressed the view that: “A lot has come down from the WWBn on education, internships and jobs.”

An Active Duty Corporal Warrior (E-4) said: “I am currently doing an internship with WW Film Career Foundation and would like to get in with Highland Studios in Carlsbad, California.”

An Active Duty Corporal Warrior (E-4) explained: “We are required to have five hours of productive time a day. This week I started an internship with my landlord as a carpenter. I used to be a carpenter and worked for my father. I have not done carpentry for four and a half years and am enthusiastically getting back into it. I am ready to get out. I think interning is right for me.”

An Active Duty Corporal Warrior (E-4) said: “I am taking a class on colleges, admissions, etc., so I can have a school picked out and already know what I will study.”

An Active Duty Lance Corporal Warrior (E-3) explained that “When I first arrived all I did was go to medical appointments. But, they trickled down to one to two appointments per week so I filled my time by either going to the horse stables or participating in other workshops. Currently, from 0700 to 1600 daily, I do an internship as a computer tech. I will be starting school on the 21st of April (2011) for my certification.”

An Active Duty Lance Corporal (E-3) stated: “I signed up for classes at Riverside Community College with the goal to get an Associate’s Degree. I am also enrolled in the Sandler’s Institute for gun-smithing.”

An Active Duty Lance Corporal Warrior (E-3) explained “I spend my time doing Marine Corps Institute classes where I basically read a book and answer test questions. There are Marine Corps Institute classes I can use for college credits.”

An Active Duty Lance Corporal Warrior (E-3) stated: “I do not have a lot of appointments so that is why I keep school on my schedule.”

An Active Duty Lance Corporal Warrior (E-3) explained “I have been told I am getting out of the Marine Corps so I am going to vocational training right now for metal fabrication, welding and milling.”

An Active Duty Lance Corporal Warrior (E-3) explained “I have already visited four different schools and am hoping to get into a local school- ITT Technical Institute. My Recovery Care Coordinator has been very helpful. They have looked into ITT Technical Institute and a local Junior College. I at least want to get started on my general education classes. There are a lot of people to help; there is a career counselor at the WWBn who will help with schools and Tuition Assistance concerns. If there is something I am interested in, I just refer it to my section leader and they do their best to get it for me.”

An Active Duty Lance Corporal Warrior (E-3) explained “I know where to go and who to talk to for assistance. I recently received help from within the WWBn and enrolled and completed two economics classes and one history class. My goal is to study history and become a history teacher.”

A Reservist Lance Corporal Warrior (E-3) stated: “They are doing a pretty darn good job...I am currently taking one computer class and have been hooked up with an internship with the Balboa Parks Association IT department.”

B.1. Equal Access to Medical Care

An Active Duty First Sergeant Warrior (E-8) stated there was no difference in access to medical care between the Active Duty and Reserves; they all have equal access.”

A Reservist Gunnery Sergeant Warrior (E-7) indicated there was no difference in access to medical care between the Active Duty and Reserve. The Gunnery Sergeant stated: “For both these groups, across-the- board, they get equal access to care.”

A Reservist Gunnery Sergeant Warrior (E-7) expressed the view that all Warriors in Transition (both Reserve and Active Duty Warriors) received equal access to patient care and services.

An Active Duty Staff Sergeant Warrior (E-6) and his spouse said they believed there was no difference in access to medical care between the Active Duty and Reserves. They agreed that: “It is pretty straight forward; if a guy needs care, he gets it.”

A Reservist Staff Sergeant Warrior (E-6) also said that all Warriors in Transition (both Active Duty and Reserve Warriors) received equal access to patient care and services.

A Reservist Staff Sergeant Warrior (E-6) stated that all WWBn Recovering Service Members (Warriors) had equal access and treatment within the medical facilities. He thought the biggest problem was that Reservists in the unit on Active Duty would sometimes revert from Active Duty status to Reservist status because the administrative procedures to keep them in an Active status had not been followed. It took approximately a month to administratively correct this issue when it occurred. During this time, a Reservist technically did not have TRICARE medical insurance benefits. It has been a challenge for unit administrative personnel to adequately support Reservists in this situation.

An Active Duty Sergeant Warrior (E-5) indicated that all Recovering Service Members (both Active Duty and Reserve Warriors) received equal access to medical services. She explained that she really did not know of any differences and that she had not heard of any unequal access to care.

A Reservist Sergeant Warrior (E-5) expressed the view that all Recovering Service Members (both Active Duty and Reserve Warriors) received equal access to medical services.

An Active Duty Corporal Warrior (E-4) said there was no difference in access to medical care between the Active Duty and Reserve. The Corporal stated: “As far as the medical care, we are all treated the same.”

An Active Duty Lance Corporal Warrior (E-3) also said there was no difference in access to medical care between the Active Duty and Reserves. The Lance Corporals stated: “We are all “Active Duty” while we are in this battalion.” (WWBn-West)

A Reservist Duty Lance Corporal Warrior (E-3) stated: “Yes, everyone has the same access and treatment within the medical facilities.”

B.2. Consolidation of Warrior Services

The following comment was received during a group interview with Active Duty Senior NCO Warriors (E-7 and E8). The group explained: “The entire process should be a ‘One-Stop-Shop.’ Paperwork seems to get lost when it moves from one office to another, especially when the offices are not in the same location.”

B.3. Post-Traumatic Stress Disorder Services

The following comment was received during a group interview with Active Duty Sergeant Warriors (E-5). The group expressed: “We list one accomplishment towards transitioning as attending OASIS, which is an intensive inpatient course.”

C.1. Lengthy Transition Times

An Active Duty Sergeant Warrior (E-5) explained that she feels bad for the Warriors because a lot of the Warriors have been at WWBN-West for a long time and they just want to get away.

An Active Duty Corporal Warrior (E-4) explained that he had hit a certain level when his appointments slowed down and there was only so much he could do. Now he feels like he is wasting his time. He fills part of his time by going to physical training twice each day. He summed it up by saying: “The waiting process can be “soul sucking”...there is only so many times you can fix your resume.”

An Active Duty Lance Corporal Warrior (E-3) explained that the WWBn used to be the best place for him. He went on to say: “But now the day-in and day-out routine is consuming and I feel like I am getting stale. The medical board process and the separation process take too long.” He explained he gets anxiety about being in limbo and he worries about everything. He said, “I would rather be in Afghanistan than sitting here.”

An Active Duty Lance Corporal Warrior (E-3) stated: “The only problem is that the healing and transition process takes too long.”

An Active Duty Lance Corporal Warrior (E-3) said: “The process is just too long and too drawn out.”

An Active Duty Lance Corporal Warrior (E-3) explained that after a while the medical appointments start dwindling and Warriors...“start scrounging for schedule fillers.” He expressed that the process needs to speed up. He stated: “Warriors spend years here. There is only so much transition you can do before it becomes busy work.”

An Active Duty Private First Class Warrior (E-2) explained that the medical board process is way too long for most people and recommended that the Marine Corps go back to “Home Awaiting Orders.”³⁷

C.2. Lack of Dedicated Primary Medical Care for Camp Pendleton Warriors

An Active Duty Gunnery Sergeant Warrior (E-7) stated that: “The situation with not having a dedicated Primary Care Manager (PCM) is ‘absolutely a problem.’ The Wounded Warrior doctor is an Internal Medicine doctor with “one million” other responsibilities. WWBn-West needs at least one full time position and it could be an Independent Duty Corpsman.”

An Active Duty Staff Sergeant Warrior (E-6) stated he was concerned that the Warrior battalion did not have its own Medical Officer and that there was only one PCM assigned to the Warrior battalion. He explained that the Warrior battalion’s PCM was actually an Internal Medicine Doctor at the Naval Hospital Camp Pendleton and was responsible for 500 or more patients plus 160 Warriors.

³⁷ Marine Corps Separation Manual (MARCORSEPMAN). A Marine on active duty found Unfit by the PEB, whose continued treatment is not warranted, and who has unconditionally accepted the preliminary findings of the Informal PEB may, subject to the Marine's consent and the command's approval, be ordered home to await final disposition of proceedings.

An Active Duty Staff Sergeant Warrior (E-6) indicated: “We compete with the rest of the Marine Corps for appointments. The Wounded Warrior Battalion should have a doctor and a mental health doctor of their own.”

A Reservist Staff Sergeant Warrior (E-6) stated that: “We only have one doctor but he does not only see us. They can only fit three appointments a day to see him. They have to prioritize. It took over a month to see him to get an appointment for an MRI. We need our own doctors who have training to deal with what we actually have. If you fix the doctor issue, Marines could move on faster, have fewer financial problems, and make room for other Marines.”

An Active Duty Sergeant Warrior (E-5) explained that she believed the WWBn needed a Battalion Aid Station where they would have one or two medical officers to focus on the Warriors and take care of sick call and appointment referrals. She stated: “I have not seen my PCM yet because it is next to impossible.” (This Warrior had been attached to the WWBn for two and a half months at the time of the interview.)

An Active Duty Sergeant Warrior (E-5) explained that the WWBn required its own PCM for sick call and for other medical appointments because there were scheduling problems to see the naval hospital’s PCM. He stated: “We need our own PCM.”

An Active Duty Sergeant Warrior (E-5) expressed: “It is ridiculous to have to get an appointment with the only medical officer we have. Our PCM is an Internal Medicine doctor for the whole hospital; and this is the Wounded Warrior Battalion.”

An Active Duty Corporal Warrior (E-4) expressed his concern when he described how “our PCM has changed seven times in the past two years and our current PCM has many other patients besides the Warriors. We need a Battalion Aid Station to function as an actual battalion.”

An Active Duty Corporal Warrior (E-4) stated: “Our primary care doctor has to see his other internal medicine patients so he is extremely busy, which has a negative impact on the Warriors. We need a medical officer on site.”

An Active Duty Corporal Warrior (E-4) said: “Getting in with the PCM is a nightmare”

An Active Duty Corporal Warrior (E-4) expressed: “They should have one doctor that is our doctor. The doctors at the hospital take forever to see you. It is like a cat and mouse game. We have 150 guys, seventy in transit and eighty to ninety here, and need our own doctor in the barracks.”

An Active Duty Lance Corporal Warrior (E-3) explained: “I’ve had times when I could not get in to see my PCM and had to wait a week or so. One day I woke up vomiting and had to wait four hours to see a doctor because Warriors only have three slots for sick call and the PCM also takes care of other patients at the Navy hospital.”

An Active Duty Lance Corporal Warrior (E-3) said: “There is no Medical Officer assigned to the battalion.”

An Active Duty Lance Corporal Warrior (E-3) expressed: “We need our own medical officer for the battalion. We are the only battalion in the Marine Corps that does not have a Medical Officer and our name is “Wounded Warriors”. I think we need a medical officer.”

An Active Duty Private First Class Warrior (E-2) said: “We need a full time physician on call 24 hours a day.”

C.3. Use of Warriors for Battalion Staff Duties

An Active Duty Gunnery Sergeant Warrior (E-7) simply stated that he believed that: “Warriors should not be section leaders.”

An Active Duty Staff Sergeant (E-6) Warrior explained that many of the section leaders have been wounded and gone through the system themselves.

An Active Duty Staff Sergeant Warrior (E-6) said that there are problems when a leader is also a Warrior. He stated: “We have patient-staff (Wounded Warrior who are staff) types and it is hard for them to balance their own recovery with dealing with all the Warriors issues. Anybody “normal” (a staff person who is not also a Wounded Warrior) is going to be hard pressed to have to deal with Warrior issues.”

A Reservist Sergeant Warrior (E-5) explained that the First Sergeant who is also a Warrior is a roadblock in the Chain-of-Command dealing with discipline issues. He stated: “This First Sergeant is not consistent and is too nice because he is also a patient (Warrior) and identifies too much with the patients (Warriors).”

An Active Duty Corporal Warrior (E-4) stated: “It is stressful for the guys coming into the WWBn and it seems pretty chaotic because the WWBn is understaffed. This leads to all kinds of negative issues when Warriors become section leaders.”

An Active Duty Corporal Warrior (E-4) explained that her relationship with her Squad Leader/Platoon leader “kind of gets her a little.” She explained that other patients (Warriors) are in charge of her and that she did not like to have her medical information exposed to another patient (Warrior).”

C.4. Incomplete Consideration for Warriors Healing and Transition Location Preferences

An Active Duty Sergeant Warrior (E-5) explained that his main goal was to get back home to his wife no matter what it takes to get there and that he was looking for internships near his home.

An Active Duty Corporal Warrior (E-4) stated: “I got hit in 2009 and I am just starting my medical board now; one and a half years later. I cannot afford to move my wife and child here.”

An Active Duty Corporal Warrior (E-4) explained that he had trouble getting Temporary Assignment Duty orders for his wife to move from Washington State and ended up paying \$2000 to move her, which was not reimbursed.

An Active Duty Lance Corporal Warrior (E-3) explained that he is enrolled at the University of Minnesota and will wait to go home to do his schooling there.

An Active Duty Lance Corporal Warrior (E-3) also explained that he was going to start classes but is waiting on his Expiration of Active Duty date. He will go to school near his home in Florida.

An Active Duty Private First Warrior Class (E-2) stated: “I did not want to go to college here. I want to move to Georgia near my family and go to school there at Savannah Technical College; I have not decided on a major yet. The medical board process is way too long for most people and the Marine Corps needs to go back to “Home Awaiting Orders.”

C.5. Lack of Sufficient Support for Warriors Family Members and Support Persons

An Active Duty First Sergeant Warrior (E-8) explained that there is nothing for the spouses outside the occasional “pamper me” stuff like Spa Day or Big Bear Dinner. He went on to explain that he does not believe there are many, if any, programs for the children of Warriors.

An Active Duty Staff Sergeant Warrior (E-6) who was accompanied by his wife during his interview explained that it would have been nice to have some type of home healthcare aide training. The Warrior’s spouse explained that she was a bit overwhelmed by all the care and activities she was involved in and did have a fear about flushing her husband’s PICC lines.³⁸

A Reservist Staff Sergeant Warrior (E-6) simply stated: “Wives need to be more involved.”

An Active Duty Sergeant Warrior (E-5) explained that that the family support is not provided as much as his wife would like.

An Active Duty Sergeant Warrior (E-5) explained that he did not remember if the Family Readiness Officer called his wife to introduce herself. He went on to state: “But either way, I do not get any family support.”

An Active Duty Sergeant Warrior (E-5) recommended that the biggest program the DoD needs is for kids.

An Active Duty Sergeant Warrior (E-5) explained that the WWBn needs to incorporate the wife more. He stated: “A lot of people do not realize the spouse gets dragged through the same stuff.

³⁸ A Peripherally Inserted Central Catheter (PICC) is a long catheter introduced through a vein in the arm, then through the sub-clavian vein into the superior vena cava or right atrium to administer parenteral fluids or medications or to measure central venous pressure.

Your spouse is your number one caregiver and when you go down your spouse needs to know the chain of command; who does what, and where to go for resources.”

An Active Duty Sergeant Warrior (E-5) stated: “My comment on Spouse Education- My wife is trying to attend college here and has been trying to contact the spouse education program but receives no calls back. The education office seems to be blind-sided when I ask about scholarships available for my wife.”

An Active Duty Corporal Warrior (E-4) explained that there was nothing for the children to help them deal with Warriors’ situations.

A Reservist Lance Corporal Warrior (E-3) expressed” “We need more accessibility for spouses.”

C.6. Lack of Adequate Computer Interfaces Used to Track Warrior Healing and Transition Progress

The following comment was received during a group interview with Active Duty NCO Warriors (E-5 thru E-7). The group expressed: “Clear out the redundancy; we, as Warriors, seem to enter the same data in multiple areas and spend too much time typing it all in which is problematic here because computers often go down. This seems too often be the case with Common Access Card (CAC) enabled computers.”

C.7. Travel Challenges for Warriors at Twentynine Palms

The following comment was received during an interview with a Reservist Staff Sergeant Warrior (E-6). The Staff Sergeant said that: “Transportation could be a problem at times.”

C.8. End of Active Duty Service Dates affect on US Government Military Identification Cards and Base Pass/Vehicle Decals Expiration Dates

The following comment was received during a group interview with Active Duty Staff Sergeant Warriors (E-6). The group explained that renewing ID cards and vehicle stickers usually takes 3-4 hours for ID cards and another 3-4 hours for vehicle stickers. It also requires arranging for the spouse and family to plan to spend one day taking care of this. This can cause a financial burden if the spouse has to repeatedly take off from work and/or child care.

C.9. Ineligibility to Transfer Unused Post 9-11 G.I. Bill Benefits

The following comment was received during an interview with an Active Duty Sergeant Warrior (E-5). The Sergeant explained that he would like to reach the required mark in the Marine Corps so he can give his GI Bill to his daughter. He suggested that Warriors be exempt from having to reach the required mark to transfer the benefits to their children.

D.1. Inconsistent Medical Case Manager Patient Load Guidance

An Active Duty Staff Sergeant Warrior (E-6) said that: “The Nurse Case Managers are ‘great’ but there are just not enough of them.”

D.2. Lack of Specificity in Medication Management Policies for Naval Hospital Camp Pendleton

An Active Duty First Sergeant Warrior (E-8) expressed the view that: “Abusing meds is an issue attributed to no continuity with doctors and Warriors having to depend on the Emergency Room for sick-call. There are two issues. First, the Emergency Room could prescribe medications while unaware of Warriors’ current medications. Second, the Emergency Room could prescribe medications that Warriors’ doctors were unaware of.”

A group interview with Active Duty Staff Sergeant Warriors (E-6) claimed: “The Naval Hospital Camp Pendleton relies on drugs instead of real therapy.”

An Active Duty Staff Sergeant Warrior (E-6) stated: “Some guys build up a tolerance for medications; some are drug-seekers. The doctors do not know the Warriors that well so they keep upping the medications.”

An Active Duty Staff Sergeant Warrior (E-6) spouse said “Some of the Warriors who are mad at the world are also on heavy narcotics.”

An Active Duty Sergeant Warrior (E-5) said: “Some of the medications have bad side effects.”

D.3. Twentynine Palms Non-Adherence to TRICARE Travel-Time Requirements for Specialty Care Medical Appointments

An Active Duty Junior Enlisted Warrior explained: “I was at WWBn-West Detachment Twentynine Palms. Naval Medical Center San Diego told me they would take care of my TBI specialty medical care but the WWBn at Camp Pendleton was responsible for fixing my wounds. So, I had to go to Naval Medical Center San Diego twice a week for my TBI specialty medical care, which was approximately 285 miles roundtrip. Twentynine Palms only had orthopedics and physical therapy for specialty medical care so I gave up and moved from Twentynine Palms to Camp Pendleton to get my wounds healed.”

D.4. Lack of Adequate Information Systems Computer Interfaces

There were no specific Warrior comments concerning either the Composite Health Care System or the Armed Forces Health Longitudinal Technology Application.

Appendix A. Scope, Methodology, and Acronyms

We announced and began this overall assessment of Wounded Warrior programs on April 16, 2010. Based on our objectives, the assessment was planned and performed to obtain sufficient evidence to provide a reasonable basis for our observations, conclusions, and recommendations. The team used professional judgment to develop reportable themes drawn from multiple sources, to include interviews with individuals and groups of individuals, observations at visited sites, and reviews of documents.

The geographic spread of WWBn-West is different than any other we had encountered during this project. Because the bulk of the battalion is split between three separate Southern California locations, there are some variances in who we interviewed as compared to previous locations. We visited the Wounded Warrior Battalion-West as well as the Naval Medical Center San Diego, Naval Hospital Camp Pendleton and Naval Hospital Twentynine Palms from 11 thru 22 April, 2011. During our site visits to these locations we observed battalion operations and formations; viewed living quarters, campus facilities, and selected activities at the medical facilities; and examined pertinent documentation. We also conducted meetings and interviews – ranging from unit commanders, staff officers, and cadre, to civilian staff and contractors – as shown below:

- WWBn-West Commander, and Staff
 - WWBn-West Operations and Personnel Officers
 - WWBn-West Platoon Sergeants
 - WWBn-West Section Leaders
 - WWBn-West Staff Corpsman
 - WWBn-West Chaplain
 - VA Federal Coordinator
 - VA Military Service Representative
 - Veterans Service Organization Liaison
 - PEBLO
 - Internal Transition Office
 - Transition Center External Staff
 - Transition Coordinator
 - Regional Limited Duty Officer
 - Family Readiness Officer
 - Family Support Coordinator
 - DES Supervisor
 - DES Attorney
 - Medical Transcriptions Supervisor
 - Call Center
 - Deployment Health Center
 - Medical Coordinator
- Naval Medical Center San Diego
 - Hospital Director and Staff
 - Primary Care Managers
 - Nurse Case Managers
 - Recovery Care Coordinators
 - Office of Neuro-Trauma
 - C-5 Program
 - OASIS
 - Volunteers
 - Naval Hospital Camp Pendleton
 - Hospital Director and Staff
 - Primary Care Managers
 - Nurse Case Managers
 - Recovery Care Coordinators
 - Office of Neuro-Trauma
 - Sleep Medicine Clinic Center of Excellence
 - TBI Clinic
 - Pharmacy
 - Naval Hospital Twentynine Palms
 - Hospital Director and Staff
 - Primary Care Managers
 - Nurse Case Managers

Further, we performed interviews with WTB recovering Service members, to include 68 individual interviews with Marines, and five group interviews with additional Marines grouped by rank. The five group interviews were comprised of the following participants:

- Marine Gunnery Sergeant Warriors and Above (E-7 and above)
- Marine Staff Sergeant Warriors (E-6)
- Marine Sergeant Warriors (E-5)
- Marine Corporals (E-4)
- Marine Junior Enlisted Warriors (E-1 thru E-3)

We prepared standardized sets of questions that were used during individual and group sessions, which were tailored to the type or group of personnel being interviewed. Those interviews primarily included but were not limited to recovering Marines and key members of the transition team: primary care managers, medical services providers, medical case managers, transition personnel and battalion leadership. The standardized interview questions for these groups included topics such as access to care, use of Comprehensive Recovery Plans, job responsibilities for these key members, working relationships amongst staff, and discipline issues within the battalion.

Use of Technical Assistance and Computer-Processed Data

The DOD Office of the Inspector General, Deputy Inspector General for Audit, Quantitative Methods and Analysis Division, used a simple random sample approach to determine the number of recovering Marines we should interview at WWBn-West to obtain a representative sample. The random sample was used to avoid any biases that might have been introduced by selecting interviewees non-statistically.

The analysts used an alpha roster provided by the Wounded Warrior-West that identified Warriors by name, rank, and WWBn-West company or detachment assignment. As of 15 March 2011, there were 230 Marines in WWBn-West assigned to Naval Medical Center San Diego, Camp Pendleton and Twentynine Palms, comprising the total population from which we drew our random sample.

The analysts used a program called the Statistical Analysis System and its internal random number generator to assign random values to each individual, then sorted all 230 Marines into random number sequence. The analysts then calculated a sample size of 53 Warriors for individual interviews. The sample size is based on a 90 percent confidence level, a planned margin of error of 10 percent, and the statistically conservative assumption of a 50 percent occurrence rate.

The team used this approach to first determine whether any reportable themes (noteworthy practices, good news, issues, concerns, and challenges) were identified by those most impacted by their assignment to the WWBn-West, the recovering Marines. We met with or interviewed others – ranging from, unit commanders, staff officers, and cadre, to civilian staff and contractors – to corroborate the identified themes or to identify other reportable themes not readily known to the Warriors.

On 28 March, 2011, we provided the list of Warriors to be interviewed from our randomly generated sample to WWBn-West. With a requirement of 53 interviews, we selected from the randomized roster the first 23 Warriors from the Detachment at Naval Hospital, San Diego, the first 32 from Camp Pendleton and the first five from the Detachment at Twentynine Palms and sent them to the Battalion to schedule the Warriors into the available time slots. If the Battalion was unable to fill all time slots due to a Marine being unavailable we provided additional names as needed until the roster was full. We advised the Command that a justification must be provided for any individuals in that sequence that were unable to attend an interview. Below are the results from our individual Warrior interviews at WWBn-West.

Of the 60 Warriors (53 plus an additional seven) initially selected based on the random number ordered roster with random order numbers 1 through 60 (of 230):

- 28 were interviewed/32 were excused
- 39 additional Warriors were interviewed in accordance with the random ordered roster (designated alternates)/ 40 were excused; random order numbers 61 through 139 (of 230)
- At an individual Warrior's request, we did conduct one interview with a Warrior who was not on the provided list.

The Battalion provided an acceptable excuse for all Warriors who were unavailable for the interviews. We believe that the information obtained from the 53 Warriors interviewed who were selected in random number sequence, the 14 additional individuals interviewed who were on the random number ordered roster, and the one individual who requested an individual interview, provided a credible indication of the views of the total population.

Acronym List

The following acronyms were used in this report.

AHLTA	Armed Forces Health Longitudinal Technology Application Interface
CHCS	Composite Health Care System
CTP	Comprehensive Recovery Plan
DES	Disability Evaluation System
DODI	Department of Defense Instruction
DOD IG	Defense of Defense Inspector General
DVA	Department of Veterans Affairs
DVBIC	Defense Veterans Brain Injury Center
EAS	End of Active Duty Service
FIRP	Federal Individual Recovery Plan
GAO	Government Accountability Office
HIPAA	Health Insurance Portability and Accountability Act
IDES	Integrated Disability Evaluation System
LDRP	Labor Delivery Recovery and Postpartum
LIMDU	Limited Duty
MCTFS	Marine Corps Total Force System
MCWITTS	Marine Corps Wounded Ill and Injured Tracking System

MEB	Medical Evaluation Board
MedBolts	Medical Board Online Tri-Service Tracking System
MEBLO	Medical Board Liaison Officer
MSW	Multi-Service Ward
MSC	Military Service Coordinator
NCO	Non-Commissioned Officer
NMCSD	Naval Medical Center San Diego
NJP	Non-Judicial Punishment
PDA	Personal Digital Assistant
OASIS	Overcoming Adversity & Stress Injury Support
PCM	Primary Care Manager
PEB	Physical Evaluation Board
PEBLO	Physical Evaluations Board Liaison Officer
PTSD	Post-Traumatic Stress Disorder
PTSD IOP	Post Traumatic Stress Disorder Intensive Outpatient Program
RCC	Recovery Care Coordinators
RCP-SS	Recovery Coordination Program - Support Solution
SWFRT	Southwest Region Fleet Transportation
UCMJ	Uniform Code of Military Justice
USNS	United States Navy Ship
TBI	Traumatic Brain Injury
TBI/PTSD	Traumatic Brain Injury and Post Traumatic Stress Disorder
VA	Department of Veterans Affairs
WARP	Warrior Athletic Reconditioning Program
WTB	Warrior Transition Battalion

Appendix B. Summary of Prior Coverage

During the last six years, there has been a multitude of prior coverage on DOD and Department of Veterans Affairs (DVA) healthcare services and management, disability programs, and benefits. The Government Accountability Office (GAO), the Department of Defense Inspector General (DOD IG), and the Naval Audit Service have issued 19 reports specific to DOD Warrior Care and Transition Programs. Unrestricted GAO reports can be accessed over the Internet at <http://www.gao.gov>. Unrestricted DOD IG reports can be accessed at <http://www.dodig.mil/PUBS/index.html>. Naval Audit Service reports are not available over the Internet.

GAO

GAO Report No. GAO-12-718T, “Military Disability System, Preliminary Observations on Efforts to Improve Performance,” May 23, 2012

GAO Report No. GAO-12-27R, “DOD Mild Traumatic Brain Injury,” October 24, 2011

GAO Report No. GAO-11-551, “Defense Health Care: DOD Lacks Assurance That Selected Reserve Members Are Informed about TRICARE Reserve Select,” June 3, 2011

GAO Report No. GAO-11-572T, “Federal Recovery Coordination Program Enrollment, Staffing, and Care Coordination Pose Significant Challenges,” May 13, 2011

GAO Report No. GAO-11-633T, “Military and Veterans Disability System: Worldwide Deployment of Integrated System Warrants Careful Monitoring,” May 4, 2011

GAO Report No. GAO-11-32, “VA Health Care: VA Spends Millions on Post-Traumatic Stress Disorder Research and Incorporates Research Outcomes into Guidelines and Policy for Post-Traumatic Stress Disorder Services,” January 24, 2011

GAO Report No. GAO-11-69, “Military and Veterans Disability System: Pilot Has Achieved Some Goals, but Further Planning and Monitoring Needed,” December 6, 2010

GAO Report No. GAO-09-357, “Army Health Care: Progress Made in Staffing and Monitoring Units that Provide Outpatient Case Management, but Additional Steps Needed,” April 20, 2009

GAO Report No. GAO-09-31, “Defense Health Care: Additional Efforts Needed to Ensure Compliance with Personality Disorder Separation Requirements,” October 31, 2008

GAO Report No. GAO-08-635, “Federal Disability Programs: More Strategic Coordination Could Help Overcome Challenges to Needed Transformation,” May 20, 2008

GAO Report No. GAO-08-615, “DOD Health Care: Mental Health and Traumatic Brain Injury Screening Efforts Implemented, but Consistent Pre-Deployment Medical Record Review Policies Needed,” May 30, 2008

GAO Report No. GAO-08-514T, “DOD and VA: Preliminary Observations on Efforts to Improve Care Management and Disability Evaluations for Service Members,” February 27, 2008

GAO Report No. GAO-07-1256T, “DOD and VA: Preliminary Observations on Efforts to Improve Health Care and Disability Evaluations for Returning Service Members,” September 26, 2007

GAO Report No. GAO-06-397, “Post-Traumatic Stress Disorder: DOD Needs to Identify the Factors Its Providers Use to Make Mental Health Evaluation Referrals for Service Members,” May 11, 2006

DOD

Department of Defense Recovering Warrior Task Force, 2010-2011 Annual Report, September 2, 2011

DOD IG

DODIG Report No. 2012-067, “Assessment of DoD Wounded Warrior Matters – Camp Lejeune,” March 30, 2012

DOD IG Report No. SPO-2011-010, “Assessment of DOD Wounded Warrior Matter- Fort Drum,” September 30, 2011

DOD IG Report No. SPO-2011-004, “Assessment of DOD Wounded Warrior Matters – Fort Sam Houston,” March 17, 2011

DOD IG Report No. IE-2008-005, “DoD/VA Care Transition Process for Service Members Injured in Operation Iraqi Freedom/Operation Enduring Freedom,” June 12, 2008

DOD IG Report No. IE-2008-003, “Observations and Critique of the DoD Task Force on Mental Health,” April 15, 2008

Army

Army Audit Report No. A-2011-0008-IEM, “Army Warrior Care and Transition Program,” October 21, 2010

Navy

Naval Audit Service Report No. N2009-0046, “Marine Corps Transition Assistance Management Program – Preparation Counseling Requirement,” September 15, 2009

Naval Audit Service Report No. N2009-0009, “Department of the Navy Fisher Houses,” November 4, 2008

Appendix C. Reporting Other Issues

We are performing the Assessment of DOD Wounded Warrior Matters at multiple Army and Marine Corps locations and plan to report on each location separately. As its predecessors, this report focused on whether the programs for the care, management, and transition of Wounded, Ill and Injured Marines at the Wounded Warrior Battalion-West, Camp Pendleton, California, were managed effectively and efficiently.

We also plan to report on issues, concerns, and challenges that were common among most, if not all, the Wounded Warrior Battalions and detachments at the conclusion of our Army and Marine Corps site visits. That report or multiple reports will be provided to appropriate organizations to provide information on or identify corrective actions addressing those issues, concerns, and challenges. Those organizations may include but are not limited to the Office of the Deputy Undersecretary of Defense for Wounded Warrior Care and Transition Policy; the Deputy Commandant for Manpower and Reserve Affairs; the Wounded Warrior Regiment; and the U.S. Navy Bureau of Medicine and Surgery.

This appendix captures issues, concerns, and challenges we identified at the WWBn-West and Naval Medical Center San Diego. Naval Hospital Camp Pendleton and Twentynine Palms (with observation references noted) that may likely be included in an additional report(s). We may issue an additional report(s) before the conclusion of our Marine Corps site visits if we consider these other matters of interest urgent.

Table 6. Potential Items for Future Reports

Issue, Concerns, and Challenges	Report Reference(s)
Is there a difference in the delivery of healthcare for Active Duty, Guard, and Reserve Warriors?	Observation B.1 Page 22
How does the total time required to heal and transition in the Wounded Warrior Battalion affect Warriors’ healing and transition?	Observation C.1 Page 35
How can the uses of “Home Awaiting Orders: and the Temporary Disabled/Retired (TDRL) lists affect Warriors’ healing and transition?	Observation C.1 Page 35
How does the location of Wounded Warrior Battalions affect Warriors’ healing and transition?	Observation C.4 Page 53
How do the current eligibility requirements to transfer unused Post 9-11 G.I. Education Bill benefits to family members affect Warriors’ healing and transition?	Observation C.9 Page 72
How does Warriors’ access to medical care affect Warriors’ healing and transition?	Observation D.3 Page 85
What is the effect on healing and transition of wounded, ill, or injured Marines not attached or assigned to Wounded Warrior Battalions?	N/A

How does the current military structure of Wounded Warrior Battalions affect Warriors' healing and transition?	N/A
How do current PCS/TAD pay, re-imburement, and entitlement policies affect Warriors' healing and transition?	N/A
How do current non-medical attendant policies affect Warriors' healing and transition?	N/A
How can the use of the National Disaster Medical System improve Warriors' recovery and transition?	N/A
How can a longitudinal study to track the long-term results of the Wounded Warrior program improve Warriors recovery and transition?	N/A

Appendix D. Wounded Warrior Battalion-West Patient Referral Questionnaire



WOUNDED WARRIOR BATTALION-WEST (WWBn-W) PATIENT REFERRAL

All sections must be filled out completely.

Date of Request:

Patient information

Rank:

Name:

Last 4:

Phone:

Short description of wound/illness/injury:

Date of Injury:

Combat related (check one): Yes No

Unit Information

Unit:

Unit POC:

Phone:

Email:

Unit Executive Officer Name:

Unit Executive Officer E-mail:

*This document may contain information covered under the Privacy Act, 5 USC 552(a), and/or Health Insurance Portability and Accountability Act (PL 104-191) and its various implementing regulations and must be protected in accordance with those provisions. Healthcare information is personal and sensitive and must be treated accordingly. If this correspondence contains healthcare information, it is being provided to you after appropriate authorization from the patient or under circumstances that do not require patient authorization. Redisclosure without additional patient consent or as permitted by law is prohibited. Unauthorized redisclosure or failure to maintain confidentiality subjects you to application of an appropriate sanction. If you have received this correspondence in error, please notify the sender at once and destroy any copies you have made. "A covered entity may use AND DISCLOSE the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission..."

UNITED STATES MARINE CORPS
CAMP PENDLETON, CALIFORNIA 92055

IN REPLY REFER TO:
6202
ADJ

From: Commanding Officer,
To: Commanding Officer, Wounded Warrior Battalion-West
Subj: RECOMMENDATION FOR ASSIGNMENT TO WOUNDED WARRIOR BATTALION-WEST ICO
USMC

1. The following assessment is submitted to assist the Commanding Officer of Wounded Warrior Battalion-West in the determination of transferring subject named service member to Wounded Warrior Battalion-West:

- a. Summary of Service Member's wound/illness/injury causing this referral to Wounded Warrior Battalion-West:
- b. Service member's MOS/Description:
- c. Service member's current billet:
- d. Is member currently working out of his specialty because of the medical condition:
- e. What are the member's current physical limitations?
- f. Member's current height: and weight:
- g. Is the member within weight and body fat standards:
- h. If not within height/weight standards, is the member currently on weight control?
- i. To your knowledge, is the member fully complying with the prescribed appointments and treatment for the therapy?
- j. Has the member complied with prescribed appointments/treatments for the therapy in the past?
- k. What is the average number of work hours per week that the member's condition has required the member to be away from current duties for treatment, evaluation, and/or recuperation?
- l. Is member pending disciplinary action or involuntary administrative separation for misconduct? If yes, explain.
- m. Does the member have a history of disciplinary issues or misconduct?
If yes, explain:
- n. Is a Line of Duty Investigation required surrounding the circumstances of the injury/accident? (**If yes, please forward a copy to WWBN-W**)
- o. If a Line of Duty Investigation is required but not complete, when will it be complete? Date: Point of Contact:

- p. What is the member's marital status?
 - q. Does the Marine have any children? If so, how many?
 - r. Is the member's family co-located with the member or do they live elsewhere? If they live elsewhere, state where they live?
 - s. Where is the service member currently billeted/living?
 - t. Will the service member require billeting at the Wounded Warrior Battalion-West Barracks?
 - u. Is the service member medically and legally cleared to drive? If no, explain:
 - v. Does the service member or spouse own a vehicle?
 - w. If the service member lives off base, will he/she have transportation to get to Wounded Warrior Battalion?
 - x. Are there any other known transportation issues? Explain:
 - y. Does the member have a history of substance abuse or alcohol abuse or dependency? If yes, explain:
 - z. Does the member have a history of suicidal or homicidal ideations? If yes, explain:
 - aa. Does the member own a firearm?
 - bb. Was the injury incurred while deployed in support of OIF/OEF? -
 - cc. Was the injury combat related?
 - dd. Does the Service Member have any Fitness Report Date Gaps? If yes, confirm they will be complete before the Service Member is sent to WWBn-W:
2. Commanding Officer; explain in your opinion, why would Wounded Warrior Battalion-West be the best place for the member: (Usually a couple paragraphs long.) Provide any additional information or concerns that may be relevant.
3. POC at this command is Phone Number: E-mail address:

(sign name)
(print name)
Commanding Officer

All referrals must be completely filled out and endorsed by the service member's Commanding Officer. It is up to the service member's parent command to ensure a referral package is completely filled out. Once complete, send to wbnw_referrals@usmc.mil or to respective WWBn-W Detachment Officers-in-Charge for entry into the referral boarding process.

Medical Case Manager Comments

If no Medical Case Manager is assigned state why:

Name:

Phone:

Email:

1. Describe the primary diagnosis or mechanism of injury causing this referral to Wounded Warrior Battalion-West:
2. Which Military Treatment Facility (hospital) would provide the most appropriate care for this service member?
3. Average number of appointments per week, what are they for, and location (NHCP, NMCS, Scripps, etc):
4. Number of missed appointments in past 90 days: Reasons why missed (if known):
5. Who is the service member's primary physician?
6. Does the service member have any upcoming surgeries?
7. If so, what is the surgery for?
8. When and where will the surgery take place?
9. Estimated length of Convalescent Leave:
10. Has the Marine been screened for PTSD and/or TBI?
11. If Service Member was screened for PTSD and/or TBI, what were the results?
12. Is there a history of suicidal/homicidal ideations or attempts? If yes, explain:
13. Is the service member medically cleared to drive?
14. If not cleared to drive, explain:
15. Does the service member have any specific medical needs for billeting/housing? If yes, explain:
16. What is the medical care plan for the service member?

17. Is the service member on Limited Duty?
18. If the service member is on Limited Duty, for what period?
19. Is the service member most likely to receive a PEB?
20. Why, in your opinion, would the Wounded Warrior Battalion be the best place for the service member (be descriptive/convincing)
21. Other considerations, comments:

(**sign name**)
(print name)

All referrals must be completely filled out and endorsed by the service member's Commanding Officer. It is up to the service member's parent command to ensure a referral package is completely filled out. Once complete, send to wbnw_referrals@usmc.mil or to respective WWBn-W Detachment Officers-in-Charge for entry into the referral boarding process.

Unit Medical Officer/Primary Care Provider Comments

Rank/Name:

Phone:

Email:

1. Describe the primary diagnosis or mechanism of injury causing this referral to Wounded Warrior Battalion-West:
2. Which Military Treatment Facility (hospital) would provide the most appropriate care for this service member?
3. Estimated recovery period:
4. Do you feel that the member is capable of returning to full duty?
5. Why, in your opinion, would the Wounded Warrior Battalion be the best place for the service member: (be descriptive/convincing)
6. Other considerations, comments:

(sign name)
(print name)

All referrals must be completely filled out and endorsed by the service member's Commanding Officer. It is up to the service member's parent command to ensure a referral package is completely filled out. Once complete, send to wbnw_referrals@usmc.mil or to respective WWBn-W Detachment Officers-in-Charge for entry into the referral boarding process.

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Appendix E. Management Comments

Commandant of the Marine Corps Comments



DEPARTMENT OF THE NAVY
HEADQUARTERS UNITED STATES MARINE CORPS
3000 MARINE CORPS PENTAGON
WASHINGTON, DC 20350-3000

IN REPLY REFER TO:
7500
RFR-80
MAY 12 2012

From: Commandant of the Marine Corps
To: Office of the Deputy Inspector General, Special Plans
and Operations, Department of Defense

Subj: COMMANDANT OF THE MARINE CORPS (CMC) RESPONSE TO
DEPARTMENT OF DEFENSE INSPECTOR GENERAL (DODIG) DRAFT
REPORT PROJECT NO. D2010-DC00SPO-0209.003, "ASSESSMENT OF
DOD WOUNDED WARRIOR MATTERS - WOUNDED WARRIOR BATTALION -
WEST HEADQUARTERS AND SOUTHERN CALIFORNIA UNITS"

Ref: (a) DODIG Memorandum dtd 27 Mar 2012

Encl: (1) HQMC Official Comments to DODIG Recommendations

1. Official responses required by the reference are provided at enclosure (1).
2. Based on corrective actions completed, the Marine Corps requests DODIG close recommendations A.1.1., B.1., C.1.2., C.4., C.5.1., C.5.2., C.7.1., C.7.2., and C.8.
3. The Marine Corps appreciates the opportunity to respond to the report.
4. If you have any questions about the responses, please

JOHN E. WISSLER
Deputy Commandant
for Programs and Resources

Copy to:
NAVINGEN (N4)
DMCS
CMC (HS)
CG MARFORPAC
CO. WWR

UNCLASSIFIED

**DODIG DRAFT REPORT DATED MARCH 27, 2012
D2010-D00SPO-0209.003**

**“ASSESSMENT OF DOD WOUNDED WARRIOR MATTERS - WOUNDED
WARRIOR BATTALION-WEST HEADQUARTERS AND SOUTHERN
CALIFORNIA UNITS”**

**US MARINE CORPS COMMENTS
TO THE DODIG RECOMMENDATIONS**

RECOMMENDATION A.1.1: The DODIG recommends that the Commander, Wounded Warrior Regiment (WWR) ensure all procedures for handling electronic protected health information are compliant with Health Insurance Portability and Accountability Act (HIPAA) requirements. (See page 15/DODIG Draft Report.)

USMC RESPONSE: Concur. WWR ensures HIPAA compliance, to include annual personnel training requirements.

RECOMMENDATION A.1.2: The DODIG recommends the Commander, Wounded Warrior Regiment implement policy that ensures the use of HIPAA compliant, wireless electronic communications to notify Warriors of medical appointments is only done with the consent of the Warrior, and that the notifications contain applicable privacy notices, the minimum amount of information needed, and are only e-mailed to confirmed addresses. (See page15/DODIG Draft Report.)

USMC RESPONSE: Concur. WWR will implement, within 90 days, the recommended policy regarding the handling of wireless electronic communications.

RECOMMENDATION A.2: The DODIG recommends WWBn-West's noteworthy practice of having Warriors engage in work internships and educational opportunities based upon Warriors' desires and needs, and their commitment to productive use of Warrior's time in support of their recovery and transition may be applicable for utilization at other WWBn's, as well as Army Warrior Transition Units, and should be considered for prompt implementation, where appropriate. (See page17/DODIG Draft Report.)

USMC RESPONSE: Concur with comment. Medical Officer of the Marine Corps (Health Services) will work with Wounded Warrior Regiment (M&RA), Navy Bureau of Medicine and Surgery (responsible for in-garrison care mission), and other stakeholders to identify health service support manning requirements to provide health service staff functions, dedicated primary care management, and coordination of health care services for Marine and Sailors at Wounded Warrior Battalion-West, as well as other Wounded Warrior units. A proposed health services manning solution will be formulated by 01 June 2012.

Enclosure (1)

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RECOMMENDATION B.1.: The DODIG recommends the Commander, Wounded Warrior Regiment ensure relevant battalion staff and administration personnel who support Reservist Warriors receive adequate training so that Reservist Warriors' recovery and transitions are not delayed or negatively affected by administrative procedures. (See page 20/DODIG Draft Report.)

USMC RESPONSE: Concur with comment. All personnel within the WWR and WWBn-W staff should have adequate knowledge of the unique administrative requirements of reservists on Medical Hold who are in the Integrated Disability Evaluation System (IDES) process. There is no difference between how a mobilized reserve Marine is administratively handled in comparison to an active duty Marine at the end of current contract. WWR provides staff reserve-specific computer-based training modules and the Regiment's virtual resource center includes information on reserve-specific issues.

RECOMMENDATION C.1.2.: The DODIG recommends the Commander, Wounded Warrior Regiment implement processes to determine if Warriors' conditions improve to the point they can be released from the Wounded Warrior Battalion and complete their transition at an alternate appropriate location. (See page 32/DODIG Draft Report.)

USMC RESPONSE: Non-concur with comment. The Commandant of the Marine Corps has established that the WWR has primary oversight of the non-medical care of wounded, ill, and injured (WII) Marines. This care includes transition and discharge. Generally, only the most acute cases are joined to the WWR. Transferring a WII Marine from the WWR to "an alternate location," presumably another unit, would defeat the purpose of having a single unit with oversight and potentially place the WII Marine in a position of being served by a unit less prepared to assist with his/her non-medical care needs.

RECOMMENDATION C.2.: The DODIG recommends the Medical Officer of the Marine Corps (Health Services) identify the correct configuration for a Battalion Surgeon, Medical Officer, Battalion Aid Station or other appropriate equivalent medical services to provide dedicated Primary Care Management (PCM) support for Warriors at Camp Pendleton. (See page 36/DODIG Draft Report.)

USMC RESPONSE: Concur with comment. Medical Officer of the Marine Corps (Health Services) will work with Wounded Warrior Regiment (M&RA), Navy Bureau of Medicine and Surgery (responsible for in-garrison care mission), and other stakeholders to identify health service support manning requirements to provide health service staff functions, dedicated primary care management, and coordination of health care services for Marines and Sailors at Wounded Warrior Battalion-West, as well as other Wounded Warrior units. A proposed health services manning solution will be formulated by 01 Jun 2012.

Enclosure (1)

UNCLASSIFIED

RECOMMENDATION C.3.2.: The DODIG recommends the Commander, Wounded Warrior Regiment implement policy that Warriors assigned to Warrior battalions to recover and transition will not be assigned staff positions that require Warriors to lead or have authority over other Warriors. (See page 41/DODIG Draft Report.)

USMC RESPONSE: Non-concur with comment. Depending upon the overall comprehensive transition plan of a WII Marine, as well as his/her compliance with the five Lines of Operation programs, we have established that some Marines flourish in staff positions. Staff positions provide certain WII Marines a feeling of self-worth, especially those Marines who wish to return to full duty. WWBn-W will establish a policy within 90 days to address this matter and allow for WII Marines to serve in staff positions only on a case-by-case basis.

RECOMMENDATION C.3.3.: The DODIG recommends the Commander, Wounded Warrior Regiment implement policy that Corpsman Warriors assigned to Warrior battalions to recover and transition will not be assigned corpsman responsibilities. (See page 41/DODIG Draft Report.)

USMC RESPONSE: Non-concur with comment. Please see rationale from C.3.2. above.

RECOMMENDATION C.4.: The DODIG recommends the Commander, Wounded Warrior Regiment, implement official policy that determines the location of Warriors' recovery and transition based on factors that include Warriors' preferences. (See page 43/DODIG Draft Report.)

USMC RESPONSE: Non-concur with comment. Existing policy, Marine Corps Order 6320.2D (Administration and Processing of Hospitalized Marines) and WWR Order 6300.1A (Administrative Procedures for Acceptance of Wounded, Ill, Injured, or Hospitalized Personnel to the Wounded Warrior Regiment) addresses the location of warriors' recovery and transition. Additional policy is not required to satisfy the IG's recommendation.

RECOMMENDATION C.5.1.: The DODIG recommends the Commander, WWBn-West, identify all necessary programs that prepare Warriors' families and other significant care givers to fully contribute to their Warrior's recovery and transition. (See page 45/DODIG Draft Report.)

USMC RESPONSE: Concur with comment. WWBn-W has established a standardized process through a published campaign plan, Wounded Warrior Battalion-West Order 3010.1, to ensure all Marines and their families receive the same information and benefits, regardless of their location. Some of the standardized programs for family members and support programs that WWBn-W is establishing or has established are as follows:

Enclosure (1)

UNCLASSIFIED

(1) Currently, WWBn-W is working with the Defense and Veterans Brain Injury Clinic (DVBIC) to schedule quarterly TBI/PTSD classes for spouses and family members. WWBn-W is establishing an orientation program to introduce the families to the battalion and explain both the medical process as well as the additional programs provided through the five Lines of Operation programs.

(2) Special Compensation for Assistance with Activities of Daily Living (SCAADL) has been implemented and the WWR is working with the OSD Office of Wounded Warrior Care and Transition Policy to provide training to the caregivers of SCAADL recipients.

(3) The WWBn-W Family Readiness Officer plans two family events per year that are directed toward children.

(4) The WWBn-W Chaplain hosts quarterly weekend getaways, of which two are open to children.

(5) The WWBn-W Spirit Line of Operation Program Manager is currently resourcing programs/events that are child-friendly, such as a recent joint effort with the San Diego Padres.

(6) WWBn-W utilizes programs for children offered through Marine Corps Community Services. These programs are publicized regularly. Families OverComing Under Stress (FOCUS) is a specific program in place to help children understand how to talk about the physical and mental injuries sustained by their parent, and how to deal with their feelings associated with those injuries. FOCUS also offers parenting classes through New Parent Support, a communication class.

(7) WWBn-W has established weekly coffee meetings dedicated to wives. Different events are discussed and questions are answered. eMarine was established to make sure information is always available to both the Marine and his/her family.

RECOMMENDATION C.5.2.: The DODIG recommends the Commander, Wounded Warrior Regiment develop the appropriate budget, and resource and staff all appropriate programs necessary to prepare Warriors' families and other significant care givers to fully contribute to their Warrior's recovery and transition. (See page 45/DODIG Draft Report.)

USMC RESPONSE: Concur with comment. The WWR's budget reflects a commitment to ensuring WII Marines' families and other caregivers fully contribute to their recovery and transition. Examples include, but are not limited to: caregiver trainings, the Recovery Care Coordination Program, our Medical Cell, Hope and Care Centers, our family support programs, the Wounded Warrior Call Center and the Wounded Warrior Regiment Mobile App.

Enclosure (1)

UNCLASSIFIED

RECOMMENDATION C.6.: The DODIG recommends the Deputy Commandant for Manpower and Reserve Affairs determine the requirements of all necessary computer-based and web-based systems and all interfaces required to support Marine Corps Wounded Warrior processes, and program for, fund, and resource all valid computer-based and web-based systems and interfaces. (See page 50/DODIG Draft Report.)

USMC RESPONSE: Partially concur with comment. M&RA will continue to work systems requirements to ensure internal Marine Corps systems provide the Wounded Warrior Regiment and its subordinate battalions the functionality needed to effectively manage its wounded Marine population. Additionally, we will coordinate with external agencies at the CON and DoD levels to ensure interfaces are developed to allow bi-directional transfer of information.

RECOMMENDATION C.7.1.: The DODIG recommends the Commander, WWBn-West identify all requirements necessary to fully support all WWBn-West, Detachment Twentynine Palms transportation needs. (See page 53/DODIG Draft Report.)

USMC RESPONSE: Concur with comment. During the DoD IG visit, there was not an issue meeting the transportation requirements for Marines assigned to WWBn-W. The issue was Marines assigned to other Twentynine Palms-based units were not receiving adequate transportation support when they had appointments at Naval Hospital Camp Pendleton, Naval Medical Center San Diego, or other San Diego hospitals. In November 2011, the Marine Corps Air Ground Combat Center Chief of Staff and Naval Hospital Twentynine Palms met to discuss the transportation concerns. As a result, a base shuttle was instituted two days per week and supported through Twentynine Palms base logistics section.

RECOMMENDATION C.7.2.: The DODIG recommends the Commander, Wounded Warrior Regiment program for, fund, and resource the required transportation requirements necessary to fully support all WWBn-West, Detachment Twentynine Palms transportation needs. (See page 53/DODIG Draft Report.)

USMC RESPONSE: Concur with comment. Please see rationale from C.7.1.

RECOMMENDATION C.8.: The DODIG recommends the Commander, Marine Corps Installations-West implement policy and procedures that ensure Warriors and Warriors' dependents renewal of government identification cards and base pass/vehicle registration decals does not interfere with Warriors' recovery and transition or impose a burden on dependents. (See page 55/DODIG Draft Report.)

Enclosure (1)

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USMC RESPONSE: Concur, with comments as follows:

(1) Contact was made with the wounded Warrior Bn (WWBn) Commanding Officer. He indicated that in his view this issue had largely been resolved. He assigned his XO as liaison to coordinate and/or implement solutions tailored to accommodate wounded warriors.

(2) During the discourse, it was determined that the mechanisms in place to accommodate wounded warriors were sufficient and working well:

- WWBn Marines and their dependants receive "second-in-line" privileges at any of the three Pass & ID centers aboard Camp Pendleton for DEERS and/or vehicle registration. Second in line means the WWBn individual is next following completion of the transaction ongoing at a particular window. If on the rare occasion a window is open, the individual would have "front of line" privileges.

- WWBn Staff knows who to contact within the Pass and ID hierarchy to coordinate unusual situations. This could include dedicating one or more windows within a Pass & ID center to WWBn personnel - during or after normal working hours to include weekends.

- Where possible, Pass & ID transactions are conducted via proxy (i.e., WWBn Staff and Pass & ID personnel on behalf of a WWBn Marine or Dependent).

(3) Vehicle decals and ID cards are issued per the recommendation of the WWBn CO or his Staff or 3 years - whichever is less. If they do not know, or if it is difficult for them to assess, Pass & ID centers will re-issue ID cards and decals in 90 day increments.

ADDITIONAL COMMENTS:

1. In addition to the required comments, we provide the following additional comments for consideration and inclusion in the final report.

a. Subsequent to the DoDIG's April 2011 assessment, the following changes have taken place at WWBn-W that have significantly enhanced care:

Enclosure (1)

UNCLASSIFIED

(1) In October 2011, WWBn-W opened the Warrior Hope and Care Center (WHCC). The WHCC provides counseling, reconditioning and transition services for WII Marines, Sailors, and their families. The WHCC is a 30,000 square foot structure and accommodates wounded warrior support ranging from family readiness, mental health, Recovery Care Coordinators, and hosts the battalion's Warrior Athlete Reconditioning Program. More specifically, the WHCC provides activities for children, has computer labs, provides music therapy and expressive arts, education, and various transition activities.

(2) In September 2011, WWBn-W organized an Operational Planning Team to assess best practices and shortfalls across the battalion. As a result, on 20 Feb 12, WWBn-W Order 3010.1 Campaign Plan was published in order to focus the battalion efforts and standardize processes across all five Lines of Operation (Medical, Mind, Body, Spirit, and Family). The standardization of these processes allows the battalion's main effort, the Recovery Team, to accurately track the individual WII Marine through four defined phases within their medical recovery as well as focus all approved assets/resources on the individual Marine at the appropriate time.

(3) WWBn-W and its higher headquarters have significantly improved manpower strength, most notably in the Section Leader-to-patient ratio.

(4) In November 2011, the Naval Hospital Camp Pendleton's Integrated Disability Evaluation System (IDES) office moved into a building less than 100 yards from the current WWBn-W barracks. The building consolidated the entire IDES team to include: PEBLOs, both civilians who initiated the DES process and military who advise the service members on their ratings; the Veterans Administration Military Service Coordinator, who reviews the service member's medical records and schedules the VA clinic examinations; and the IDES attorney who reviews the package with the service member before it is signed and sent to the Physical Evaluation Board in Washington, D.C. as well as assists the service member in the event the findings are different than expected and a reconsideration or formal board hearing is requested. Additionally, more administrative support and leadership was identified and hired. These actions, in conjunction with WWBn-W diligence in ensuring that necessary documentation for the IDES process was submitted in a timely manner resulted in advancing from one of the poorest IDES performing military treatment facilities to one of the top performers within the Department of the Navy. Currently, the number of WWBn-West Camp Pendleton Marines who have been in the MEB Phase beyond the 100 day goal is less than five percent.

2. WWR also provides the following comments on recommendation C.2: we strongly support this recommendation and will work with the Medical Officer of the Marine Corps and Navy Medicine to address the recommendation.

Enclosure (1)

UNCLASSIFIED

3. Additional editorial comments provided for accuracy are as follows:

a. Throughout the report, Comprehensive Transition Plan should be amended to read "Comprehensive Recovery Plan."

b. On page 2, the mission of the WWR should be amended to include assistance to "wounded, ill and injured Marines."

c. On page 6, Wounded Warrior Battalion-West organization chart should reflect the following organizational chart:

Enclosure (1)

Marine Corps Installations West - Marine Corps Base, Camp Pendleton Comments



UNITED STATES MARINE CORPS
MARINE CORPS INSTALLATIONS WEST – MARINE CORPS BASE
BOX 555010
CAMP PENDLETON, CALIFORNIA 92055-5010

1000
CG
30 APR 2012

From: Commanding General
To: Commandant of the Marine Corps, Programs and Resources
(RFR)
Subj: ASSESSMENT OF DOD WOUNDED WARRIOR MATTERS: WOUNDED
WARRIOR BATTALION-WEST HEADQUARTERS AND SOUTHERN
CALIFORNIA UNITS
Ref: (a) Department of Defense Office of the Inspector General
Draft Report dated 27 March 2012; Project No.
D2010-D00SPO-0209.003

1. Per the requirements set forth in reference (a), the following is submitted:

C.8. Topic. End of Active Duty Service Dates Affect on U.S. Government Identification Cards and Base Pass/Vehicle Decal Expiration Dates

Issue. Some Warriors were required to remain on active duty beyond their End of Active Duty Service date for medical or administrative reasons. As a result, government identification cards and base pass/vehicle registration decals for these Warriors and all their dependents expired and were usually only extended in 90-day increments. Therefore, Warriors had to take time away from their recovery and transition to renew these documents which risked being detrimental to the Warrior and a burden on the Warrior's family.

C.8. Recommendation. We recommend the Commander, Marine Corps Installations-West implement policy and procedures that ensure Warriors and Warriors' dependents renewal of government identification cards and base pass/vehicle registration decals does not interfere with Warriors' recovery and transition or impose a burden on dependents.

Response

1. Contact was made with the Wounded Warrior Bn (WWBn) Commanding Officer. He indicated that in his view this issue had largely been resolved. He assigned his XO as liaison to

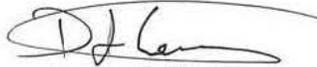
Subj: ASSESSMENT OF DOD WOUNDED WARRIOR MATTERS: WOUNDED
WARRIOR BATTALION-WEST HEADQUARTERS AND SOUTHERN
CALIFORNIA UNITS

coordinate and/or implement solutions tailored to accommodate wounded warriors.

2. During the discourse, it was determined that the mechanisms in place to accommodate wounded warriors were sufficient and working well:

- WWBn Marines and their dependants receive "second-in-line" privileges at any of the three Pass & ID centers aboard Camp Pendleton for DEERS and/or vehicle registration. Second in line means the WWBn individual is next following completion of the transaction ongoing at a particular window. If on the rare occasion a window is open, the individual would have "front of line" privileges.
- WWBn Staff knows who to contact within the Pass & ID hierarchy to coordinate unusual situations. This could include dedicating one of more windows within a Pass & ID center to WWBn personnel - during or after normal working hours to include weekends.
- Where possible, Pass & ID transactions are conducted via proxy (i.e. WWBn Staff and Pass & ID personnel on behalf of a WWBn Marine or Dependant).

3. Vehicle decals and ID cards are issued per the recommendation of the WWBn CO or his Staff or 3 years - whichever is less. If they do not know, or if it is difficult for them to assess, Pass & ID centers will re-issue ID cards and decals in 90 day increments.



D. J. TERANDO
Chief of Staff

Copy to:
COMMCICOM
COMMARFORPAC
CO, Scty Bn
CIG
AC/S G-3/5

Department of the Navy, Office of the Assistant Secretary Manpower and Reserve Affairs Comments



DEPARTMENT OF THE NAVY
OFFICE OF THE ASSISTANT SECRETARY
(MANPOWER AND RESERVE AFFAIRS)
1000 NAVY PENTAGON
WASHINGTON, D.C. 20350-1000

MEMORANDUM FOR CHIEF, MEDICAL ASSESSMENT DIVISION, OFFICE OF
THE DEPARTMENT OF DEFENSE INSPECTOR
GENERAL

SUBJECT: Department of Defense Inspector General Report (DODIG-2010-D00SPO-
0209.003) – Assessment of DoD Wounded Warrior Matters – Camp
Pendleton

Thank you for the opportunity to review and provide additional feedback to the
DoD final report. Please see attachment 1 for the Department of the Navy's
supplemental responses.



A handwritten signature in black ink, appearing to read "Russell W. Beland".

Russell W. Beland
Deputy Assistant Secretary of the Navy
(Military Manpower & Personnel)

Attachments:
As stated

Assessment of DoD Wounded Warrior Matters - Camp Pendleton
(Report No. DODIG-2010-D00SPO0209.003)

C.1.1. We recommend the Secretary of the Navy take action to ensure that each phase of the Integrated Disability Evaluation System process is accomplished within the established timelines for every Warrior assigned or attached to the Wounded Warrior Battalions.

- The Secretary of the Navy is committed to ensuring the fair and timely disability evaluation of Recovering Warriors. Under the current IDES structure, 295 days appears to be an unrealistic goal. The Department of the Navy (DoN) is continually reviewing staffing, procedures, and technology to implement the seamless transition of its Marines and Sailors within the Integrated Disability Evaluation System (IDES) and reduce the average number of days to complete the processing. Recognizing portions of the IDES process are dependent on processing outside of our control, the DoN notes important accomplishments in the areas within our control.
- The IDES timeline goal of 295 days was established to reduce the legacy joint DoD/VA DES processing of 540 days. In April 2012, processing time for USMC was 316 days and 355 days for Navy. Within the 295 day goal, there are four phases: Medical Evaluation Board (MEB) Phase (100 days); Physical Evaluation Board (PEB) Phase (120 days); Transition Phase (45 days); and VA Benefits Phase (30 days). Although DoN is meeting the MEB and PEB phase goals, we are exceeding the Transition Phase and VA Benefits Phase by an average of 22 days and 31 days respectively.
- To come closer to the 295 day overall IDES goal in a fair and timely manner, the DoN implemented the following major actions:
 - Convened monthly Video Teleconferencing (VTC) involving key IDES personnel from BUMED, PEB, VA, and Service Headquarters.
 - Improved staffing at MEBs in FY11 by hiring 10 doctors and 37 additional case managers for those locations needing additional, targeted support. The dedicated MEB physician staff is also essential to a vision of program sustainment through local education and training, as well as actively moving the day-to-day MEB caseload. Hiring of 23 additional MEB doctors in FY13 will complete resource requirements.
 - Increased PEB staffing by 47% and leveraged a point-to-point case file transfer methodology. DoN is currently moving 75% of Navy and 69% of USMC PEB cases through the PEB Phase in less than 120 days.
 - Significantly reduced average time spent in the MEB Phase by leveraging existing technology, via DoD's Armed Forces Health Longitudinal Technology Application (AHLTA), to streamline development of the Narrative Summary

(NARSUM). Currently, 86% of Navy and 73% of USMC cases are meeting the 100-day phase goal.

- Leveraged existing technology by instituting the Electronic File transfer of all IDES cases to and from the PEB and VA using the SAFE transfer site. See <https://safe.amrdec.army.mil/safe2/Welcome.aspx>.
- Leveraged existing, desk-top IT applications to build operational reporting capabilities at the MTF using the Veteran's Tracking Application (VTA), which has led to significant improvements in IDES case file workflow management and greatly improved processing timeliness.
- Presently developing a technology solution and/or process improvement between the VA and Service Headquarters regarding the DD-214 transfer to shorten the Transition Phase and VA Benefits Phase.
- Conducted an Industrial-Engineer-Study to validate, improve, and recommend MTF manning and resource solutions at Camp Lejeune Military Treatment Facility.
- Conducted an Industrial-Engineer-Study to validate, improve, and recommend PEB manning and resource solutions.
- Senior leadership participation and collaboration across the DoN, within the Office of the Secretary of Defense (OSD) and with the Department of Veterans Affairs (VA) contributes significantly to improved IDES processing time.

C.3.1. We recommend the Secretary of the Navy fully staff Wounded Warrior Battalions with non-Warrior Marine Corps and Navy personnel.

- Concur with comment. Staffing the Wounded Warrior Battalions is supported by existing resourcing and programming processes. The management of the wounded warrior population should leverage Marine and Sailor assignment to staff positions where appropriate, particularly in support of Marines who intend to return to full duty.

C.3.2. We recommend the Commander, Wounded Warrior Regiment implement policy that Warriors assigned to Warrior battalions to recover and transition will not be assigned staff positions that require Warriors to lead or have authority over other Warriors.

- Concur with comment. Wounded Warrior Battalion will establish a policy within 90 days to address this matter and allow for WII Marines to serve in staff positions only on a case-by-case basis. Depending upon the overall comprehensive transition plan of a WII Marine, as well as his/her compliance with the five Lines of Operation programs, we have established that some Marines flourish in staff positions. Staff positions provide certain WII Marines a feeling of self-worth, especially those Marines who wish to return to full duty.

C.3.3. We recommend the Commander, Wounded Warrior Regiment implement policy that Corpsman Warriors assigned to Warrior battalions to recover and transition will not be assigned corpsman responsibilities.

- See C.3.2.



DEPARTMENT OF THE NAVY
OFFICE OF THE ASSISTANT SECRETARY
(MANPOWER AND RESERVE AFFAIRS)
1000 NAVY PENTAGON
WASHINGTON, D.C. 20350-1000

**MEMORANDUM FOR CHIEF, MEDICAL ASSESSMENT DIVISION, OFFICE OF
THE DEPARTMENT OF DEFENSE INSPECTOR
GENERAL**

**SUBJECT: Department of Defense Inspector General Report (DODIG-2012-067) –
Assessment of DoD Wounded Warrior Matters – Camp Lejeune**

Thank you for the opportunity to review and provide additional feedback to the DoD final report. Please see attachment 1 for the Department of the Navy's supplemental responses.



A handwritten signature in black ink, appearing to read "Russell W. Beland".

Russell W. Beland
Deputy Assistant Secretary of the Navy
(Military Manpower & Personnel)

Attachments:
As stated

Assessment of DoD Wounded Warrior Matters - Camp Lejeune
(Report No. DODIG-2012-067)

D.2. We recommend the Secretary of the Navy take action to ensure that each phase of the Integrated Disability Evaluation System (IDES) process is accomplished within the established timelines for every Warrior assigned or attached to the Wounded Warrior Battalions.

- The Secretary of the Navy is committed to ensuring the fair and timely disability evaluation of Recovering Warriors. Under the current IDES structure, 295 days appears to be an unrealistic goal. The Department of the Navy (DoN) is continually reviewing staffing, procedures, and technology to implement the seamless transition of its Marines and Sailors within the Integrated Disability Evaluation System (IDES) and reduce the average number of days to complete the processing. Recognizing portions of the IDES process are dependent on processing outside of our control, the DoN notes important accomplishments in the areas within our control.
- The IDES timeline goal of 295 days was established to reduce the legacy joint DoD/VA DES processing of 540 days. In April 2012, processing time for USMC was 316 days and 355 days for Navy. Within the 295 day goal, there are four phases: Medical Evaluation Board (MEB) Phase (100 days); Physical Evaluation Board (PEB) Phase (120 days); Transition Phase (45 days); and VA Benefits Phase (30 days). Although DoN is meeting the MEB and PEB phase goals, we are exceeding the Transition Phase and VA Benefits Phase by an average of 22 days and 31 days respectively.
- To come closer to the 295 day overall IDES goal in a fair and timely manner, the DoN implemented the following major actions:
 - Convened monthly Video Teleconferencing (VTC) involving key IDES personnel from BUMED, PEB, VA, and Service Headquarters.
 - Improved staffing at MEBs in FY11 by hiring 10 doctors and 37 additional case managers for those locations needing additional, targeted support. The dedicated MEB physician staff is also essential to a vision of program sustainment through local education and training, as well as actively moving the day-to-day MEB caseload. Hiring of 23 additional MEB doctors in FY13 will complete resource requirements.
 - Increased PEB staffing by 47% and leveraged a point-to-point case file transfer methodology. DoN is currently moving 75% of Navy and 69% of USMC PEB cases through the PEB Phase in less than 120 days.
 - Significantly reduced average time spent in the MEB Phase by leveraging existing technology, via DoD's Armed Forces Health Longitudinal Technology Application (AHLTA), to streamline development of the Narrative Summary

(NARSUM). Currently, 86% of Navy and 73% of USMC cases are meeting the 100-day phase goal.

- Leveraged existing technology by instituting the Electronic File transfer of all IDES cases to and from the PEB and VA using the SAFE transfer site. See <https://safe.amrdec.army.mil/safe2/Welcome.aspx>.
- Leveraged existing, desk-top IT applications to build operational reporting capabilities at the MTF using the Veteran's Tracking Application (VTA), which has led to significant improvements in IDES case file workflow management and greatly improved processing timeliness.
- Presently developing a technology solution and/or process improvement between the VA and Service Headquarters regarding the DD-214 transfer to shorten the Transition Phase and VA Benefits Phase.
- Conducted an Industrial-Engineer-Study to validate, improve, and recommend MTF manning and resource solutions at Camp Lejeune Military Treatment Facility.
- Conducted an Industrial-Engineer-Study to validate, improve, and recommend PEB manning and resource solutions.
- Senior leadership participation and collaboration across the DoN, within the Office of the Secretary of Defense (OSD) and with the Department of Veterans Affairs (VA) contributes significantly to improved IDES processing time.

D.2.1. We recommend the Surgeon General of the Navy and Chief, Navy Bureau of Medicine and Surgery update policies and procedures for overall Navy Medicine poly-pharmacy management and medical reconciliation.

BUMED concurs with this recommendation, although with the following comments: The specific language of this recommendation implies that there should be one process for poly-pharmacy management and medication reconciliation throughout the Navy Medicine Enterprise. However, the current BUMED position is that detailed, specific guidance for poly-pharmacy management and medical reconciliation must be developed and implemented at the MTF level. BUMED strongly concurs with the recommendation for updated policies and procedures at Naval Hospital Camp Pendleton, but we maintain that developing and updating local policies under the authority of the MTF Commanding Officer would best serve patients, in that it would match local policies and capabilities to the needs of the particular patient population. A detailed, centralized policy would be difficult to implement, considering the wide variation of practice settings in Navy Medicine. That being said, BUMED will continue to emphasize the requirement for effective medication management policies at the local level to promote safe and effective patient care.

In support of local MTF healthcare operations, BUMED established the Navy Comprehensive Pain Management Program (NCPMP) to improve the capability and capacity of the Navy's pain management resources, and to foster healing and reduce suffering from acute and chronic pain. Key NDAA and ASD(HA) directives are to ensure the availability of standardized and multidisciplinary comprehensive pain management programs throughout the MHS. The NCPMP is deploying pain management manpower assets, initially focusing on "pain hotspots" to enable and promote multidisciplinary pain care, including Complementary and Alternative Medicine (CAM) techniques. In addition, the NCPMP has implemented Telemedicine services to increase access to pain specialty care, and to provide education and consultation with pain medicine specialists for patients and primary care providers. The NCPMP is also enhancing the training of providers throughout Navy Medicine in CAM techniques, initially focusing on battlefield (first aide) and medical acupuncture, to increase the number of therapeutic options for providers.

These activities are key to optimizing pain care "medication management," as they give providers non-pharmacologic therapeutic options. These clinical procedures are bolstered by policy dissemination and training. Specifically, the NCPMP is finalizing Interim Guidance for Pain Management, which aims to standardize and optimize a biopsychosocial approach to Pain Management, in accordance with state-of-the-art DoD/VA and civilian Clinical Pathway Guidelines (CPGs). Areas of focus include a requirement for a qualitative assessment of pain, an appropriate referral for multidisciplinary care, and a Chronic Opioid Therapy Safety (COTS) program. COTS requires screening for the appropriateness of any opioid prescription, the use of Opioid Care Agreements (OCAs), sole providers, and surveillance for adherence with urine drug tests (UDTs). A BUMED Publication will follow the Interim Guidance for sustainment. Two training programs have also been created to address prescription medication misuse. The training programs, 'Do No Harm' and 'The War at Home', are being hosted on MHS-Learn for providers and service members, respectively.



DEPARTMENT OF THE NAVY
OFFICE OF THE ASSISTANT SECRETARY
(MANPOWER AND RESERVE AFFAIRS)
1000 NAVY PENTAGON
WASHINGTON, D.C. 20350-1000

**MEMORANDUM FOR CHIEF, MEDICAL ASSESSMENT DIVISION, OFFICE OF
THE DEPARTMENT OF DEFENSE INSPECTOR
GENERAL**

SUBJECT: Department of Defense Inspector General Report (DODIG-2010-D00SPO00-0209.003) – Assessment of DoD Wounded Warrior Matters –Navy Medicine West Response

This letter provides additional information to the Department of the Navy (DoN) Official Response signed by Dr. Russell Beland on 2 July 2012 for the Wounded Warrior DODIG Assessment. Please see Navy Medicine West and Commandant of the Marine Corps comments at attachment 1.



A handwritten signature in black ink, appearing to read "Mike Bridges".

Mike Bridges
Captain, Medical Service Corps
Special Assistant for Health Affairs
(Military Manpower & Personnel)

Attachments:
As stated

Navy Medicine West Comments



DEPARTMENT OF THE NAVY
NAVY MEDICINE WEST
4170 NORMAN SCOTT ROAD SUITE 5
SAN DIEGO, CA 92136-5521

IN REPLY REFER TO:
5041
Ser MOOA/ 0257
13 APR 12

MEMORANDUM FOR CHIEF BUREAU OF MEDICINE AND SURGERY

Subj: DODIG DRAFT REPORT ON ASSESSMENT OF DOD WOUNDED WARRIOR
MATTERS – NAVY MEDICINE WEST RESPONSE

Ref: (a) EKM Tasker DCN 2012UGENERAL – 005428c
(b) DODIG Draft report on Assessment of DoD Wounded
Warrior Matters, Project No. D2010-D00SPO-0209.003
dated 27 March 2012

1. In accordance with reference (a), the following is provided
in response to reference (b).

(a) **General.** Navy Medicine West recommends consistency
throughout the report with respect to the naming of the Military
Treatment Facilities visited/assessed. For example, Naval
Medical Center, San Diego is called "Balboa" and "Naval
Hospital" in some portions of the report and in other portions
it is called Naval Medical Center, San Diego. The correct names
for the three facilities visited are Naval Medical Center San
Diego (NMCS), Naval Hospital, Camp Pendleton (NHCP) and Naval
Hospital Twentynine Palms (NHTP).

(b) **General.** Navy Medicine West believes the DODIG
Report does not adequately reflect NMCS's true mission
statement and scope of care (pages 8 & 9 of the report refer).
Request that the DODIG Report incorporate the following changes:

(1) There are approximately 250,000 people in San
Diego County eligible to receive care at Naval Medical Center
San Diego (NMCS), the largest academic medical center in Navy
Medicine. Over 95,000 beneficiaries are enrolled for primary
care and many thousands more receive specialty care. This care
is provided by more than 6,600 military and civilian staff. To
augment that staff and to expand the scope of services available
to its patient population, Naval Medical Center San Diego has
taken the lead in introducing many innovative partnership and
resource sharing programs with the Veteran's Administration and
other civilian health systems and providers.

(2) Naval Medical Center San Diego is first and
foremost a military command. The center has five medical

Subj: DOD DRAFT REPORT ON ASSESSMENT OF DOD WOUNDED WARRIOR
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mobilization teams including the hospital ship USNS Mercy. These teams deploy to the Western Pacific and Southeast Asia at various times during the year. It is the center's mission to deliver top-quality, patient centered healthcare; Prepare and deploy military personnel in support of Combatant Commander requirements; Shape the future of military medicine through education, training, and research.

(c) **General.** Navy Medicine West does not understand the NMCS D Case Manager and Client data presented in Table 3 (page 60 of the report). While the paragraphs preceding Table 3 speak to Case Management support to WW, the data reflected in Table 3 indicates that the five NMCS D Nurse Case Managers interviewed had no WW assigned. This may be a simple error of data transposition within the table (of Non-Warriors and Warriors), and is meant to reflect case management provided by NMCS D Combat and Comprehensive Complex Casualty Care (C5) case managers. Alternatively, this data may reflect case management performed by NMCS D's Directorate of Healthcare Business case managers (who provide primarily non-warrior services). In either case, clarification or correction is necessitated.

(d) **General.** Navy Medicine West believes Table Four (page 60 of the report) reflects less than 50% of Case Managers at Naval Hospital Camp Pendleton (NHCP). Table should be annotated as reflecting a "sample" of NHCP case load.

(e) **Response to recommendation C.2.** We recommend the **Medical Officer of the Marine Corps (Health Services) identify the correct configuration for a Battalion Surgeon, Medical Officer, Battalion Aid Stations or other appropriate equivalent medical services to provide dedicated Primary Care Management (PCM) support for Warriors at Camp Pendleton. (Non-concur).** In September 2011, NHCP embedded within the WWBn as a Primary Care Manager one of their own providers whose sole patient empanelment is 220 WW patients. (This starkly contrasts with typical civilian 'concierge' panels of 850-900 patients, typical military and civilian empanelment of 1300 and 2400 patients, respectively). With this NHCP MTF PCM assignment, WWs reap the benefits of enrollment within a Medical Home Port, including same day access, secure messaging abilities with their healthcare team, and active management of their healthcare. Proposed Wounded Warrior Primary Care Management, provided by Marine Corps Health Services Personnel (vice Navy Medicine, NHCP staff) will create more problems than it would solve, including

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fragmentation of care and communication challenges as the WW
accesses Specialty Services at the MTF.

(f) **Response to recommendation D.1.2.** We recommend the
Commander, Navy Medicine-West implement policy to assign
dedicated medical case managers to patients assigned or attached
to WWBn-West Warriors. (Concur). While Navy Medicine West
Instruction 6320.1 formally directs the following items, many
were in place before the Instruction was promulgated on 10
November 2011.

(1) All WWs will initially be assigned a Clinical
Case Manager (CCM). Continuing CCM services will be contingent
upon WW needs.

(2) CCMs will be dedicated at MTFs with routinely
greater than 36 WWs, carrying a case load of no more than 20 WWs
per CCM.

(3) Dedicated CCMs will be imbedded within the WWBn
West detachment whenever possible.

(4) MTFs will utilize CCM extenders (i.e., LVN/LPNs,
admin support staff) if unable to fill CCM positions. CCM
extenders will work under the supervision of the CCM.

Additional Information NHCP: Warriors currently checking
in to WWBn-West Detachment at Camp Pendleton are assigned a
dedicated WW Case Manager that will remain their case manager
throughout their care.

Additional Information Naval Hospital 29 Palms (NHTP): At
the time of the DODIG visit, NHTP only had 4 of their 8 case
managers positions filled. They currently have six positions
filled with three of those designated to the 29 Palms WWBn-West
Detachment.

(g) **Response to recommendation D.1.3.** We recommend the
Commander Navy Medicine-West ensure enough medical case
managers are assigned to prevent them from being overloaded and
unable to provide all necessary support required by Warriors.
(Concur). Navy Medicine West instruction 6320.1 dated 10
November 2011 outlines the WW to Case Manager ratio to be no
more than 20:1.

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medications. If there are any concerns additional clinical pharmacist review is conducted.

(i) **Response to recommendation D.3.** We recommend the Commander, Navy Medicine-West implement procedures to ensure all TRICARE standards are met regarding WWBn-West Warrior's access to care, including for referring medical care appointments. (Concur). NHTP has a contracted TBI program manager in house. Since the DODIG visit, they have decreased WW travel requirements, including agreements/utilization of TBI/Vestibular and OT civilian providers at Eisenhower Medical Center in Rancho Mirage, CA (68 miles away). Also, since the DODIG visit, based on demand analyses, NHTP has instituted part-time "circuit riders" from NMCSD. These specialties include Podiatry (2 days per month), Neurology (2.5 days per month), and Otolaryngology (2 days every other month).

(j) **Response to recommendations D.4.2.a.** We recommend the Commander, Navy Medicine West ensure policy and procedures are in place to guarantee that all Warriors' medication profiles are maintained accurately and are properly reconciled (Concur). While Navy Medicine West Instruction 6320.1 formally directs the following items, many were in place before the Instruction was promulgated on 10 November 2011:

(1) MTF's will identify designated/dedicated clinical pharmacists to provide WW services.

(2) All WWs will receive a deliberate medication review and reconciliation conducted by a clinical pharmacist, within three working days of assignment to the WW unit/program.

(3) The deliberate medication review will minimally include the following elements:

a. A review of the patient's medication profile and medical history, using electronic health record (EHR) information systems (CHCS and AHLTA).

b. A reconciliation of medications listed in the EHR with medications reported by patient.

c. Consideration of medications appropriateness, effectiveness, dosage and monitoring.

d. Assessment of drug-drug, drug-disease, and

Subj: DOD DRAFT REPORT ON ASSESSMENT OF DOD WOUNDED WARRIOR
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drug-food /herbal interactions.

e. WW compliance with prescribed therapy.

f. Polypharmacy challenges.

g. Assessment of need for restrictive dispensing of opioid, benzodiazepine, tricyclic antidepressant, anti-psychotic, or insomnia relieving medications.

h. Educate WW about his/her medications.

Additional Information NHCP: After initial evaluation, the WW's Primary Care Manager (PCM) is responsible for regular follow-up with the WW (typically once per month) to review medications.

(k) **Response to recommendation D.4.2.b.** We recommend the Commander, Navy Medicine West ensure policy and procedures are in place to guarantee that all Warriors' medical information is accurately shared between medical facilities so that Warriors receive proper medical treatment within established access-to-care standards (Partially Concur. Given the current enterprise-wide medical information programs and processes used by Navy Medicine West and other Navy, Army and Air Force Regional Commands, the DOD IG Report should distinguish between those issues which require enterprise action/policy (like linking data systems) from those which can be changed/impacted by a specific Regional command). Navy Medicine and the MHS as an enterprise has multiple safety mechanisms in place to ensure safe amounts and combinations of medications are prescribed to beneficiaries. One example of this is PDTS (Pharmacy Data Transaction Service). Physicians and other authorized prescribers utilize an extremely robust database called PDTS (Pharmacy Data Transaction Service) that automatically screens prescriptions for interactions against other prescribed medications when they are entered into the computer. This database captures all prescription medications that the individual received by incorporating prescription data from more than 56,000 retail pharmacies, 889 military treatment facilities regardless of service, and all prescriptions from the TRICARE/Express Scripts mail service, making it the most extensive compilation of prescription information in North America. The PDTS allows DoD to improve the quality of its prescription service and reduce pharmaceutical costs by conducting Prospective Drug Utilization Reviews (ProDURs) on each new and refill prescription against

Subj: DOD DRAFT REPORT ON ASSESSMENT OF DOD WOUNDED WARRIOR
MATTERS – NAVY MEDICINE WEST RESPONSE

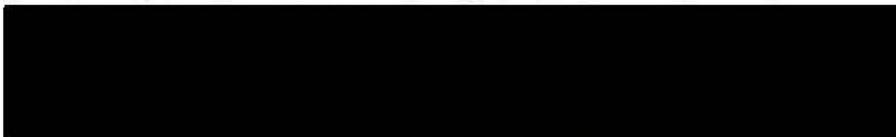
the beneficiary's complete drug profile. The central data repository also allows DoD to monitor and track patient usage and provider prescribing patterns throughout the MHS.

Interactions and duplicates immediately bounce back electronically from PDTS to the prescriber to be evaluated and action must be taken to override the warning if warranted/ desired for the individual patient. Prescribers frequently balance the risks and benefits to determine if the interaction warrants consideration of a different medication or if the initial choice will be the best choice. Since inception in 2000, the system has identified more than 540,000 potential level 1 drug interactions, resulting in 13% of these prescriptions being cancelled. Other outcomes were discontinuation of the interacting medication, adjustment of dosing, or continuing therapy if warranted.

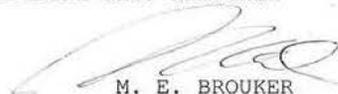
Additionally, the warning again shows up at the pharmacy during processing. The pharmacist will check the reason entered for the prescriber's override and if they agree, they will continue to process. If the pharmacist is uncertain, they contact the prescriber and discuss the interaction and implications to resolve any concerns before either continuing or canceling the prescription in favor of another medication.

As an additional safety mechanism, medication reconciliation is performed by the physician, nurse, medical assistant or hospital corpsman at every visit. A list of medications is generated from the records system and the patient is asked if the list is what they are actually taking and if they are taking any supplements or medications that are not on the list and need to be added.

Additional information NHTP: Working with NMW, the Multi-Service Market Office and NMCS, NHTP has obtained NMCS CHCS access. NHTP Case Managers and Referral Management staff can now view appointments at NMCS, ensuring WWS obtain specialty treatment within access-to-care standards.



Subj: DOD DRAFT REPORT ON ASSESSMENT OF DOD WOUNDED WARRIOR
MATTERS - NAVY MEDICINE WEST RESPONSE



M. E. BROUKER
Chief of Staff

Office of the Assistant Secretary of Defense Health Affairs Comments



TRICARE
MANAGEMENT
ACTIVITY

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS
7700 ARLINGTON BOULEVARD, SUITE 5101
FALLS CHURCH, VA 22042-5101

JUN 12 2012

MEMORANDUM FOR DEPUTY INSPECTOR GENERAL, DEPARTMENT OF DEFENSE

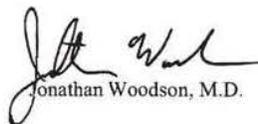
SUBJECT: Department of Defense Response to Department of Defense Inspector General Draft Report, "Assessment of DoD Wounded Warrior Matters – Wounded Warrior Battalion-West Headquarters and Southern California Units," Project No. D2010-D00SPO-0209.003, March 27, 2012

This is the Office of the Assistant Secretary of Defense for Health Affairs' (OASD(HA)) response to the Department of Defense Inspector General (DoD IG) Draft Report, "Assessment of DoD Wounded Warrior Matters – Wounded Warrior Battalion-West Headquarters and Southern California Units," Project No. D2010-D00SPO-0209.003, March 27, 2012. We concur with recommendation D.4.1 assigned to ASD(HA).

Additionally, I have been asked by the Acting Under Secretary of Defense for Personnel and Readiness (USD(P&R)) to respond and provide concurrence with recommendation C.9. We have provided detailed responses to these recommendations (Attachment 1).

Thank you for the opportunity to review and comment on the draft report. The point of contact




Jonathan Woodson, M.D.

Attachment:
As stated

RESPONSES TO RECOMMENDATIONS

RECOMMENDATION D.4.1: We recommend the Office of the Assistant Secretary of Defense for Health Affairs develop and resource solutions to Composite Health Care System (CHCS) data sharing difficulties.

TRICARE Management Activity (TMA) Response: Concur. TMA addressed this recommendation previously in response to “Assessment of DoD Wounded Warrior Matters – Camp Lejuene,” Project No. D2010-D00SPO-0209.00, December 9, 2011.

As stated in that response, efforts are underway to enhance the medical reconciliation capability within the Armed Forces Health Longitudinal Technology Application (AHLTA)/CHCS. Currently, Department of Defense (DoD) health care providers are able to document changes to medication orders made by DoD providers but are unable to do so for medication orders from non-DoD providers, to include Department of Veterans Affairs (VA) and civilian providers. Two system change requests have been approved to address this:

- Allow users to mark as “Taking/Not Taking” each patient’s current medications regardless of the source system. For example, the source systems include but are not limited to AHLTA, CHCS, VA, or the Pharmacy Data Transaction System. This update can be done during a patient encounter or without initiating an encounter.
- Change the status of a medication to “Taking/Not Taking” when a user marks an over the counter medication as “Taking/Not Taking.”

Currently, these enhancements are targeted for funding in Fiscal Year (FY) 2014. The program office is considering other funding options prior to the planned FY 2014 funding.

RECOMMENDATION C.9: We recommend the Acting Under Secretary of Defense for Personnel and Readiness (USD(P&R)) recommend that the Secretary of Defense (SecDef) consider expanding eligibility for warriors assigned to Wounded Warrior units so that they can transfer unused Post 9/11 Government Issued (GI) education benefits to their spouse or children when medical conditions preclude the warrior from meeting the length-of-service eligibility requirements to transfer these benefits.

USD(P&R) Response: Concur with the objective of the recommendation to maximize the ability of Wounded Warriors to transfer benefits under the Post-9/11 GI Bill. The Post-9/11 GI Bill, for purposes of promoting recruitment and retention, allows members of the Armed Forces to elect to transfer all or a portion of educational entitlement to a spouse or child. Extending the existing transferability provision for any purpose other than the promotion of recruiting or retention would not satisfy the intent of the transferability authority absent a legislative change.



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, DC 20301-1200

AUG 07 2012

HEALTH AFFAIRS

MEMORANDUM FOR DEPUTY INSPECTOR GENERAL, DEPARTMENT OF DEFENSE

SUBJECT: Department of Defense Response to Department of Defense Inspector General Draft Report, "Assessment of DoD Wounded Warrior Matters – Wounded Warrior Battalion-West Headquarters and Southern California Units," Project No. D2010-D00SPO-0209.003, March 27, 2012

Attached please find the Office of the Assistant Secretary of Defense Health Affairs (OASD(HA)) additional response to the Department of Defense Inspector General (DoD IG) Draft Report, "Assessment of DoD Wounded Warrior Matters – Wounded Warrior Battalion-West Headquarters and Southern California Units," Project No. D2010-D00SPO-0209.003, March 27, 2012. Recommendation D.1.1 was assigned to the Under Secretary of Defense (Personnel & Readiness), but falls under my OASD(HA) responsibility.

Responses were previously provided on April 24, 2012 and June 12, 2012 addressing recommendations D.4.1 and C.9, respectively (attached).

Sincerely,

A handwritten signature in black ink, appearing to read "A. Middleton".

Allen W. Middleton, SES
Chief Financial Officer
Office of the Chief Financial Officer

cc:
OUSD(P&R) (Eric Wetzel)

**DEPARTMENT OF DEFENSE INSEPECTOR GENERAL DRAFT REPORT – DATED
March 27, 2012**

(D2010-DOOSPO-209.003)

**“Assessment of DoD Wounded Warrior Matters-Wounded Warrior Battalion-West
Headquarters and Southern California Units”**

**OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)
COMMENTS**

RECOMMENDATION D.1.1: We recommend the Undersecretary of Defense for Personnel and Readiness implement policy that establishes and requires adequate medical case management staffing ratios specific to the Wounded Warrior program based on patient acuity, complexity and evidence-based practices.

DOD RESPONSE: Concur. We concur with the recommendation and are working towards establishing case manager staffing ratios that will consider variables associated with acuity and complexity of care coordination requirements, and consistent with the statutory requirements of the National Defense Authorization Act for Fiscal Year (FY) 2008, Section 1611(c)(3)(C) recognizing that the Secretaries of the Military Departments concerned may waive such limitation with respect to a given manager for not more than 120 days in the event of unforeseen circumstances. The expiration date for DTM 08-33 was May 31, 2012 (attached). A formal request was submitted for an additional 6-month extension. A response to this extension request has not yet been received.

Special Plans & Operations

Provide assessment oversight that addresses priority national security objectives to facilitate informed, timely decision-making by senior leaders of the DOD and the U.S. Congress.

General Information

Forward questions or comments concerning this assessment and report and other activities conducted by the Office of Special Plans & Operations to spo@dodig.mil

Deputy Inspector General for Special Plans & Operations
Department of Defense Inspector General
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Alexandria, VA 22350-1500



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Inspector General Department of Defense

