March 1, 2016

The Honorable John McCain
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The enclosed report responds to section 703 of the National Defense Authorization Act for Fiscal Year 2014 (Public Law 113-66) which requires the Department of Defense (DoD) and the Department of Veterans Affairs (VA) to jointly develop and implement a comprehensive policy on improvements to the care, management, and transition of recovering members of the Armed Forces with Urotrauma. This provision requires development and implementation of a comprehensive policy to address the specific needs of members who are Urotrauma patients, including: eligibility for the Recovery Care Coordination Program pursuant to the Wounded Warrior Act (10 U.S.C. 1071 note); an emphasis on the return of members who have recovered to active duty when appropriate; and the transition of recovering members from DoD to VA.

The report includes evaluation from a panel of Urotrauma experts. Their findings demonstrate that Urotrauma almost never occurs in isolation; but rather, it is most often seen in patients with multiple (and often life-threatening) injuries. The policies for Interagency Complex Care Coordination were evaluated, and it was determined that the DoD/VA Memorandum of Understanding, along with the VA Directive and DoD Instruction that support it, meet the need for overarching policy to support Urotrauma patients. These policies are attached for your reference.

Thank you for your interest in the health and well-being of our Service members, Veterans, and their families. A similar letter is being sent to the Chairpersons of the Congressional Defense and Veterans Affairs committees.

Sincerely,

Sloan D. Gibson
Deputy Secretary
Department of Veterans Affairs

Brad R. Carson
Acting Principal Deputy
Under Secretary of Defense
for Personnel and Readiness

Enclosures:
As stated

cc:
The Honorable Jack Reed
Ranking Member

March 1, 2016

The Honorable William M. "Mac" Thornberry
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The enclosed report responds to section 703 of the National Defense Authorization Act for Fiscal Year 2014 (Public Law 113-66) which requires the Department of Defense (DoD) and the Department of Veterans Affairs (VA) to jointly develop and implement a comprehensive policy on improvements to the care, management, and transition of recovering members of the Armed Forces with Urotrauma. This provision requires development and implementation of a comprehensive policy to address the specific needs of members who are Urotrauma patients, including: eligibility for the Recovery Care Coordination Program pursuant to the Wounded Warrior Act (10 U.S.C. 1071 note); an emphasis on the return of members who have recovered to active duty when appropriate; and the transition of recovering members from DoD to VA.

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Deputy Secretary
Department of Veterans Affairs

Brad R. Carson
Acting Principal Deputy
Under Secretary of Defense
for Personnel and Readiness

Enclosures:
As stated

cc:
The Honorable Adam Smith
Ranking Member

March 1, 2016

The Honorable Harold Rogers
Chairman
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The enclosed report responds to section 703 of the National Defense Authorization Act for Fiscal Year 2014 (Public Law 113-66) which requires the Department of Defense (DoD) and the Department of Veterans Affairs (VA) to jointly develop and implement a comprehensive policy on improvements to the care, management, and transition of recovering members of the Armed Forces with Urotrauma. This provision requires development and implementation of a comprehensive policy to address the specific needs of members who are Urotrauma patients, including: eligibility for the Recovery Care Coordination Program pursuant to the Wounded Warrior Act (10 U.S.C. 1071 note); an emphasis on the return of members who have recovered to active duty when appropriate; and the transition of recovering members from DoD to VA.

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Sloan D. Gibson
Deputy Secretary
Department of Veterans Affairs

Brad R. Carson
Acting Principal Deputy
Under Secretary of Defense
for Personnel and Readiness

Enclosures:
As stated

cc:
The Honorable Nita M. Lowey
Ranking Member

March 1, 2016

The Honorable Johnny Isakson
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The enclosed report responds to section 703 of the National Defense Authorization Act for Fiscal Year 2014 (Public Law 113-66) which requires the Department of Defense (DoD) and the Department of Veterans Affairs (VA) to jointly develop and implement a comprehensive policy on improvements to the care, management, and transition of recovering members of the Armed Forces with Urotrauma. This provision requires development and implementation of a comprehensive policy to address the specific needs of members who are Urotrauma patients, including: eligibility for the Recovery Care Coordination Program pursuant to the Wounded Warrior Act (10 U.S.C. 1071 note); an emphasis on the return of members who have recovered to active duty when appropriate; and the transition of recovering members from DoD to VA.

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Sloan D. Gibson
Deputy Secretary
Department of Veterans Affairs

Brad R. Carson
Acting Principal Deputy
Under Secretary of Defense
for Personnel and Readiness

Enclosures:
As stated

cc:
The Honorable Richard Blumenthal
Ranking Member

March 1, 2016

The Honorable Jeff Miller
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The enclosed report responds to section 703 of the National Defense Authorization Act for Fiscal Year 2014 (Public Law 113-66) which requires the Department of Defense (DoD) and the Department of Veterans Affairs (VA) to jointly develop and implement a comprehensive policy on improvements to the care, management, and transition of recovering members of the Armed Forces with Urotrauma. This provision requires development and implementation of a comprehensive policy to address the specific needs of members who are Urotrauma patients, including: eligibility for the Recovery Care Coordination Program pursuant to the Wounded Warrior Act (10 U.S.C. 1071 note); an emphasis on the return of members who have recovered to active duty when appropriate; and the transition of recovering members from DoD to VA.

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Sloan D. Gibson
Deputy Secretary
Department of Veterans Affairs

Brad R. Carson
Acting Principal Deputy
Under Secretary of Defense
for Personnel and Readiness

Enclosures:
As stated

cc:
The Honorable Corrine Brown
Ranking Member

March 1, 2016

The Honorable Thad Cochran
Chairman
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The enclosed report responds to section 703 of the National Defense Authorization Act for Fiscal Year 2014 (Public Law 113-66) which requires the Department of Defense (DoD) and the Department of Veterans Affairs (VA) to jointly develop and implement a comprehensive policy on improvements to the care, management, and transition of recovering members of the Armed Forces with Urotrauma. This provision requires development and implementation of a comprehensive policy to address the specific needs of members who are Urotrauma patients, including: eligibility for the Recovery Care Coordination Program pursuant to the Wounded Warrior Act (10 U.S.C. 1071 note); an emphasis on the return of members who have recovered to active duty when appropriate; and the transition of recovering members from DoD to VA.

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Sloan D. Gibson
Deputy Secretary
Department of Veterans Affairs

Brad R. Carson
Acting Principal Deputy
Under Secretary of Defense
for Personnel and Readiness

Enclosures:
As stated

cc:
The Honorable Barbara A. Mikulski
Vice Chairwoman

Department of Veteran Affairs
Department of Defense
Report to Congress
Care and Transition of Members of the Armed Forces with Urotrauma

The estimated cost of this report or study for the Department of Defense is approximately $9,600.00 in Fiscal Years 2014 - 2015. This includes $0 in expenses and $9,600.00 in DoD labor.
Generated on 2015 Dec 04 Ref ID: 4-1E22F75

Department of Veteran Affairs
Department of Defense
Report to Congress
Care and Transition of Members of the Armed Forces with Urotrauma

PURPOSE

The Departments of Defense and Veterans Affairs (the Departments) are pleased to submit this report in response to the requirement of section 703 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2014 (PL-113-66), *Comprehensive Policy on Improvements to Care and Transition of Members of the Armed Forces with Urotrauma*. Section 703 requires the Secretaries of Defense and Veterans Affairs to jointly develop and implement a comprehensive policy on improvements to the care, management, and transition of recovering members of the Armed Forces with urotrauma. The policy is required to address the specific needs of members who are urotrauma patients, including eligibility for the Recovery Care Coordination Program pursuant to the Wounded Warrior Act (10 U.S.C. 1071 note); the return of members who have recovered to active duty when appropriate; and the transition of recovering members from receipt of care and services through the Department of Defense (DoD) to receipt of care and services through the Department of Veterans Affairs (VA). After a thorough review, the Departments are pleased to report that current policies and procedures address all facets of the legislation.

Background

Urogenital trauma comprises a small but important subset of battlefield injuries. Previously reported statistics indicate that approximately 5% of all battlefield casualties sustained a urogenital injury during recent conflicts. In the battlefield setting, most patients who sustain urogenital injuries are also critically injured patients with multiple organ system injuries, shock, excessive blood loss, and often compromised cardiac, pulmonary, and neurologic function. These severely injured patients are commonly called *polytrauma patients,* and the urogenital manifestations of their injuries often pose the least risk to survival. Resuscitation, control of hemorrhage and airway, and wound debridement are critical priorities. Definitive urogenital procedures are generally best delayed until all life threatening injuries and conditions are stable.

The most debilitating urogenital injuries over the past 13 years of war have resulted from Dismounted Complex Blast Injury (DCBI). DCBI generally includes the traumatic amputation of at least one leg, severe injury to at least one remaining extremity, and major injury to other pelvic organs including the rectum, spinal cord, or other intra-abdominal organs in addition to urogenital organs. A task force convened by the US Army Surgeon General in 2011 highlighted evidence-based best practices for the care of these injuries: aggressive tourniquet use, early use of fresh whole blood and blood products, hypothermia prevention and management, and "damage-control" resuscitation and surgery. When coupled with rapid medical evacuation to definitive care- getting

injured warriors to the necessary level of clinical care at the appropriate time, within hours rather than days or weeks as in previous conflicts- these practices have resulted in an overall battlefield injury survival rate of over 98%.

Analysis for This Report

In response to the requirements of section 703, the Departments convened an interagency work group of senior leaders involved in the care of these patients to review existing policy and identify opportunities for improvement. Three policy areas were considered: 1) acute care and stabilization; 2) reconstruction and rehabilitation; and 3) care coordination. To more thoroughly understand recent injury patterns, the work group requested that the US Army Institute of Surgical Research conduct a review of battle-related urogenital trauma from January 2011 through August 2013 (the most recent date for which complete information was available). Those data are presented in Table 1. Of the 366 Service members with urogenital injuries who survived to be admitted to a Combat Support Hospital, 244 had complicated injuries that met the definition for "*Severe Polytrauma,*" with 219/366 receiving 10 or more units of blood ("*Massive Transfusion*") within the first 24 hours following injury.

	Total (n=366)	Severe Polytrauma (n=244)	Less Severe Polytrauma (n=122)
Massive Transfusion-No. (%)			
Yes	219 (59.8)	197 (80.7)	22 (18.0)
No	147 (40.2)	47 (19.3)	100 (82.0)

Table 1. Prevalence of Polytrauma among Male U.S. Service Members Sustaining Urogenital Injury during Operations Enduring Freedom and Iraqi Freedom, by Massive Transfusion Status, Department of Defense Trauma Registry, 2011-2013.

Acute Care Policies Reviewed

In response to previous Congressional requests (2011) concerning patients with urogenital injuries, the Department of Defense has adopted policies that:

1. ***Require pre-deployment training programs and clinical guidelines for forward surgeons that emphasize appropriate urinary diversion and minimal genital tissue debridement (especially gonadal) in order to preserve maximal future function.*** Of the 366 Service members with urogenital injuries reviewed for this report, the vast majority of injuries were managed conservatively. Less than 3% of those injured required surgical removal of both testicles, and genital tissue conservation was possible in over 99%. Based on this analysis, the task force concluded that current policy is effectively ensuring minimal tissue loss

and is affording injured Service members the best chance for successful reconstruction.

2. ***Ensure appropriate urogenital surgeon staffing at all levels of the combat trauma system.*** DoD reviewed urology staffing and carefully considered recommendations from various stakeholders to place more urologists in forward locations. Based on available clinical data reflecting excellent rates of initial urogenital tissue conservation in forward surgical settings, DoD urogenital trauma experts and reconstructive urologists determined that urogenital trauma needs of injured Service members are being met with high reliability. It was their opinion that forward surgical urologic outcomes are of high quality, and that placing more urologists in forward positions is not necessary at this time.

3. ***Require the Joint Theater Trauma System to provide Clinical Practice Guidelines for Urologic Trauma Management, and to actively monitor compliance with those guidelines.*** Existing urogenital trauma guidelines are under scheduled review to incorporate current experience, and will be re-published later this year. In addition, DoD has carefully reviewed recently released American Urologic Association Urotrauma Guidelines (2014), and has ensured that military combat casualty guidelines are in alignment. The workgroup also reviewed the recommendations of the Dismounted Complex Blast Injury Task Force (2011) and confirmed that those recommendations have been incorporated into policies and practice.

Reconstruction/ Rehabilitation Policy

Both Departments strongly agree that long-term complications of urogenital injury greatly impact the lives of surviving warriors, and are committed to providing expert post-injury reconstruction and rehabilitation to minimize incontinence, impotence, voiding dysfunction, and infertility. DoD believes that urogenital reconstructive surgery should optimally be done by fellowship-trained reconstructive urologists in referral centers maintaining sufficient annual volume to ensure appropriate quality. These referral centers should be accountable for the outcomes of reconstructive surgery, including continence, voiding function, and potency. To accomplish this, DoD has:

1. Expanded and maintained significant expertise in reconstructive urology, with eight fellowship-trained reconstructive urologist billets that easily meet the clinical demands of the 1383 Service members with severe urogenital trauma injured since 2001 who either remain as DoD beneficiaries or who have transitioned to VA.
2. Developed partnerships with VA Polytrauma Rehabilitation Centers and identified civilian medical centers that fully meet the recovery needs of wounded and injured Service members.
3. Committed $15 million to research through the Armed Forces Institute of Regenerative Medicine to support research on the creation of bio-engineered bladders, urethras, penile erectile tissue, and sphincter tissue. Although these

studies remain investigational, they have provided cutting edge results that will revolutionize medical practice in the future.

VA provides medically necessary care and treatment determined by health care professionals to promote, preserve, or restore the health of the individual (38 CFR §17.38). Veterans Health Administration (VHA) Directive 1091, Plastic Reconstructive Surgery, ensures the delivery of reconstructive surgical services, when medically necessary, for injury to body structures. This includes those injuries acquired through urotrauma. Currently, 66 VHA medical facilities located across all regions of the country have the capability to provide care and treatment to the Veteran or Service member with urogenital trauma. In addition, when VHA is unable to provide timely or geographically accessible care, it refers eligible Veterans for care in the community under its non-VA care authorities, including the Choice Act, when the requirements of those authorities are met.

A small number of patients with severe urogenital trauma, even after reconstruction, are unable to naturally conceive a child, and require assisted reproductive services. VA provides assisted reproductive services to Veterans except for In Vitro Fertilization (IVF) which is excluded from the medical benefits package by regulation at 38 CFR 17.38(c) . The Assistant Secretary of Defense for Health Affairs has authorized the provision of assisted reproductive services to assist Active Duty Service members, regardless of gender, who have sustained serious or severe illness or injury while on Active Duty that led to the loss of their natural ability to conceive a child. Current policy allows for up to six IVF Cycles for a Service member and spouse and for storage of any embryos created for a period of three years. These services may be obtained at either a military treatment facility or in civilian care. (The authority for this policy is derived from section 1633 of the NDAA for FY 2008, codified at title 10, U.S.C., section 1074(c) (4), which provides an extended care benefit to assist in the reduction of the disabling effects of the member's qualifying condition.)

Care Coordination Policy

Traumatic injuries rarely impact only one body system and often require the coordination of care spanning multiple medical and rehabilitative specialty areas, a variety of care providers, as well as multiple hospitalizations over many months or even years. Care coordination begins in- theater with provider-to-provider communication and collaboration, and continues as the injured warrior is successively transferred first to Europe and then back to the United States to a DoD or VA hospital. Care coordination needs also continue beyond hospitalization into the home and community for recovery and long-term therapies to maximize quality of life and continued progress in rehabilitation gains.

Since at least 2003, the DoD and VA have strived to achieve seamless care coordination, and although results have sometimes failed to meet the full needs of Veterans and Service members, improvement efforts have been ongoing and continuous. Initiatives to address the need for data interoperability have enabled an unprecedented level of information exchange and visibility of health records between the two Departments, ensuring that documentation of care provided in one Department

will be viewable by providers receiving a patient in transfer to the other. To establish standardized processes and to ensure accountability to Service member/Veterans and their families, the DoD/VA Joint Executive Committee established an Interagency Care Coordination Committee (IC3) that oversees delivery of complex care coordination for seriously wounded, ill or injured Service members or Veterans (SM/Vs). The two Departments also negotiated an Memorandum of Understanding (MOU) on July 29, 2014 (Appendix 1), that sets forth clear criteria, procedures, and processes for complex care coordination and describes a common operational model while defining the roles and responsibilities of clinical and administrative personnel directly involved in providing complex care coordination—the Care Management Team. The Complex Care Coordination model facilitates more effective accomplishment of the goals of the Recovery Care Coordination Program pursuant to the Wounded Warrior Act (10 U.S.C. 1071). *All patients with polytrauma are included in the IC3/ Recovery Care Coordination program.*

The two Departments have formalized the requirements for Interagency Complex Care Coordination in policy guidance. To implement the common operational model specified by the July 2014 MOU, VA Directive 0007 (Appendix 2) was issued on December 22, 2014, and DoD Instruction 6010.24 (Appendix 3) was published on May 14, 2015, both of which point to the MOU as VA and DoD policy, respectively.

A key part of the IC3 process is the assignment of a trained and empowered patient advocate (the Lead Coordinator) to each recovering SM/V. For patients with severe urogenital injury with polytrauma, this advocate will coordinate rehabilitation, reconstruction, and orthotic services as part of a holistic, patient-centered care environment.

Summary

The DoD has reviewed all facets of urogenital injury sustained in combat. The Department believes that acute care being provided accomplishes the dual goals of maximizing survival and affording the highest probability of successful urogenital reconstruction. The Department believes that it is uniquely situated to provide state of art urologic reconstruction, and to capture and be accountable for post-surgical results. The Department recognizes the multi-dimensional nature of these severe injuries, and has partnered with VA to minimize disruptions to the care continuum as patients move between the departments.

Appendices

1. MOU Between VA and DoD for Interagency Complex Care Coordination Requirements for Service Members and Veterans, July 29, 2014
2. VA Directive 0007, December 22, 2014
3. DoDI 6010.24, May 14, 2015