OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

MAR 31 2017

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

Dear Mr. Chairman:

The enclosed report is in response to Senate Report 114–255, page 205, accompanying S. 2943, the National Defense Authorization Act for Fiscal Year 2017, which requests that the Secretary of Defense submit a report detailing the present state of behavioral health services and suicide prevention programs provided by the Department of Defense (DoD) to Service members in the Reserve Component. The report also requests an evaluation to determine service disparities between Active Duty and Reserve programs.

Thirty Reserve Component programs were assessed to determine which were the most effective based on accepted metrics for performance. Although the majority of programs understood the foundations of effective programs, due to a lack of consistently applied metrics and data tracking, few were able to demonstrate program effectiveness. Those programs that were most effective track relevant metrics systematically, report their data on a regular basis, attempt to assess changes in knowledge and skills, and solicit feedback from Commanders and their participants.

DoD conducted additional analyses for the Active Duty and Reserve Component programs in order to identify service disparities across these respective communities. Programs primarily targeted either Active Duty Service members or those Reserve Component members recently completing deployments. Reserve Component members often have the added difficulty of overcoming financial, geographic, and logistic challenges to access services; however, programs have attempted to address these concerns by focusing their efforts on outreach and education activities and by collaborating with the civilian community. DoD also attempts to identify the need for behavioral health services among Reserve Component members by requiring mental health screenings pre- and post- deployment, annually, and prior to separation.

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 Chairman of the House Armed Services Committee.

Sincerely,

A. M. Kurta
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

MAR 31 2017

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 is in response to Senate Report 114–255, page 205, accompanying S. 2943, the National Defense Authorization Act for fiscal year 2017, which requests that the Secretary of Defense submit a report detailing the present state of behavioral health services and suicide prevention programs provided by the Department of Defense (DoD) to Service members in the Reserve Component. The report also requests an evaluation to determine service disparities between Active Duty and Reserve programs.

Thirty Reserve Component programs were assessed to determine which were the most effective based on accepted metrics for performance. Although the majority of programs understood the foundations of effective programs, due to a lack of consistently applied metrics and data tracking, few were able to demonstrate program effectiveness. Those programs that were most effective track relevant metrics systematically, report their data on a regular basis, attempt to assess changes in knowledge and skills, and solicit feedback from Commanders and their participants.

DoD conducted additional analyses for the Active Duty and Reserve Component programs in order to identify service disparities across these respective communities. Programs primarily targeted either Active Duty Service members or those Reserve Component members recently completing deployments. Reserve Component members often have the added difficulty of overcoming financial, geographic, and logistic challenges to access services; however, programs have attempted to address these concerns by focusing their efforts on outreach and education activities and by collaborating with the civilian community. DoD also attempts to identify the need for behavioral health services among Reserve Component members by requiring mental health screenings pre- and post- deployment, annually, and prior to separation.

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 Chairman of the Senate Armed Services Committee.

Sincerely,

A. M. Kurta
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

1 Executive Summary

The Department of Defense (DoD) submits this report in response to Senate Report 114-255, page 205, accompanying S. 2943, the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2017, which requests that the Secretary of Defense submit a report detailing the present state of behavioral health services and suicide prevention programs provided by DoD to Service members in the Reserve Components; an evaluation to determine service disparities between Active Duty and Reserve programs; and recommendations to improve the delivery of services to provide for the specific needs of Service members in the Reserve Component.

DoD evaluated behavioral health programs and clinical approaches over the past several years as new programs were developed in response to 15 years of prolonged conflict. In FY 2013, in an effort to enhance fiscal responsibility, DoD began implementing a multi-year approach to examine the program effectiveness of DoD-funded behavioral health programs, including both Active Duty and Reserve Component programs. These approximately 200 behavioral health programs include suicide prevention programs.

The ability to measure program effectiveness is key to ensuring positive outcomes, improving service delivery, and ensuring appropriate resource alignment. The most effective programs track relevant metrics systematically, report data on a regular basis, assess changes in knowledge and skills, and solicit feedback from Commanders and their participants. Across the Military Health System, despite requirements to serve both Active Duty Service members and Reserve Component members, behavioral health programs target and see Active Duty Service members more than their Reserve Component counterparts. Resultantly, Active Duty Service members access these programs more than their Reserve Component colleagues do. Access to care issues in their local community and a lack of a premium-free health care benefit are both significant barriers for Reserve Component members. This creates a discrepancy in the provision of behavioral health services between the Active Duty population and Reserve Component population. In response, Reserve Component programs implemented resourceful approaches to service delivery, such as the use of the "train the trainer" (T3) model and efforts focused on outreach and education activities.

DoD has outlined recommendations that enable Reserve Component programs to better meet the needs of their target recipients. Some recommendations include stigma reduction, validation of training models, and engaging in relevant data collection and analysis to measure program outcomes. Further, DoD recommends improving internal evaluation activities to measure program effectiveness, which will allow programs to adapt and improve their services using credible data. Finally, the identification of effective programs and services will allow informed and presumably improved policy and program decisions, remediate service gaps and redundancies, and enable the endorsement and application of best practices moving forward.

2 Introduction

As discussed in Section one, this report responds to the Senate's request for a report detailing the present state of behavioral health services and suicide prevention programs provided by DoD to Service members in the Reserve Components, to include: (1) information regarding which programs have been determined to be the most effective based on accepted metrics for performance; (2) an assessment of any disparity of available services between members of the Active Component and Reserve Component members; and (3) any recommendations for improving the delivery of these services in order to effectively and efficiently provide for the specific needs of Service members in the Reserve Component. For the

purposes of this request, Reserve Component is defined to include both Reserve and National Guard Service members.

This report includes a discussion of findings from an analysis conducted using an evidence-based rapid evaluation protocol. This method provides information regarding program efficacy, as well as verification that the services and programs provided are robust, non-duplicative, and salient to the continued mission readiness of our military forces. The DoD multi-year evaluation effort that began in FY 2013 includes site visits to review programs and an analysis of key areas indicative of program effectiveness. The key areas include established program performance measures outlined in program evaluation and public health literature. The Health Resources and Services Administration, the Center for Medicare and Medicaid Services, the Department of Veterans Affairs (VA), the United States Agency for International Development, and the RAND Corporation have used similar rapid evaluation approaches to assess large service systems that contain widely varying programming. Potential outcomes and recommendations from current DoD activities include the following: enabling the endorsement and application of best practices, identifying and permitting remediation of any redundant services or service gaps, educating key stakeholders with regard to programmatic and policy decisions, contributing to the improvement of program performance, and increasing competence and accountability in the evaluation of program effectiveness.

Additionally, DoD is implementing measures to improve evaluation capabilities and to enhance communication among care providers who provide services for both Active Duty and Reserve Component members. For example, DoD recently piloted the Behavioral Health Data Portal (BHDP) across selected programs in order to standardize data collection measures. This computerized patient self-report kiosk collects baseline and follow-up data on symptoms related to common behavioral health conditions (e.g., depression, anxiety). When collated across multiple programs, BHDP data can aid in determining the overall effectiveness of behavioral health programs. DoD also directs TRICARE purchased-care providers to use the same standardized assessment measures found in the BHDP when treating beneficiaries outside of a military treatment facility. Reserve Component members predominantly benefit from this requirement since they have limited access to DoD-funded programs and may rely more heavily on services within the civilian community due to individual geographic and logistic challenges (e.g., when a National Guard member who lives in rural Montana needs psychological assessment services).

3 Discussion

3.1 Effectiveness of Reserve Component Programs

DoD evaluated thirty Reserve Component programs to determine overall program effectiveness. Programs were grouped by service type or primary issue addressed. See ***Reserve Component Program List by Category (Tab A)*** for the full list of programs by category.

To determine effectiveness, DoD evaluated programs across four key areas:

1) **Fidelity:** the extent to which the program was implemented as planned.
2) **Sustainability:** the ability of the program to deliver its intended activities or services over time.
3) **Program Characteristics:** the program's structure and processes.
4) **Changes:** how the program encompasses changes in participants, practices, and costs.

Although assessing non-clinical programs is difficult, DoD is committed to using a science-based approach to determine effectiveness. Indicators for effective programs were identified through an in-depth review of the practice and evaluation research literature, in order to determine the most appropriate set of factors that related to the effectiveness of all applicable programs. Programs were scored within each of the four key areas using a standardized scoring process. The scoring method is applicable to the evaluation of various types of behavioral health programs at different stages of maturity. This method is also able to convert qualitative program information into quantitative scores, which is necessary to determine indicators of program effectiveness. Programs must score 80 percent or above on key indicators of effectiveness within a given area in order to show adequate evidence of program effectiveness for that particular key evaluation area. Overall evidence of program effectiveness is determined based on scores across all four key areas. See ***Program Performance Across Four Key Effectiveness Areas (Tab B)*** for breakout information on program performance across the four key effectiveness areas.

Several overarching themes were identified during the analysis of these programs:

- Programs generally performed well across the key areas of fidelity, sustainability, and program characteristics.
- The majority of programs have relevant mission statements, goals, and objectives that have remained consistent since implementation.
- Programs that have a mission statement aligned with policy guidance – as well as detailed objectives that can demonstrate achievement of intended outcomes – have the appropriate foundations for program quality and effectiveness.
- Many Reserve Component programs engage in operations that support sustainability across time, such as conducting regular meetings and staff trainings.
- A best practice identified across programs is the solicitation of Commander feedback to enhance buy-in toward the promotion of program participation and identification of those individuals who are in need of program services. Such Command support may have the potential to reduce stigma for accessing behavioral health services.

Many of the programs reviewed are subjected to regular data collection and tracking activities, despite the specification of only limited performance metrics at onset. Reserve Component programs were often established in response to a particular mandate or directive (e.g., Public Law 110-181, NDAA for FY 2008), which leaves programs to determine appropriate performance metrics of effectiveness at their discretion. While policy guidance provides direction on responsibilities and execution, it does not establish data reporting procedures that allow for more general assessments of effectiveness and efficiency. The absence of uniform data collection, analysis, and reporting affects the assessment of program effectiveness. This limitation led to lower scores in the key area of changes. Notably, many programs rely on the T3 model, which allows staff members and fellow Service members across a large catchment area to learn skills that are transferrable to their respective units.

Programs are collecting and tracking relevant information, but need assistance in analyzing their data so that they are able to identify themes and trends toward examining program outcomes. For example, the suicide prevention programs examine rates, trends, and other data using the Department of Defense Suicide Event Report system; however, it is unclear to what extent this resource is used for identifying risk factors and key outcomes.

High performing programs not only attempt to track applicable performance metrics but also examine changes in knowledge, attitudes, and behaviors, which is a key activity to determining outcomes and program effectiveness. Of special note, programs with a desired

outcome to increase or improve resiliency have an added difficulty of clearly defining resiliency in such a manner to allow accurate measurement.

3.2 Service Disparity between Active Duty and Reserve Component Programs

The comprehensive review and analysis examined service discrepancies across Reserve Component programs and all DoD-funded Active Duty behavioral health programs. Currently, the Reserve Component consists of 1,092,935 members (including inactive Reserve and National Guard Service members). DoD assessed discrepancies in services using program data encompassing descriptions of program activities and corresponding outcomes, program accessibility, waitlists, identification of individuals more or less likely to use program services, referrals to community resources, and ability to meet the target population's needs.

Access to Services

The review noted Active Duty Service members more frequently access and use program services than members of the Reserve Component across the majority of programs. Active Duty populations typically work on a military installation. Hence, they can easily access installation-based services. Programs indicated statute or policy often mandates their services for Active Duty members or for those recently mobilized or deployed to include Reserve Component members called or ordered to Active Duty under title 10 status for greater than 30 days and recently mobilized or deployed Reserve Component members. Understanding these program and eligibility nuances, DoD attempts to address the disparity in utilization by requiring mental health screenings pre- and post- deployment, annually, and prior to separation. Selected Reserve members may also enroll in the premium-based TRICARE Reserve Select product enabling access to mental health providers through TRICARE Standard coverage.

Barriers to Program Participation

Several obstacles or barriers to program participation exist across the Reserve Component programs. The following describes these barriers and potential best practices to resolve them:

- **Geographic dispersion.** By design, Reserve Component units and individuals often reside outside proximity to an installation or in geographically remote locations. Programs addressed this challenge by providing services via telephone (i.e., case management and resource provision as opposed to actual clinical services), or by providing events, trainings, and outreach activities at locations more centrally located to their target population.
- **Command support.** Participation in behavioral health trainings and briefings during drill periods is often at the discretion of the unit Command; however, inadequate Command support remains a major barrier to program participation. Reserve Component members who are not in a deployed unit or actively mobilized have limited time and resources to dedicate to receiving behavioral health services. Reserve Component members may also be unaware of or have less knowledge regarding the programs available to meet their needs than Active Duty members. Some programs have attempted to address this concern by engaging senior leaders within the Reserve Components who may be more acutely aware of Service member needs and issues.
- **Prioritization of service provision.** Although many programs do not have a waitlist to receive services, when a waitlist was necessary, Active Duty Service members or high-risk individuals were typically prioritized. During periods of resource or

funding constraint, many programs prioritized attendance for deploying units and special populations (e.g., Service members assigned to Warrior Transition Units). In addition, Reserve Component members may be required to pay out-of-pocket for services creating financial constraint.

- **Stigma.** Service members might be more likely to seek out behavioral health services outside of the military health care system due to concerns about confidentiality – particularly among higher-ranking Service members.

Referral to Community Providers

Community outreach and partnerships help to build the capabilities of the external community, enabling it to further meet the needs of members of the Reserve Component and close the gap in service provision (compared to Active Duty counterparts). External resources include, but are not limited to programs and initiatives operated by government or military organizations (DoD, VA, other federal organizations, state and local organizations, etc.), religious organizations (including military Chaplains), private non-profit organizations, private for-profit organizations, and community-based resources. Reserve Component programs also rely on resources targeted for the military community, such as Military OneSource. Military OneSource provides confidential non-clinical counseling in addition to support for financial, spousal, employment, or legal issues. Programs also often refer Reserve Component members to community providers when the behavioral health needs exceed program capabilities or due to geographic challenges. Unfortunately, difficulties arise from reliance on community resources including lack of military cultural understanding and need, lack of awareness of available services, and financial constraints.

4 Recommendations

The following recommendations aim to improve the efficiency and effectiveness of service delivery for Reserve Component members.

Collect Data to Demonstrate Program Effectiveness

Demonstrating program effectiveness is key to improving service delivery. By incorporating routine evaluation activities in program design and daily operations, programs can be better equipped to make improvements based on reliable data. The inability to measure program effectiveness brings uncertainty to whether DoD, on a holistic basis – or the program, on a service basis – has employed the right activities to meet the needs of the population served. Only a few of the programs reviewed have the essential elements to measure effectiveness such as clearly defined performance measures, a systematic collection of program activity data, or the ability to synthesize outcome data into actionable information. Although most programs expressed agreement that internal evaluation is an important activity, many programs identified challenges in conducting these tasks on a regular basis. Most often, limited resources (e.g., staffing) were the main barrier to programs incorporating evaluation activities into regular program activities. Whether determined at the statutory, policy, or program level, programs must first explicitly define the specific indicators of change to demonstrate effectiveness. Performance indicators should be specific, measurable, achievable, relevant, and time-bound (SMART), and driven by the program's mission statement and goals. Once a targeted outcome is clearly defined, programs can apply SMART principles to determine measures that will demonstrate program impact.

Programs should also institute systematic data collection efforts. While many programs collect output data (e.g., the number of trainings conducted and number of attendees), few

programs collect data on outcomes (e.g., changes or effects) resulting from program activities. Methods to demonstrate such an impact could include pre- and post-participation measures, as well as a comparison of program participants to similar Service members who are not participating. Given a large enough sample size, the program could then conclude that systematic differences in measures either before and after participation or between participants and non-participants may be a result of program activities.

Finally, DoD or individual programs should conduct structured analysis of collected data. Programs with similar activities and goals should consider using the same performance measures to allow for more robust data analysis. Ideally, data collected at the program level should be combined at a higher level, analyzed, and results distributed to program managers to encourage the use of evidence-based practices. The BHDP serves as one method for programs to collect and analyze standard behavioral health symptom metrics both at baseline and also throughout the treatment phase to better determine if program activities are effectively meeting their target population's needs.

Define and Measure Stigma

Many behavioral health programs identified reducing stigma and promoting help-seeking as targeted outcomes to improve service delivery. For example, suicide prevention programs aim to encourage personnel to report suicidal risk factors and to decrease the stigma related to seeking help. However, programs face challenges providing evidence a particular outcome resulted from program participation. Stigma may be a significant barrier to care in Reserve Component programs where Command lacks the ability to enforce participation. Programs must specifically define stigma as it relates to their target population in order to attempt to measure change. In addition to defining stigma, programs should identify standardized methods to measure stigma. Such methods should be consistent across all programs.

Validate the Train-the-Trainer Model

Programs employing a T3 model aim to address the needs of two target populations: the instructors directly trained within the program's T3 model and the end users in the field. Since this type of program expects to benefit these two target populations, program leaders need to consider two sets of outputs and outcomes when measuring program impact. Collecting data only from the end user population make conclusions drawn regarding the validity of the T3 model suspect. First, programs must determine the effectiveness of training the instructors themselves within the T3 model. Pre-post instruction measures and performance-based testing can measure outcome changes in this targeted population. Next, programs can assess the effectiveness of the T3 model by monitoring outcomes for the program participants in the field. A method for measuring the impact of a T3 model on family or behavioral health programs, for instance, is implementation of pre- and post- training measures. Finally, programs should consider systematically gathering feedback from all trainers to identify potential barriers to the implementation of the training in the field.

5 Conclusion

This review assessed thirty Reserve Component programs to determine which were the most effective based on accepted metrics for performance. Although the majority of programs understood the foundations of effective programs, due to a lack of consistently applied metrics and data tracking, few were able to demonstrate program effectiveness. The most effective programs track relevant metrics systematically, report their data on a regular basis, attempt to

assess changes in knowledge and skills, and solicit feedback from Commanders and their participants.

DoD conducted additional analyses for the Active Duty and Reserve Component programs in order to identify service disparities across these respective communities. Programs primarily targeted either Active Duty Service members or those Reserve Component members recently completing deployments. Reserve Component members often have the added difficulty of overcoming financial, geographic, and logistic challenges to access services; however, programs have attempted to address these concerns by focusing their efforts on outreach and education activities and by collaborating with the civilian community. DoD also attempts to identify need for behavioral health services among Reserve Component members by requiring mental health screenings pre- and post- deployment, annually, and prior to separation.

As a whole, programs should apply standardized metrics, such as those used in the BHDP, to assess behavioral health symptoms and determine which services and programs most effectively address the needs of their Service members. Finally, DoD recommends the following: encouraging civilian providers to use BHDP outcome metrics, engaging in internal evaluation activities that enable programs to adapt and improve their services using credible data, and identifying effective programs and services to better inform policy and program decisions, remediate service gaps and redundancies, and enable the endorsement and application of best practices moving forward.

Tab A Reserve Component Program List by Category

Category	Program Name	Service Branch
Family Programs	Air Force Family Advocacy Prevention, Outreach, and Population Behavioral Health Services	Air Force
	Army Reserve Family Programs	Army Reserve
	ARNG Family Program	Army National Guard
	Family Deployment Coping (Project FOCUS)	Navy / Marine Corps
	Strong Bonds Program	Primary: Army Secondary: Army National Guard
Suicide Prevention Programs	Air National Guard Suicide Prevention	Air National Guard
	Army Reserve Suicide Prevention Program	Army
	ARNG Suicide Prevention Program/ARNG Suicide Reduction Initiative	Army National Guard
Resilience Programs	Comprehensive Soldier Fitness/Resilience Program / Comprehensive Soldier and Family Fitness Program (CSF2)	Army
	Defender's Edge (DEFED)	Air Force
	Resilience Program	Air Force
Psychological Health Programs	ANG Directors of Psychological Health	Air National Guard
	ARNG Directors of Psychological Health	Army National Guard
	Deployment Health Assessment Program	Army G1
	Navy & Marine Corps Reserve Psychological Health Outreach Programs-N90	Navy / Marine Corps
	Non-Medical Counseling Program	DoD-wide
	Psychological Health Risk Adjusted Model for Staffing (PHRAMS)	Defense Health Agency
	USAR Directors of Psychological Health/USAR Psychological Health Program	Army Reserve
Warrior Support Programs	Air Force Wounded Warrior (AFW2) Program	Air Force
	DCoE Outreach/Transition Support Contact Call Center Program inTransition	DoD-wide
	National Guard Transition Assistance Advisors	Army National Guard
	Wounded Warrior Medical Cell	Navy / Marine Corps
	Wounded Warrior Regiment, Sgt. Merlin German Wounded Warrior Call Center	Navy / Marine Corps
Yellow Ribbon Reintegration Programs	Army Reserve Yellow Ribbon Reintegration Program (YRRP)	Primary: Army Secondary: Army Reserve
	ARNG Yellow Ribbon Reintegration Program	Army National Guard
	Psychological Health Advocacy Program	Air Force Reserve
	Yellow Ribbon Reintegration Program (Air National Guard)	Air National Guard
	Yellow Ribbon Reintegration Program (Air Force Reserve)	Air Force Reserve
	Yellow Ribbon Reintegration Program (Marine Corps)	Marine Corps
	Yellow Ribbon Reintegration Program (Navy)	Navy Reserve

Tab B Program Performance Across Four Key Effectiveness Areas*

Program Name	Service Branch	Fidelity (Total = 14)	Sustainability (Total = 20)	Program Characteristics (Total = 10)	Changes (Total = 18)
Air Force Family Advocacy Prevention, Outreach, and Population Behavioral Health Services	Air Force	14	18	10	14
Air Force Wounded Warrior (AFW2) Program	Air Force	14	18	9	13
Air National Guard Suicide Prevention	Air National Guard	6	12	10	10
ANG Directors of Psychological Health	Air National Guard	9	20	10	16
Army Reserve Family Programs	Army Reserve	9	16	10	11
Army Reserve Suicide Prevention Program	Army	14	19	9	14
Army Reserve Yellow Ribbon Reintegration Program (YRRP)	Primary: Army Secondary: Army Reserve	12	13	9	10
ARNG Directors of Psychological Health	Army National Guard	14	20	9	16
ARNG Family Program	Army National Guard	7	17	10	8
ARNG Suicide Prevention Program/ARNG Suicide Reduction Initiative	Army National Guard	14	18	10	15
ARNG Yellow Ribbon Reintegration Program	Army National Guard	14	17	9	13
Comprehensive Soldier Fitness/Resilience Program / Comprehensive Soldier and Family Fitness Program (CSF2)	Army	13	20	9	17
DCoE Outreach/Transition Support Contact Call Center Program inTransition	DoD–wide	14	18	10	16
Defender's Edge (DEFED)	Air Force	13	16	8	15
Deployment Health Assessment Program	Army G1	14	20	9	16
Family Deployment Coping (Project FOCUS)	Navy / Marine Corps	14	19	10	14
National Guard Transition Assistance Advisors	Army National Guard	14	16	10	13
Navy & Marine Corps Reserve Psychological Health Outreach Programs-N90	Navy / Marine Corps	14	18	8	15
Non-Medical Counseling Program	DoD–wide	10	12	8	8
Psychological Health Advocacy Program	Air Force Reserve	11	18	10	15
Psychological Health Risk Adjusted Model for Staffing (PHRAMS)	Defense Health Agency	14	11	8	9
Resilience Program	Air Force	13	14	10	11
Strong Bonds Program	Primary: Army Secondary: Army National Guard	14	19	10	16
USAR Directors of Psychological Health/USAR Psychological Health Program	Army Reserve	14	17	9	6
Wounded Warrior Medical Cell	Navy / Marine Corps	9	18	10	16
Wounded Warrior Regiment, Sgt. Merlin German Wounded Warrior Call Center	Navy / Marine Corps	14	17	10	11

Program Name	Service	Fidelity	Sustainability	Program	Changes
Yellow Ribbon Reintegration Program (Air Force Reserve)	Air Force Reserve	13	19	9	13
Yellow Ribbon Reintegration Program (Air National Guard)	Air National Guard	12	19	9	13
Yellow Ribbon Reintegration Program (Marine Corps)	Marine Corps	13	18	7	13
Yellow Ribbon Reintegration Program (Navy)	Navy Reserve	14	19	9	13

* Programs are listed alphabetically. Highlighted programs scored above 80 percent across all four key areas of effectiveness.