

**MEMORANDUM OF UNDERSTANDING
BETWEEN
DEPARTMENT OF VETERANS AFFAIRS (VA)
AND
DEPARTMENT OF DEFENSE (DoD)
FOR
INTERAGENCY COMPLEX CARE COORDINATION REQUIREMENTS
FOR SERVICE MEMBERS AND VETERANS**

1. **PURPOSE:** This Memorandum of Understanding (MOU) sets forth a common operational model and responsibilities to be adhered to by the Parties to support the Department of Veterans Affairs and the Department of Defense (VA/DoD) Interagency Care Coordination Committee (IC3) processes described herein. This MOU (to include all Attachments) between the VA and the DoD (hereinafter referred to as the "Parties") is the foundational document for the establishment of joint processes for complex care coordination as directed by the Joint Executive Committee (JEC) and implemented by the IC3. The Parties will use the contents of this MOU to modify or develop internal policies for governance of these processes by their respective Departments. Successful implementation of this and future joint policies and guidance requires the full support from leadership of both Parties, common communication strategies, policy synchronization, and joint monitoring of clinical, non-clinical, and administrative outcome performance metrics. This MOU and the complex care coordination model are not intended to and do not bestow or confer rights or benefits provided for under the respective statutory authorities of the Departments.

2. **AUTHORITY:** Section 1614 of Public Law 110-181, the National Defense Authorization Act for Fiscal year 2008, Title 10 United States Code (U.S.C.) Section 136, and Title 38 U.S.C. Section 523.

3. **BACKGROUND:** In 2012, the JEC approved implementation of the Warrior Care Coordination Task Force recommendation to develop and implement an interagency overarching policy for a common model of complex care coordination for Service members and Veterans (SM/Vs). The IC3 was established to oversee these efforts in accordance with the VA and DoD Secretaries' objectives to support "One Mission-One Policy-One Plan." The terms set forth in this MOU are in furtherance of this objective within the confines of the laws governing the Parties.

4. **RESPONSIBILITIES:** Consistent with this MOU, it is AGREED that the Parties shall:

- a. Support complex care coordination and implement overarching policies for the Parties on interagency complex coordination processes using a common operational model. This model shall be consistent with existing law and shall provide clarity and consistency across the full spectrum of care, benefits, and services to those who the processes herein serve.

- b. Ensure all provisions set forth in Attachment A (Criteria and Procedures) are incorporated in the Parties' respective policies to include policies of the Military Services and VA Administrations.
- c. Ensure current and future policies of the Parties and Parties' procedural documents addressing interagency complex care coordination are in alignment with this MOU.
- d. Assign responsibilities and oversight within their respective Departments for the IC3 to establish common guidelines for complex care coordination processes.
- e. Use the IC3 under the VA/DoD JEC to ensure complex care coordination policy is implemented in a consistent manner across applicable health care, benefits, and other service delivery programs by the Parties.
- f. Utilize consistent terminology, as defined in Attachment B (Definitions), Part II to the extent consistent with statuses and regulations of the respective Parties, and define roles and responsibilities for complex care coordination processes applicable to the SM/V population covered by the MOU.
- g. Ensure that SM/Vs requiring complex care coordination as described in Attachment A (Criteria and Procedures) of this MOU, have an Interagency Comprehensive Plan (ICP), described in Attachment B (Definitions), Part II, which:
 - guides the activities of their respective health care professionals, clinical case managers (CCM), non-clinical case managers (NCCM), and other service providers responsible for delivery of recovery and reintegration services, as well as keeping their respective chains of command or leadership informed about SM/V progress; and
 - supports outcomes that will demonstrate synchronization of services for SM/Vs, their families or caregivers, and their Care Management Team (CMT).
- h. Ensure that an existing member of the CMT is assigned as the Lead Coordinator (LC) for each SM/V who requires complex care coordination. The LC will communicate with the CMT while leading complex care coordination efforts for the SM/V as explained in Attachment A (Criteria and Procedures) of this MOU.
- i. Ensure mechanisms are in place to resolve concerns or conflicts regarding complex care coordination efforts within each CMT.
- j. Ensure SM/Vs are active participants in care decisions, if possible, and are engaged in the establishment and modification of the ICP throughout the course of recovery to reintegration consistent with Attachment A (Criteria and Procedures) of this MOU. Family members or caregivers should also be involved to the extent authorized by the SM/V and applicable laws or regulations.

- k. Ensure that oversight of implementation of the policies and programs established pursuant to this MOU are monitored by the IC3 which reports status and progress to the JEC on a quarterly basis or as directed by the JEC.
- l. Through the IC3:
- Accomplish policy and program oversight of IC3 processes through its subordinate work groups.
 - As needed, establish temporary work groups or sub-groups as outlined in the IC3 charter. See Attachment B, Part III (References), paragraph (c).
 - Develop detailed implementation plans, and establish and monitor performance measures to ensure effective IC3 process oversight and ongoing communications with internal audiences and external stakeholders.
 - Use the JEC's Joint Strategic Plan (JSP) as the official document to describe the IC3 and its work groups' evaluation metrics, including administrative milestones, clinical and non-clinical benefits and service milestones, processes, and outcomes as documented in Specific, Measurable, Achievable, Realistic, and Time-Bound (SMART) objectives for the JSP.
 - Provide content regarding progress towards meeting the SMART objectives for the JEC's Annual Report to Congress.
- m. Agree that this MOU does not change military command relationships or command responsibilities for engagement and support of their Service personnel.
- n. Incorporate Attachment B (Abbreviations and Acronyms, Definitions, and References) into the Parties' respective policies to the extent consistent with current statutes and regulations of the respective Parties.
- o. Ensure care, benefits, and services are provided consistently and effectively across the Departments for SM/V, minimizing fragmentation in service delivery in order to ensure consistent high quality care.
- p. Ensure that components with organizations having collective bargaining obligations satisfy those obligations as applicable.

5. **DISPUTE RESOLUTION:** The Parties agree to resolve all disputes arising under this agreement at the local level if practicable. If unable to resolve at the local level, a formal written summary describing the details of the issue should be routed through the appropriate chain of command to the IC3 Co-Chairs for appropriate staffing and presentation to the JEC, as necessary.

6. **EFFECTIVE DATE:** This MOU becomes effective on the date the last signatory signs this MOU.

7. MODIFICATIONS: This MOU may be modified in writing upon mutual consent of the Parties and will be reviewed annually to determine whether the terms and provisions are appropriate and current.

8. TERMINATION: Either party may terminate this MOU 120 days after serving written notice to the other party.

/s/ Sloan D. Gibson
Sloan D. Gibson
Deputy Secretary
Department of Veterans Affairs
7/25/14
Date
Attachments:
As stated

/s/ Jessica Wright
Jessica L. Wright
Under Secretary of Defense for Personnel and Readiness
Department of Defense
7/29/14
Date

ATTACHMENT A: CRITERIA AND PROCEDURES

1. Criteria for Complex Care Coordination:

- a. The need for complex care coordination is determined by factors including both severity of a wound, illness, or injury that is expected to result in prolonged recovery time, or extensive rehabilitation and complexity of care coordination needs involving health care, benefits, and services, including military, federal, or other governmental or community resources. In addition, Service members and Veterans (SM/Vs) in need of complex care coordination have longitudinal care and case management needs that will require an interdisciplinary team approach to achieve optimal recovery.

Such SM/Vs might include, but are not limited to, those with multiple, complex, severe conditions such as polytrauma injuries, spinal cord disorders, blindness, amputations, significant burns, complex wounds, traumatic brain injuries, psychological trauma, or other cognitive, psychological, or emotional disorders. Complex care coordination needs may result from either combat or non-combat situations. Further, due to a serious or catastrophic wound, injury, or illness, it is unlikely to highly unlikely that the Service member will return to duty, and may, or will, be medically separated/retired from the military, or it is unlikely to highly unlikely that a Veteran will return to independent living or employment. Other SM/Vs who do not meet above criteria but who may benefit from complex care coordination may be included in this model if resources permit.

The responsibility for assessment of the need for complex care coordination is made by the attending physician in conjunction with other members of the interdisciplinary Care Management Team (CMT), which includes the command representative. This is usually accomplished during the acute/stabilization stage, but may occur at any time during the course of recovery.

Complex care coordination is a SM/V-centered, needs-based system designed to support the recovering SM/V and their family or caregiver until the criteria for discontinuation have been met. In most cases, enrollment into complex care coordination should occur as early as possible in the course of a hospitalization. This model is continued as a SM/V transitions from an inpatient to outpatient setting, or is applied directly to outpatient SM/V meeting the “need” criteria above.

These SM/Vs receive an Interagency Comprehensive Plan (ICP) that has been prepared and updated by members of the CMT. The primary responsibility for maintaining and communicating the ICP to the SM/V is assigned to the Lead Coordinator (LC).

- b. Criteria for Discontinuation of Complex Care Coordination: Complex care coordination and use of the ICP continues until the CMT reviews and concurs that one of the following end points is reached:
 - SM/V returns to duty or employment with minimal or no limitations;

- SM/V has reached a level of stability making continued formal complex care coordination unnecessary;
 - SM/V requests discontinuation of services; or
 - SM/V expires or other conditions make complex care coordination unnecessary.
- c. The common operating model that details the roles and responsibilities, milestones and decision points for the management and operation of the complex care coordination model is illustrated and explained in Paragraph 2 and Figures 1 and 2 below.
- d. Technology Support: Information technology tools will be leveraged and developed as needed, to share required information that enhances and supports effective complex care coordination between the Parties. Future care, benefits, and services information technology investments by the Parties should address the interagency information sharing needs regarding the SM/V population requiring complex care coordination, and support requirements for programs directed by this MOU.
2. Overview of the Model of Complex Care Coordination:
- a. This model establishes a consistent method for complex care coordination capable of providing clinical and non-clinical information and support for recovery and rehabilitation of SM/Vs and for their families or caregivers wherever care, benefits, and services may be delivered.
- b. The complex care coordination model is SM/V-centered, needs-based, and applies to DoD and VA whether care, benefits, and services come from DoD, VA, other government agencies, or the private sector.
- c. The complex care coordination model is the foundation for a common set of rules, definitions, tools, and processes shared by all of the professionals supporting and facilitating the recovery of SM/Vs across both Departments.
- d. The model addresses and supports requirements for an ICP for SM/Vs that support realistic outcomes throughout all stages of recovery through ongoing care (see Figure 2). The ICP addresses clinical as well as non-clinical support (e.g. pay, benefits, family support, vocational rehabilitation, information, and resources, including military, federal, or other governmental and community resources). This model supports a SM/V's goals (e.g., to recover or complete rehabilitation and return to duty, employment, school, or other meaningful activities), and, if possible, SM/V, their family member(s) and/or caregiver(s) are engaged in the establishment and modification of their ICP at all stages of care, recovery, and reintegration.
- e. When returning to duty or employment is not possible, the primary objective of the model is to facilitate an ICP to help the SM/V reach and maintain the highest achievable level of independence function, life adjustment, and quality of life.

- f. This model establishes a requirement to use an ICP that is initiated timely and updated on an ongoing basis to meet the assessed needs of the SM/V as they change. A SM/V has one ICP at any given time, which is updated as needed.
- g. The ICP is tailored to each SM/V's unique needs and addresses the full spectrum of care, benefits, and services needed for optimal recovery and/or rehabilitation and may include life-long continuity of care, if necessary.
- h. This model establishes the role of the LC which is assigned to an existing member of the CMT. The LC serves as the primary point of contact for the SM/V who requires complex care coordination and their families or caregivers. The LC has primary responsibility for ensuring the establishment and update of the SM/V's ICP.
- i. Key Points of Model Illustration: Figures 1 and 2 illustrate the critical roles and relationships which support the SM/V-centered model of complex care coordination. This model depiction is not all-inclusive and does not establish a priority list, or create barriers for stakeholder involvement in complex care coordination efforts. However, it does provide for LC direct interaction with the SM/V and the rest of the CMT.

Figure 1. Care Management Team

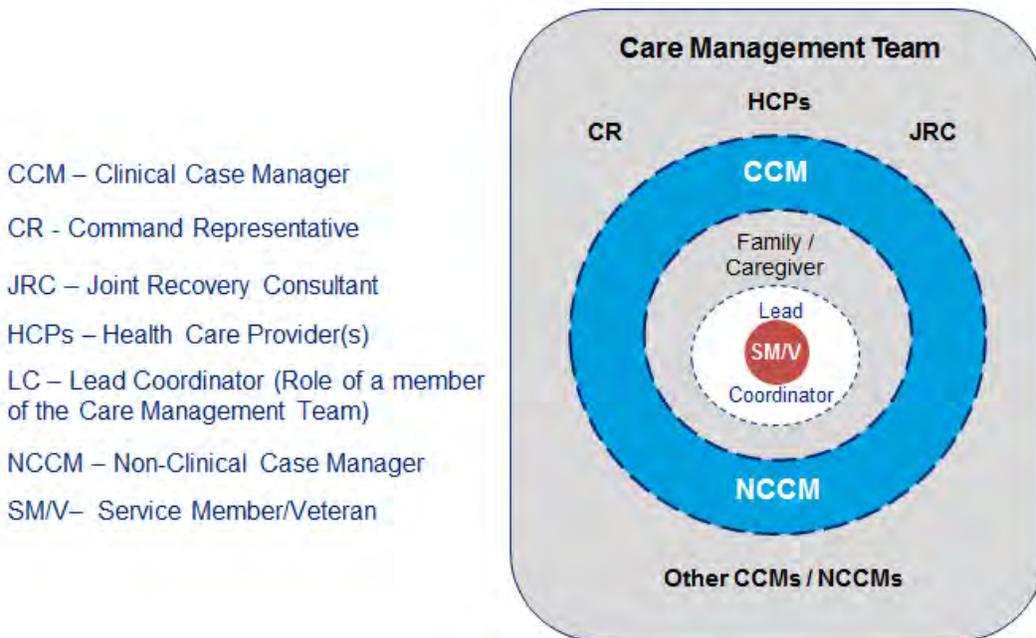
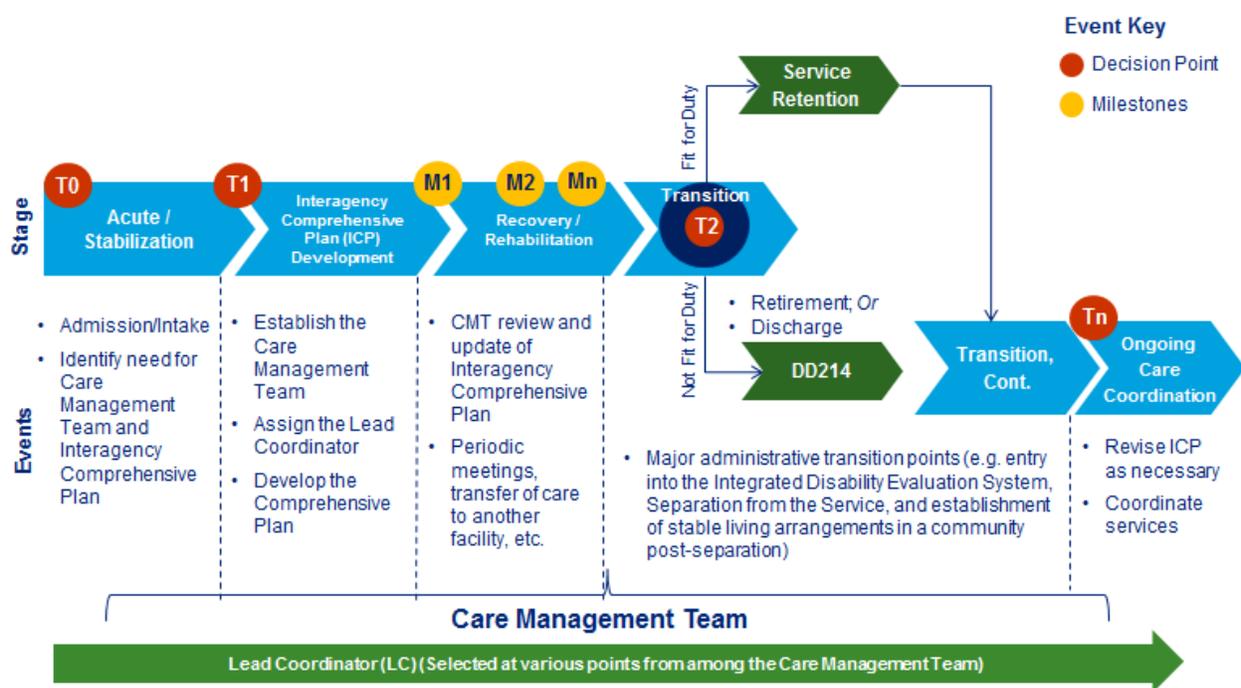


Figure 2. Common Operating Model Interagency Complex Care Coordination



Milestones and Transition Timeframes

- T0—Time of admission or identification of need for CMT and ICP.
- T1—Time of establishment of the CMT, LC, and ICP.
- M1-Mn—Milestones requiring CMT review and updating of ICP (e.g. regular periodic meetings, transfer of care to another facility, to include outside or private entities.).
- T2-Tn—Major transition points (e.g. entry into the Integrated Disability Evaluation System, Separation from the Service, establishment of stable living arrangements in a community post-separation and ongoing reassessment and complex care coordination.).

3. Principles of Complex Care Coordination:

- The CMT includes clinical case manager(s) (CCM) and non-clinical case manager(s) (NCCM). A member of the CMT is designated as the LC for each SM/V. The composition of the CMT will evolve over time, based on the needs of the SM/V, but certain members of the CMT may remain the same, even as care is transferred from one facility to another, or the SM/V moves from inpatient to outpatient status.
- SM/Vs with catastrophic wounds, illnesses, or injuries, or multiple medical conditions with an expected unstable course of recovery, which require long-term, highly complex care, benefits, and services, may also benefit from the inclusion of a Joint Recovery Consultant (JRC) as a member of the CMT. The JRCs provide information about the Departments, community, civilian facility or other governmental agency services; assist and advise about the ICP; and provide longitudinal consultation services and assistance to

the CMT, SM/V and family or caregiver. The JRC may engage as early as the time of CMT establishment, as reflected in the ICP, at the discretion of the attending physician, and upon request of the LC.

- c. The JRC may also provide consultation in less severe cases, as reflected in the ICP, when requested by the LC.
- d. Multiple CCMs and NCCMs may be involved in supporting the care of a SM/V, and will align their service with the goals, activities, and milestones captured in the ICP.
- e. If the command representative is a NCCM, she or he may continue to serve as the NCCM when the SM/V moves between a Medical Treatment Facility (MTF) and a VA Medical Center (VAMC), or a civilian facility.
- f. All members of the CMT need not be physically present at the SM/V's location, provided that appropriate participation in CMT updates and services can be delivered to meet the needs of the SM/V, family and caregivers.
- g. The CMT for a SM/V in need of complex care coordination will be convened as soon as possible, but not to exceed one week following admission to an MTF, or a VAMC. In the case of a SM/V being admitted to a civilian facility within the United States, the CMT will be convened no later than one week following notification to DoD or VA personnel of that admission. In cases of transfer between facilities and care teams, the transferring CMT will be convened in advance of transfer to facilitate a warm hand-off to the receiving LC so that care continues without interruption. For outpatients, convening of the CMT will occur within one week of an assessed need for interagency complex care coordination.

4. Responsibilities of Lead Coordinator:

- a. Department policy will identify and empower the LC role throughout each stage of recovery for the SM/V.
- b. The LC is not a separate position, but a role assigned to one of the existing members of the CMT. At the CMT initial meeting, an LC is designated and the ICP is initiated.
- c. The LC may be recommended by mutual agreement of the CMT members, including input from the SM/V, family or caregiver, and command representative.
- d. The LC is held responsible for carrying out duties within his or her normal supervisory structure. Any disagreement about who serves as LC is resolved by the:
 - MTF Commander if the SM is receiving care at an MTF;
 - VAMC Director if the SM/V is receiving care at a VAMC; or
 - Command representative or designee if the SM is receiving care at a civilian facility.

The command representative is always able to communicate with the MTF Commander or VAMC Director when a SM is at an MTF or a VAMC.

- e. The identity and contact information for the LC is documented in the ICP. The ICP is maintained by the LC, shared with the SM/V and any designated family or caregiver, and appropriately recorded.
- f. The LC, in collaboration with other CMT members, ensures that the SM/V and any designated family member or caregiver are encouraged to participate in the establishment and modification of the ICP at every stage in the SM/V's care continuum.
- g. The LC serves as the primary point of contact for SM/Vs and their families or caregivers for coordination of care, benefits, and services related to the ICP. However, other members of the CMT may communicate with the SM/V. The LC identifies potential conflicts in the ICP and facilitates resolution within the CMT.
- h. The LC communicates with the SM/V and family or caregiver on an ongoing basis (in person, when possible), and provides them with contact information for the LC and other members of the CMT. The contact information is updated as changes occur. A CMT contact information sheet is provided to the SM/V, family and caregivers.
- i. The LC is responsible to update the CMT during the regularly scheduled CMT meeting and make sure the ICP is updated on a periodic basis to include at least the following milestones: at the time of transfer from one facility to another or to another geographic area; at the time of discharge from inpatient to outpatient status; upon transfer to an outside or private entity, or upon significant change in the SM/V's condition.
- j. The LC identifies the need for and facilitates the proper phasing of care, benefits, and services to establish and maintain the ICP. The LC facilitates communication between members of the CMT about the SM/V and milestone progress, risks, and issues related to his or her complex care coordination.
- k. The LC has regular communication with the SM's command representative and provides periodic status updates no less than monthly. The NCCM may be the command representative.
- l. When a change in the LC is warranted (e.g., a SM/V transfers from one level of care or location which requires a LC change), the hand-off of accountability for care and information about the course of the recovery to date and details of the ICP is accomplished with person-to-person communication between the transferring and receiving LCs. The current LC provides the next identified LC with a summary of the course of care to date, and a current copy of the ICP and related tools.
- m. For transfers between DoD and VA when a change in the LC is warranted, LC identification and communication is facilitated by existing referral processes, including

through the VA Liaison for Healthcare, Veterans Health Administration (VHA), Operation ENDURING FREEDOM/Operation IRAQI FREEDOM/Operation NEW DAWN (OEF/OIF/OND) Program Manager, and/or VHA Specialty Program coordinators.

- n. The command representative is also included in the transfer discussion and activities for Service members.
- o. The transferring LC is responsible for providing the SM/V and family or caregiver with information about the receiving LC, inform them of any changes to the ICP, documenting the hand-off in the SM/V's ICP, and providing contact information to the SM/V and family or caregiver, including the contact information for the new LC.
- p. The receiving LC will acknowledge and document transfer of responsibility in the SM/V's health records, review the ICP, and meet with the SM/V and their family or caregiver within one workday of transfer if the SM/V is an inpatient; for outpatients, the LC should contact the SM/V and their family or caregiver within one week and arrange a meeting as soon as feasible for the SM/V.

ATTACHMENT B: ABBREVIATIONS AND ACRONYMS, DEFINITIONS, AND REFERENCES

PART I. ABBREVIATIONS AND ACRONYMS

CCM	Clinical Case Manager
CM	Case Management
CMT	Care Management Team
DoD	Department of Defense
IC3	Interagency Care Coordination Committee
ICP	Interagency Comprehensive Plan
JEC	Joint Executive Committee
JRC	Joint Recovery Consultant
JSP	Joint Strategic Plan
LC	Lead Coordinator
MCSC	Managed Care Support Contractors
MTF	Military Treatment Facility
NCCM	Non-Clinical Case Manager
OEF/OIF/OND	Operations ENDURING FREEDOM/Operation IRAQI FREEDOM, Operation NEW DAWN
RN	Registered Nurse
SM/V	Service member or Veteran
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
SW	Social Worker

PART II. DEFINITIONS

Care Management Team (CMT). The CMT includes individuals who are working together to manage, coordinate, and/or deliver the care, benefits, and services for the SM/V and to support the family or caregiver. The professions and individuals who comprise a specific CMT will vary based on the needs of the individual and their family or caregiver (e.g. health care provider(s), attending physician, nurse case manager, therapist, social worker, vocational rehabilitation specialist, Command representative, and all others providing care, benefits, and services, including military or community resources). The most appropriate CMT member already providing health care, benefits, or services, will serve as the Lead Coordinator (LC) and direct complex care coordination efforts.

Caregivers. For Service members, a caregiver is an individual who renders to an eligible Service member services to support activities of daily living and specific services essential to the safe management of the beneficiary's condition. For Veterans, a caregiver is a person who provides personal care services to a Veteran because the Veteran is either unable to perform an activity of daily living or needs supervision or protection based on symptoms or residuals of neurological or other impairment or injury. For criteria applicable to VA's Caregiver Programs, see 38 C.F.R. Part 71.

Catastrophic Wound, Injury, or Illness. In general, a permanent, severely disabling wound, illness, injury, disorder, or disease that compromises the ability to carry out the activities of daily living to such a degree that a SM/V requires personal or mechanical assistance to leave home or bed, or requires constant supervision to avoid physical harm to self or others. For active duty SMs, this wound, injury, or illness would make it highly unlikely that the SM will return to duty and will most likely be separated from the military. VA has unique definitions of similar terms for specified purposes in statute and regulation.

Clinical Case Manager (CCM). A CCM uses a collaborative process under the population health continuum to assess, plan, implement, coordinate, monitor, reassess, refer, and evaluate options and services to meet an individual's health and psychosocial needs through communication and available resources to promote quality, cost-effective outcomes. The following are examples of CCMs:

- The Managed Care Support Contractor (MCSC) CCM delivers case management (CM) to TRICARE beneficiaries in the region where they reside who meet the CM criteria outlined by the regional MCSC, receive the majority of their health care in the purchased care system, and accept the offered services.
- The Military Treatment Facility (MTF) clinical case manager delivers CM to TRICARE Prime enrolled beneficiaries who meet the criteria outlined in this document and by the Services or Joint Medical Commands, receive the majority of their health care in the Direct Care System, and accept the offered services.
- The VA OEF/OIF/OND case manager (Master's prepared registered nurse (RN) or social worker (SW)) provides both clinical and non-clinical CM services to eligible OEF/OIF/OND Veterans at VA health care facilities. OEF/OIF/OND SM/Vs with polytrauma, spinal cord injury, blindness, or traumatic brain injury diagnoses may have a specialty care case manager. Non-OEF/OIF/OND SM/Vs needing CM services can also receive services from SW or RNs in primary care or specialty areas.
- Other specialty care case managers have unique expertise in treating and case managing SM/Vs in a specific specialty care area.

Complex Care Coordination. Complex care coordination involves assisting the most severely wounded, ill, or injured SM/Vs, or those SM/Vs with complex circumstances. The SM/Vs that meet the criteria for complex care coordination, are expected to have a prolonged recovery or rehabilitation process, and may require access to clinical, social, educational, financial, and other services across various organizations and providers. The objective of the interdisciplinary complex care coordination team model is to establish and optimize the use of the Interagency Comprehensive Plan (ICP) and the resulting application of care, benefits, and services, including military and community resources, to facilitate and promote the SM/V's recovery or return to as high a level of function as achievable.

Interagency Care Coordination Committee (IC3). A committee for governance established under the Congressionally mandated JEC to implement, maintain, and oversee the provision of interagency complex care coordination of wounded, ill, or injured SM/Vs in accordance with VA-DoD Warrior Care Coordination Task Force recommendations and the IC3 Charter.

Figure 3. IC3 Relationship to JEC



Interagency Comprehensive Plan (ICP). The ICP is a SM/V-centered recovery or rehabilitation plan with identified goals for recovery and rehabilitation to ongoing care and community reintegration. The plan is developed from a comprehensive needs assessment, which identifies the recovering SM/V’s personal and professional needs and goals with input from their family or caregivers and the services and resources needed to achieve them through specific activities in those key areas, which were reviewed during assessment.

Joint Recovery Consultant (JRC). JRCs are assigned to SM/Vs who require complex care coordination. Their responsibilities include providing clinical and non-clinical assistance and advice about DoD, VA, community, and other resources available to support the ICP. It is unlikely that they will serve as the LC because they provide longitudinal consultation services and assistance to the CMT, the SM/V, and the family or caregiver. JRCs may also participate in less severe cases when consulted by the LC. This is not a new position, but rather describes the role of existing personnel who carry out these functions, as appropriate. JRCs may or may not be located where the SM/V is receiving care, benefits, or services.

Lead Coordinator (LC). The LC is a role for an existing member of the CMT who, while fulfilling their responsibilities of their primary role, assumes responsibility for coordinating the development and overseeing execution of the ICP, but the LC is not responsible for the actual delivery of care beyond their scope of practice. The LC facilitates communication and serves as the primary point of contact to the SM/V and family or caregiver, as well as the rest of the CMT, in order to avoid or reduce confusion. Lead Coordinators can be clinical or non-clinical, and are co-located with the recovering SM/V when feasible.

Non-Clinical Case Manager (NCCM). The NCCM will ensure the recovering SM/V and family or caregiver receive all the non-clinical support they need and/or to which they are entitled. The NCCM role includes: communicating with the SM/V and with the SM/V's family or other individuals designated by the SM/V regarding non-clinical matters that arise during the care, recovery, and transition of the SM/V; assisting with oversight of the SM/V’s welfare and quality of life; assisting the SM/V in resolving problems involving financial, administrative,

personnel, transitional, and other matters that arise during the care, recovery, and/or transition of the SM/V.

Seriously Ill or Injured. In the case of a member of the Armed Forces, including a member of the National Guard or Reserves, this means a wound, illness, or injury incurred by the member while on active duty in the Armed Forces that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating. It is unlikely that a SM with this type of wound, illness, or injury will return to duty in a time specified by his/her Military Department and may require medical separation from the military. This includes traumatic brain injury, psychological trauma, or other mental disorder, incurred or aggravated in the active military, naval or air service that renders the individual in need of personal care services.

PART III. REFERENCES

- a. Secretaries of Defense and Veterans Affairs, Intent Memorandum, November 2012
- b. Department of Veterans Affairs/Department of Defense, Joint Executive Committee Charter, March 20, 2012
- c. Department of Defense/Department of Veterans Affairs Interagency Care Coordination Committee (IC3) Charter, January 8, 2013
- d. Department of Defense and Department of Veterans Affairs Warrior Care Coordination Task Force Final Report, November 2012