

UNITED STATES DEPARTMENT OF DEFENSE

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TASK FORCE ON THE CARE, MANAGEMENT, AND
TRANSITION OF RECOVERING WOUNDED, ILL, AND
INJURED MEMBERS OF THE ARMED FORCES

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BUSINESS MEETING

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TUESDAY
DECEMBER 4, 2012

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The Task Force met in the Commonwealth Room of the Doubletree Hotel Washington, D.C. Crystal City, 300 Army Navy Drive, Arlington, Virginia, at 8:30 a.m., Suzanne Crockett-Jones and Major General Richard Stone, Co-Chairs, presiding.

PRESENT:

SUZANNE CROCKETT-JONES, Non-DoD Co-Chair
MAJOR GENERAL RICHARD A. STONE, MD, USAR,
Acting DoD Co-Chair
JUSTIN CONSTANTINE, JD, Member
CSM STEVEN D. DeJONG, ARNG, Member
RONALD DRACH, Member
CAPTAIN CONSTANCE J. EVANS, USN, Member
LIEUTENANT COLONEL SEAN P.K. KEANE, USMC,
Member
COLONEL KAREN T. MALEBRANCHE, RN, USA
Retired, Member
STEVEN J. PHILLIPS, MD, Member
DAVID REHBEIN, MS, Member
COLONEL RUSSELL A. TURNER, MD, USAF Retired,
Member

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ALSO PRESENT:

DENISE F. DAILEY, PMP, Executive Director
MICHAEL CONNER, NGB Warrior Support Office
COLONEL JILL K. FARIS, Deputy Surgeon, Army
National Guard

RAYMOND HOLDEMAN, Deputy Division Chief
Personnel, Army National Guard

JESSICA JAGGER, PhD, MSW, Research Staff

COLONEL KEITH KNOWLTON, U.S. Physical
Disability

Agency & Reserve Components Soldier
Medical Support Center

SUZANNE LEDERER, PhD, Research Staff

ELSPETH RITCHIE, Institute of Medicine,
Committee on the Assessment of Ongoing Effects
in the Treatment of Post-Traumatic Stress
Disorder

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P-R-O-C-E-E-D-I-N-G-S

8:30 a.m.

MS. DAILEY: Ladies and gentlemen,
if I could please have everyone seated, and we
will start our meeting. Good morning.

CO-CHAIR CROCKETT-JONES: Thank
you, Ms. Dailey.

Welcome to the first business
meeting of our third year of effort.

Over the last two years, the
Recovering Warrior Task Force has vigilantly
assessed the procedures and level of care for
wounded, ill and injured service members,
through input from medical care subject matter
experts, chains of command, various service
members and family members.

We've gathered this data through the
execution of 25 installation visits, 10 business
meetings, which structured our 56 overall
recommendations.

These recommendations were
submitted to the Secretary of Defense, through

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1 our two annual reports.

2 During this third fiscal year, we'll
3 continue our work through site visits and
4 business meetings, to provide substantial
5 recommendations that will address the level of
6 care and support provided to our service members
7 and families.

8 Before we begin, I would like to ask
9 these members of the Task Force to introduce
10 themselves. Why don't you start, Mr. Rehbein?

11 MEMBER REHBEIN: Start on this end,
12 and thank you, Suzanne. It's been a while. Six
13 months goes by sometimes quicker than you think.

14 Anyway, I'm Dave Rehbein, Army
15 Veteran, research scientist, past National
16 Commander, and I'm glad to be back on the Task
17 Force for the third year.

18 MEMBER DeJONG: Good morning, all.
19 Command Sergeant Major Steven DeJong, National
20 Guard Bureau.

21 MEMBER MALEBRANCHE: Karen
22 Malebranche from BHA, the Executive Director of

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1 Interagency Health Affairs.

2 MEMBER PHILLIPS: Steve Philips,
3 physician. I work at National Institutes of
4 Health, retired Army.

5 MEMBER CONSTANTINE: Good morning,
6 I am Justin Constantine. I am a Major in the
7 Marine Corps Reserve.

8 I'm here in my position as an
9 attorney, and I'm an attorney in the Marine Corps
10 Reserve and my normal day job is an attorney with
11 the FBI Counter-Terrorism Team. Thanks.

12 MEMBER DRACH: Good morning. Ron
13 Drach. I'm retired from the U.S. Department of
14 Labor, of the Disabled American Veterans, and I
15 am one of the non-DoD members.

16 MEMBER TURNER: Good morning.
17 Russ Turner, physician from San Antonio, retired
18 Air Force Aero-Space Medicine.

19 MEMBER EVANS: Good morning.
20 Captain Constance Evans with the Bureau of
21 Medicine, nurse, Case Management Department.

22 MEMBER STONE: And I'm Rich Stone.

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1 I'm the Army Deputy Surgeon General and Deputy
2 Commanding General for support.

3 CO-CHAIR CROCKETT-JONES: And I'm
4 Suzanne Crockett-Jones. I am the civilian
5 Co-Chair of the Task Force and the spouse of a
6 recovering Army infantry officer, and thank you,
7 all, for that introduction.

8 General Stone is working with me to
9 run the morning session of today's meeting, and
10 I'll turn that over to him now.

11 MEMBER STONE: Good morning, again.
12 We're going to begin this morning talking about
13 our visit to the Walter Reed National Military
14 Medical Center.

15 As you know, we visited that site on
16 the 13th to the 15th of November. This was the
17 first visit of our fiscal year.

18 In September 2011, Walter Reed Army
19 Medical Center merged with the National Navy
20 Medical Center at Bethesda, consolidating into
21 the Walter Reed National Military Medical
22 Center, as a result of the Base Realignment and

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1 Closure Act.

2 This most recent trip marked our
3 first visit to Walter Reed since this
4 association had joined these two hospitals into
5 a joint service care facility, after the closing
6 of Walter Reed in July of 2011.

7 This allowed the services time to
8 get used to the newly formed joint relationships
9 and us to do our discovery of how they were doing.

10 The members that were in attendance
11 during this past visit included myself, Ms.
12 Crockett-Jones, Command Sergeant Major DeJong,
13 Mr. Drach, Captain Evans and Dr. Philips.

14 At this point, we would like to begin
15 then, with a discussion of our impressions of
16 that visit.

17 CO-CHAIR CROCKETT-JONES: That's
18 okay. I want to say that our visit was extended.
19 It's because of the joint nature of that
20 facility. We had a lot of potential focus
21 groups, and so, we had -- and we had a lot of
22 information to sort of take in. It was kind of

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1 a long and exhausting installation visit.

2 For those of you who have done other
3 installation visits, you know we get, quite
4 frequently, when asking family members and
5 service members who the primary source of
6 information is, who the team member is that is
7 most significant in their recovery, we often get
8 nurse case managers as the answer, but that was
9 not the case at Walter Reed.

10 We sort of had an outlier there, and
11 so, if I can get some of the other folks who were
12 on that visit, to talk about maybe some of the
13 impressions they have about why we got sort of
14 a different view of the recovery team.

15 MEMBER DeJONG: You know, part of
16 what we see there is a lot of high, you know, very
17 seriously injured multiple amputees, and
18 physical therapy was actually one of the key
19 players in their recovery team.

20 We also were able to validate some
21 of the past recommendations that we've had and
22 some of the talk we've had over the last two

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1 years, of acuity-based staffing for both nurse
2 case managers and non-medical case managers,
3 because these recovering warriors, they have
4 serious injuries, and then they also have a lot
5 of family members with them, either a spouse or
6 a mother, primarily, who are also in the area
7 with them and living with them.

8 So, those non-medical case managers
9 were running, you know, managing the case of the
10 soldier or the airman or the Marine, whoever it
11 was, and then they also were taking care of that
12 family, on top of it.

13 So, acuity-based staffing for that
14 was definitely validated at this site.

15 MEMBER PHILLIPS: Yes, I certainly
16 agree with that.

17 I learned something, which should
18 have been obvious to me the whole past three
19 years or two and a half years, that the manager
20 and the choice of the manager probably depends
21 on where they are in the phase of recovery.

22 Most of the remote bases that we

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1 visited, the nurse case manager really does run
2 the show, because of all of the offsite visits
3 and necessary management activities that the
4 service member needs.

5 But again, as the Sergeant Major
6 pointed out, at Walter Reed, the acuity is such
7 that the in-house people are really managing
8 everything, and I'm sure the nurse case manager
9 is very aware of what is going on, but not really
10 playing an active role.

11 So, I think it depends on where they
12 are in their spectrum of care and activity.

13 MEMBER EVANS: And I have to agree,
14 just leaving Walter Reed, one of the things that
15 we noticed.

16 The service member, they're very
17 engaged in the MATC and rehab, and so they spend
18 a lot of time in the rehabilitative part of care,
19 and so, that is who they see as their primary
20 person, as far as "taking care of me," that's
21 what they see, because that is where they are,
22 as far as in care.

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1 I think what we have done, and what
2 they have done at the hospitals, they realize
3 that we need to look at the acuity-based, and so,
4 they are looking at the numbers very closely.

5 We at Navy Medicine look at the
6 numbers, Army look at the numbers, and actually,
7 we're coming -- I think the ratio of anywhere
8 from 10 to 20, I think, you know, both services
9 take in the base of acuity.

10 And so, when you look at where they
11 are in stage of care, who they see every day, they
12 are in rehab, and so, physical therapy is --
13 that's the therapist that they know, and they
14 develop a close relationship with that
15 therapist, and so, that is who they recognize as,
16 "That is the most important person in my care
17 right now."

18 As they transition to
19 re-integration, getting ready to go back to home
20 or back to the active duty side, they then
21 realize that they start depending on my
22 non-medical or medical case manager, and then I

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1 start depending on, "I need to transition to the
2 VA."

3 So, I think it's appropriate what
4 was seen. It was surprising, I think, to us,
5 because we want to hear the nurse case manager,
6 but that is not where they are in care, and so
7 I think that is very appropriate.

8 MEMBER DRACH: Well, one of the
9 things that I had not heard before, and I was very
10 pleased to hear up there, was the issue of
11 transportation, that at least the Marines were
12 really up front about taking care of the
13 transportation needs of not only the warriors
14 but also the family members, whether it's back
15 and forth to the airport or wherever it may be,
16 and that service was available, as I recall,
17 pretty much 24/7.

18 The other thing that I was not aware
19 of, which again, I was very pleased, that they've
20 worked very closely with the State of Maryland
21 Motor Vehicles, so that those individuals that
22 are still on active duty could be issued the

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1 handicapped placard that allows them to park in
2 handicapped spaces that are designated in the
3 public arena. So, I was pleased to hear that.

4 The other thing, and I think it's
5 pretty common, we've heard it at a lot of site
6 visits, that there seems to be a disconnect
7 between what the Command thinks is going on and
8 how successful it is and how great it is, and how
9 the service members and the warriors and some of
10 the family members perceive the services there.
11 They don't always match up.

12 MEMBER STONE: Ron, I wonder if
13 you'd spend some time expanding on that.

14 CO-CHAIR CROCKETT-JONES: Sir, one
15 key point to that is the CTP-CRP again. The
16 Commands say it works very well, and we are
17 briefed that the CTP is this document that is
18 transitioning all of their care.

19 Again, when we talked to the
20 warriors themselves, or even so much the
21 families and the warriors, the CTP is unheard of.

22 Some of that confusion seems to be

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1 what they call it, or what the non-medical case
2 managers, squad leaders and so forth refer to it
3 as, but again, there seems to be a disconnect in
4 the CTP and how the Command views that as a very
5 good document versus the warrior and the family
6 not really knowing what we were talking about in
7 the focus groups.

8 MEMBER EVANS: Sir, that was across
9 the board, we had two different focus groups and
10 in both groups, we tried to use different
11 terminology for, you know, transition plan, I
12 mean, we just tried to trigger some type of, you
13 know, word to help the service member recall that
14 transition plan or recovery plan, and across the
15 board, they have not. They expressed they had
16 never heard of it.

17 MEMBER STONE: Sir, I wonder if
18 you'd -- one of the reasons we took a little bit
19 of time, before we went into this institution,
20 was the merger between two major long-legacy
21 cultures in the Army and the Navy, in two premier
22 hospitals.

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1 Did we learn any lessons from that
2 in our visit?

3 CO-CHAIR CROCKETT-JONES: I think
4 we did. I can say that cadre that we're in
5 charge of transition units, did not express --
6 they did not feel like it was a joint forces
7 installation.

8 They expressed sort of a sense of
9 being on borrowed space. There was a lack of
10 ownership they have, and sort of a lot of
11 cultural clashing between, you know, having to
12 ask for rooms and support for recovering
13 warriors coming in from, you know, reservists
14 coming back into medical care, from somewhere
15 else.

16 There was a bit of stress in getting
17 those needs met when you have to. You're
18 responsible for meeting someone's needs and you
19 have to go ask, and maybe you're not going to get
20 a yes for what you need to support that person.

21 So, we did run into that in a couple
22 of different cases, in the folks that we talked

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1 to. I can't say that we noticed that in results
2 to service members themselves. I don't think we
3 had anyone expressing that they felt their
4 recovery, their personal trajectory, their
5 personal arc of recovery felt displaced or
6 lessened, because of who they were dealing with
7 in the installation.

8 So, they're succeeding at some
9 level, but it's not easy yet, for those who are
10 working the system, but it's awfully young, it's
11 awfully new to them.

12 MEMBER DeJONG: I would agree with
13 that, that it's --

14 CO-CHAIR CROCKETT-JONES: No, go
15 ahead.

16 MEMBER DeJONG: I would agree with
17 that, that it's not seen at the recovering
18 warrior level. It's not seen at the care level,
19 but at the Command and staff level, you have a
20 lot of, "This is theirs. This is --" -- there
21 is not a collaborative effort to run that Command
22 as a joint command. It is still Navy versus --

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1 you know, Navy side, Army side.

2 Whereas, I think things may or may
3 not be smoother if it was more of a collaborative
4 effort at the Command and staff level.

5 MEMBER EVANS: I agree. I would
6 have to concur. I think they still -- it's still
7 very -- it's not unified. It's not one.

8 So, you still have Marine Corps,
9 Army, Navy, Air Force, and they all have their
10 space separate. They all have their case
11 managers. They all have their recovery care
12 coordinators.

13 You know, even, let's get down to the
14 PEBLOs, and so, they all have the same title, but
15 because I work for Army or I work for Marine
16 Corps, I'm not -- it's not one.

17 So, it's still very separate, and
18 again, they've only been at this for about a
19 little bit over a year now.

20 But at some point, it should be
21 seamless and so, the warriors should not have to
22 worry about going to, you know, the Army RCC or

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1 PEBLO. They should be able to go to any PEBLO,
2 same for the Navy and Marine Corps, and it's not
3 there, and that's -- hopefully, if we go back in
4 a year, we'll see progress. But it is
5 definitely separate.

6 MEMBER PHILLIPS: I want to make two
7 comments. One on a personal level.

8 I received my care at Navy, and now
9 I receive my care at Walter Reed. I also make
10 rounds over there. I interact in the cardiac
11 program.

12 At that level, it's fairly seamless.
13 I always ask the folks, Army, Navy, "Where are
14 you from?" You know, whatever. But it works.
15 It seems to work at that level.

16 At the administrative level that you
17 were talking about, I think we've seen this
18 across the board, that there is a disconnect, or
19 somewhat of a disconnect between the
20 administration of the care and the care itself.
21 The care is excellent. That is just a personal
22 comment.

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1 I think related to my visit, to
2 amplify some of the comments, the Command, and
3 what we hear, there is always somewhat of a
4 disconnect, but the Command always -- to support
5 the Command itself, in general, the Command
6 always seems to welcome our comments, even
7 though some of our comments may not be very nice
8 at times. Hopefully, it seems to suggest that
9 they respond to those.

10 One consistent thing that we always
11 hear, and I heard again at Walter Reed, was lack
12 of communication and information for the family,
13 and especially as they move further on
14 downstream.

15 Comments like, "We had trouble
16 getting refills. We don't know how to do that.
17 The TBI clinic is not responsive. The emergency
18 warrior clinic, we don't know how to do that,"
19 and then the group, we're interacting with each
20 other and said, "Oh, it's easy, you do it this
21 way or you do it that way."

22 So, I think that is a broad issue.

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1 The communication and the permission for
2 communication, the family members and care
3 givers, is an issue.

4 CO-CHAIR CROCKETT-JONES: Yes, I'd
5 agree with that.

6 I think that over the past couple of
7 years, I think we've seen this -- the beginnings
8 of a cultural shift. I think that families are
9 getting more access to information than they
10 were a couple of years ago.

11 But I think that this is a difficult
12 process, and I am not minimizing the importance
13 of cadre and leadership to do that outreach. In
14 fact, I think it's absolutely essential.

15 But I also think that we're going to
16 see some -- it's going to take time for families
17 to come to the realization that it's okay to
18 access information through leadership.

19 This is a new concept, and along with
20 all the things that happen when your service
21 member, your family member is injured, you have
22 to learn that some of the things, the distance

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1 that you kept from the Command and leadership,
2 that distance can be breached now.

3 It's just -- it's going to take us
4 some time, to see some good results.

5 I think though, the answer is in
6 leadership outreach, and we're still -- we
7 haven't quite figured out the optimal time.

8 In-patient people seem to have
9 plenty of information and access, and when they
10 don't have information, they have an easy fix.
11 Someone is always coming into that room, and when
12 you ask them a question, it can eventually get
13 answered, so the right person gets filtered to
14 you.

15 Out-patient, that dynamic changes
16 radically, and you don't have -- everyone that
17 you encounter is not going to have a way to get
18 you the right person and the answer to your
19 question, and so, we did see that, as we have in
20 many places.

21 I will say, we saw that the family
22 support coordinator and -- what was the other --

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1 there was an FSC -- there are two people, one was
2 Marine and one was Army, and I wish I knew their
3 acronyms.

4 MEMBER EVANS: All right, so, one is
5 Linda with the Army.

6 CO-CHAIR CROCKETT-JONES: Yes,
7 Linda.

8 MEMBER EVANS: And she is like,
9 she's the same as the Marines. She's the
10 equivalent of family support. I'm not sure of the
11 exact acronyms. But they're the same dual --

12 CO-CHAIR CROCKETT-JONES: Yes, and
13 then those two folks were doing good work. I'm
14 not sure that they're enough. But they are
15 effective, at what they're trying to do.

16 So, I think that we're seeing some
17 good ideas. I'd like to see them come a little
18 more to fruition and spread a little more upward.

19 MEMBER EVANS: And I'd like to echo
20 what Dr. Phillips said, that the in-patient --
21 you know, I was just an in-patient there, and the
22 care is fabulous. I had an Army nurse. I had

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1 a Navy nurse, seamless. You know, couldn't tell
2 -- they were both wonderful nurses.

3 I think again, when we look at the
4 warrior transition from in-patient to
5 out-patient, going through that continuum of
6 care, it's not as seamless as it should be.

7 So, they get a lot of information
8 in-patient. They have a lot of people tending
9 to their needs, but as soon as they start that
10 transition, that's where we need to strengthen.
11 That's where we need to improve.

12 MEMBER STONE: And in that
13 transition to ambulatory care or out-patient
14 services, is there anything unique in that
15 institution, because it is a joint institution,
16 versus the other sites that we've visited?

17 MEMBER DeJONG: What was surprising
18 was the access and the diagnosis of TBI care, at
19 that facility, being pretty high-profile, that
20 in-patient, they had a lot of -- and both PTSD
21 and TBI, but primarily TBI, when they transition
22 to out-patient, there was -- not having a lot of

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1 significant impact on the soldier's symptoms,
2 somewhat downplaying the symptoms, and not
3 really taking a lot of what might be a symptom
4 to the warrior seriously enough to run them
5 through extensive testing.

6 MEMBER EVANS: Just pondering the
7 question.

8 I think when you look at the
9 different other facilities, and so, when you're
10 talking about Walter Reed Bethesda, I think
11 they're so heavily concentrated on the
12 in-patient, and that we have the support there
13 for the out-patient side.

14 But the focus, I would say, is just
15 a heavy concentration on in-patient. You know,
16 I would think that is the reason that we see that
17 trend to lessen, as they move to the ambulatory
18 side of that -- lessen that support.

19 CO-CHAIR CROCKETT-JONES: My
20 impression was that when they are in-patient,
21 everybody owns them. Everybody is responsible
22 for that patient, and when they get to

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1 out-patient, somebody owns them, but not
2 everybody.

3 That is my overall, you know, that
4 is sort of the long view for me, was that
5 in-patient, it didn't matter who walked in the
6 door. That was the patient. Out-patient, you
7 go back to -- if you weren't assigned to me, I
8 don't own you.

9 MEMBER PHILLIPS: It's a total
10 culture change. You know, you leave home when
11 you're 18. Mom no longer makes your bed and
12 cooks your meals.

13 You go from in-patient to
14 out-patient, you have to spend 20 minutes trying
15 to find a parking spot. There are long lines at
16 the pharmacy. I mean, things are done well, but
17 it's just a culture change, which I don't think
18 the families and the warriors are briefed enough
19 about what to expect.

20 I mean, these folks are excellent.
21 If you tell them, "This is what is going to
22 happen," they'll go along with it. If you don't

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1 prepare them ahead of time, and I think we're not
2 preparing them enough, I'm just suggesting that,
3 with information, and this is how it's going to
4 be. "I'm sorry, but it's going to be difficult
5 to find a parking spot."

6 The little things that need to be done for you
7 to get to your next appointment, are difficult.

8 MEMBER MALEBRANCHE: I have a
9 question.

10 I, unfortunately, did not go on this
11 visit, but I'm wondering, there we have a VHA
12 liaison at that facility, and I'm wondering if
13 any of the families spoke about that, and if that
14 helped the transition, because we don't have
15 them at the military facility, but we have about
16 20 out there, across the country, and did that
17 come up or make any difference in transition or
18 follow-up in the VA?

19 MEMBER STONE: It did, although the
20 acuteness of the care and the youngness in which
21 they were into their injury recovery, there was
22 very little visibility until such time as there

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1 was consideration of the poly-trauma centers.

2 So, if there was consideration of
3 the poly-trauma centers, then families began to
4 really value the input of the VA liaisons.

5 Now, please understand, I speak from
6 not just our visit there, but the fact that my
7 wife and I visit there every four to six weeks,
8 and visit wounded and talk to them, and we have
9 followed a number of casualties through the VA
10 system, and done visits and follow-up there,
11 just to think about how this works.

12 So, there is a number of things that
13 I'd like to think about, about this visit.

14 Number one, the concept of combining
15 two premier healthcare institutions in the midst
16 of a war is one that is high-risk work, and I
17 think we need to recognize the really
18 spectacular work that has gone on, to not drop
19 the ball.

20 You have all complimented and
21 recognized that the critical care medicine that
22 is going on at this institution is really a

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1 testament to the Navy and the Army really working
2 hard to bring these two institutions together.

3 I would ask you to think about, at
4 the end of this year, whether we want to make
5 comment on just a decision made to take a
6 high-risk decision like this, and do it in the
7 middle of a war.

8 Now, BRACC gets started a long time
9 before, but when war starts, these are our two
10 primary intake institutions.

11 As much as we saw some problems in
12 the leaders trying to get the cultures of 100
13 years of legacy work of the Army and the Navy
14 together, it was almost invisible at the
15 critical care level.

16 But yet, there was an effect on
17 cadre, and cadre often felt displaced, and I
18 think that I would ask you to capture that, as
19 we come to our third year recommendations of how
20 joint -- development of a joint institution in
21 the middle of a war can have a profound affect
22 on cadre.

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1 Last year, we made a decision to
2 submit a recommendation on acuity-based case
3 management, and this was a perfect example of
4 where set DoD ratios may not make sense, that
5 acuity-based adjustment to both the cadre of NCO
6 management, as well as to how we manage very
7 complex battle injuries, may need to change.

8 And yet, there is still, even in a
9 joint institution, huge component interest, and
10 each of the service members and their families
11 want the identity of their services, and
12 therefore, expect to have component interest and
13 liaisons that is unique to their services.

14 We all acknowledge the fact that
15 this institution does the impossible, and they
16 do it spectacularly, and there is not one of us
17 that goes up there for visits, that doesn't see
18 that extraordinary work in saving lives and
19 dealing with incredibly complex battle
20 injuries.

21 There is no doubt that we began this
22 war with very difficult musculoskeletal wounds,

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1 amputations, but the evolution to begin to see
2 the pelvic trauma and the evolution of the
3 understanding of pelvic trauma that has occurred
4 over these last few years, as we've dismantled
5 the Marine Corps and the Army in this ground war
6 has been very complex battle injuries, that we
7 need to capture recognition of, and how we might
8 help lead the Department forward.

9 But yet, we tackle what we've seen
10 in the first two years, of the transition points
11 to ambulatory care, still with lots of bumps in
12 the road.

13 And what your comments really
14 reflect is, all of those transition points that
15 we're still struggling with, are we handing off
16 properly, where the confusion and the anxiety
17 comes to our families, who do very well in the
18 critical care medicine phase, but that is, we
19 begin to hand off, in a campus that frankly, has
20 a few more barriers than what they might have
21 experienced in other campuses.

22 This is not a campus that was

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1 necessarily built for really disabled service
2 members, that need to move around that campus.
3 It's hilly. There is lots of barriers. There
4 is lots of stuff.

5 So, I would ask you to think about
6 that, and then think about whether we want to
7 reinforce or strengthen some of our previous
8 recommendations on acuity-based case
9 management, the complexity of this, and whether
10 really trying to do an experiment in joint
11 development is appropriate.

12 Now, this facility is going to come
13 under -- JTF Cap Med did a very articulate
14 presentation to us. The Commander General
15 Jones talked about JTF Cap Med. The Department,
16 the SECDEF is about to make some additional
17 decisions on the future of JTF Cap Med, and how
18 we manage this capital region.

19 Totally unique from the other areas
20 of our delivery system, which are much more
21 service-specific, unless you get to the forward
22 edge of the battle, and in the forward edge of

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1 the battle, as you know, these are very joint
2 operations.

3 So, we say that works well, because
4 the Generals stay far away from it.

5 So, now, with that said, any comments or
6 thoughts on my views on this?

7 MEMBER EVANS: I think excellent
8 viewpoint, and I think we all concur with -- this
9 is definitely new, new to all services, new to
10 medicine, and it's going to take some time.

11 We all, back at Walter Reed, would
12 say, you know, five years from now, when we all
13 retire, the new folks will come in and they'll
14 say, "What were all the issues? Why did you have
15 these types of issues going on?"

16 So, I think that is excellent. One
17 of the recommendations that I would make, is that
18 the JTF, although we have the services
19 representation at JTF, maybe we need to consider
20 one of the recommendations that we have someone
21 from JTF on our Task Force.

22 I mean, if we can have input from

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1 that, if they're going to -- you know, whatever
2 the SECDEF decisions are, we will need some type
3 of representation on this Task Force.

4 CO-CHAIR CROCKETT-JONES: I would
5 also just like to say that one of the things that
6 becomes sort of more clear, when we look at a
7 Joint Task Force site, is the consistency,
8 policy consistency that leads to everyone
9 meeting the same standard of care and program
10 access, and that when we visit individually the
11 individual services institutions, and we sort of
12 re-calibrate what everything is called, and who
13 is filling what role, and how those are
14 functioning, it becomes -- you know, you can see
15 how each works individually.

16 But I think that we've had concerns
17 about standards across service, does everyone
18 get the same access to programs and do policies
19 bring everyone to the same level of care?

20 And certainly, the in-patient Joint
21 Task Force situation in Walter Reed, and that
22 critical in-patient care, everyone is getting

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1 the same standard of care. I think it becomes
2 clear, that things are very service-dependent.

3 Your experience in out-patient is
4 service-dependent, and I know that, you know,
5 consistently, we heard once again, as we have
6 heard every place, we've encountered SOCOM
7 wounded, ill and injured, they wish for
8 everyone, that every wounded, ill and injured
9 service member would get the same care they do.

10 Whether that is reasonable or
11 practical or not, it does at least give us an idea
12 that we should not -- it can be frustrating for
13 families and for service members, when they are
14 co-located in a place like Walter Reed, they get
15 to see more clearly where their service may be
16 excelling and where their service may not be
17 giving them the same standard of care.

18 And so, I think we have -- it's a good
19 place to keep an eye and to seriously consider
20 the responses we got from the service members and
21 family members in the focus groups as to how much
22 of an impact a lack of standardized policy and

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1 programs between services, how much it really
2 does have an impact on those wounded, ill and
3 injured.

4 MEMBER DeJONG: I agree, and a
5 caveat, some of that transition from in-patient
6 to out-patient, in talking with the squad
7 leaders and the non-medical case managers, part
8 of their challenge and part of what they have
9 been -- you know, their responsibility is to make
10 this wounded warrior more independent and more
11 responsible for their goal that they see as an
12 out-patient care and non-medical case manager is
13 to make them completely independent on their
14 own.

15 So, there is going to be a
16 frustration at some point in time, to where as
17 in-patient, everything is coming to you, and on
18 out-patient, you have to make the transition at
19 some point in time, to start reaching out for
20 some of the things that you need to become more
21 independent.

22 So, that is a challenge of some of

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1 the -- to defend some of the staff, that they are
2 trying to find the balance of how to make them
3 more independent and how to help them on their
4 way to being either returned to duty in some
5 similar fashion, or transition to the VA outside
6 of the military, and be on their own.

7 MEMBER STONE: Sergeant Major, you
8 bring up an important point, and that is a sense
9 of independence.

10 We have seen, as we've -- we're out
11 at Balboa, dramatic independence of
12 catastrophically injured Marines, much
13 different views on senses of independence and at
14 what point independence is appropriate.

15 How do we capture that, that might
16 create a sense of frustration amongst families,
17 when we're working towards independence, rather
18 than dependence? Is it possible?

19 MEMBER DeJONG: Sir, I don't know if
20 it's completely possible, because each
21 individual is going to be a little bit different
22 as to where they are in becoming independent in

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1 each individual situation.

2 I think that is where the cadre and
3 the staff -- it's very difficult and it's a
4 tender situation, to where you have to almost go
5 person by person.

6 So, again, this would caveat some of
7 the acuity-based care. You might recognize
8 that one person is willing to become more
9 independent a little bit quicker than the next
10 person, and you might have to spend a little bit
11 more time, based off of injuries and recovery
12 towards independence, and I think it's going to
13 be a warrior-independent issue, and I don't know
14 if we can capture it as a whole, but I'd be
15 willing to hear from other members.

16 MEMBER TURNER: Just a spin to the
17 Command Sergeant Major's point.

18 I think also, the further you are
19 away from the in-patient, as we said, the
20 in-patient, we have very good standards.

21 The further away you get from the
22 in-patient, as you approach independence, as has

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1 been said many times, that is where the standards
2 of care start to vary, not only from service to
3 service, but also, geographically.

4 So, then in addition to the
5 individual cases, as Sergeant DeJong said, now,
6 you have that flow towards independence affected
7 by differing standards of care, which just from
8 my view, a lot is based on different skill sets
9 of the cadre and the people providing the care,
10 the further you get away from the in-patient.

11 So, just to summarize, the further
12 you get away from in-patient care, that is where
13 the disparities, as we've identified, start to
14 occur, and standards of care and expertise level
15 of the cadre.

16 MEMBER PHILLIPS: You know, in many
17 respects, it's a form of personnel management.
18 It's complex, and it's a very difficult
19 situation, and I don't know if there is a real
20 answer.

21 I mean, Harvard Business School 101,
22 you maximize the strong points, you minimize the

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1 weak points.

2 My experience in medicine, I could
3 do the identical operation on two different
4 patients, and you have to manage the patient and
5 family totally differently because of their
6 psychological and physical makeup.

7 So, it's a difficult issue, and as
8 Steve was saying, it's very individualized, and
9 I think if we look at it, based on acuity, as was
10 mentioned, and perhaps use some technologies of
11 personnel management, from that point of view,
12 without losing the compassion, I think that is
13 important.

14 MEMBER EVANS: I think you ask a
15 challenging question there.

16 So, but at the beginning, you said,
17 at San Diego, we were able to see a sense of
18 independence, and at Walter Reed Bethesda, we
19 were not.

20 And so, I think it would be -- maybe
21 we should look at San Diego, and in our report,
22 take those best practices and recommend to all

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1 our tri-services, our big hospitals that take
2 care of our warriors, what they're doing at San
3 Diego, to have that sense of independence.

4 It's a challenge at Walter Reed
5 Bethesda, I can tell you.

6 MEMBER CONSTANTINE: This is the
7 first time that I've heard that the goal or a goal
8 during out-patient care is independence, and
9 that makes sense to me.

10 I certainly never heard that from
11 anyone when I was in out-patient, and I wonder
12 if anyone who is in out-patient is told that.

13 I certainly understand, from a
14 caregiver level, that's what we're all pushing
15 for, because these wounded warriors need to move
16 on and get the care they need, and pick up where
17 they left off before they deployed.

18 It kind of reminds me when I was in
19 Defense Council in the Marine Corps, no matter
20 who came in my door, I had a standard speech, I'd
21 talk to them.

22 So, at base level, every client had

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1 the same information on what their options were
2 going to be, going forward, court martial,
3 guilty plea, NJT, whatever.

4 But then, everyone had their own
5 case and we got each of their cases, and we talked
6 about how things may play out for them down the
7 road.

8 Same here. I wonder if every patient
9 is getting, at least at the base level, the same
10 information as they walk out of the door from
11 Walter Reed, as to what their resources are, what
12 the goals are, because if they don't know they're
13 being pushed towards independence, it sure is
14 going to feel like they're getting pushed out the
15 door.

16 Obviously, I have a lot of mouth
17 issues, since I was shot in the mouth when I was
18 there, and they showed my wife, when I was an
19 in-patient, how to clean my mouth every day with
20 this thing, it was like a lollipop, it was a stick
21 with a sponge on the end. I don't know the name
22 of it, and some of you guys are aware of that,

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1 what it is.

2 It's critical to clean the inside of
3 the mouth, because it's soft and you can do that.

4 However, it was impossible for us to
5 get any of those, when I was in out-patient. My
6 plastic surgeon tried to put a special request
7 in to the system at Bethesda, and couldn't.
8 Could not get those ordered.

9 So, we would have to --
10 unfortunately, we live in Falls Church. We'd
11 drive up there, hopefully, we'd run into a nurse
12 that we knew there up on the wing, who would go
13 into the storage room and grab us a handful of
14 them, and put them in our bag and we would walk
15 out with them, until you know, the point came
16 where there was so much turnover, we didn't know
17 anyone there anymore, and we couldn't really do
18 that.

19 If I had lived 100 miles farther
20 away, it wouldn't have even been an option, and
21 it just seems silly, that as an in-patient, that
22 is easy, that is a no-brainer, you walk around

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1 the corner and it's there.

2 As soon as you're out -- and this is
3 just one example, but every warrior has an
4 example, and if I had more time, I could come up
5 with five more, probably.

6 So, I just feel like I think there
7 is a huge -- I'm going back to 2006, but there
8 is a huge disparity in the level of care, and as
9 an end-user, it seems like that level of
10 commitment is not there either.

11 So, I understand the challenges. I
12 don't think the flagship medical systems, even
13 though BRACC awards are good, they're not going
14 to be revisited. That is water under the
15 bridge, I guess.

16 But it sounds like from -- I read
17 their reports from this thing, and it doesn't
18 sound like a whole lot of improvement has
19 occurred in six years, when it comes down to how
20 that spouse feels, about how much she knows,
21 walking out the door there and taking care of her
22 husband who is, you know, in a whole different

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1 place, or how he feels, his family is getting
2 taken care of. And that is what is on his mind,
3 is his care, yes, but how his family is getting
4 taken care of in that process.

5 So, frankly, I was a little
6 disappointed in reading the interviews of the
7 families, about some of the same concerns they
8 had are ones that we had six years ago.

9 CO-CHAIR CROCKETT-JONES: I just
10 want to also say, we have talked in this Task
11 Force about sort of predictive time lines that
12 over time, the medical treatment leadership has
13 seen enough folks coming through to have an idea
14 of how long a time line of recovery is going to
15 be, given a certain set of injuries, and we know
16 it's going to be different for individuals, but
17 at an individual level.

18 But we have talked before about this
19 idea that if we know someone is a single amputee
20 or a double-amputee, that we should be able to
21 give them a sense of how long they're going to
22 be in transition, how long they're going to be

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1 in-patient, how long they're going to be
2 out-patient, and give them a sense of the
3 hallmarks of their transition.

4 I would say that this is a similar
5 thing. There should -- we should be giving them
6 a sense of where they're going to land, as far
7 as -- and be independent.

8 I think this is connected to that
9 same idea of using the data that is already out
10 there, to give people some predictions and some
11 -- I don't mean hallmarks, some milestones, so
12 that we can tell them, you know, "You'll probably
13 be needing physical therapy of this level for
14 this amount of time, and if you need more, you'll
15 get more."

16 But you know, that will give you an
17 idea of how you're doing and how close you are
18 to independence.

19 I think this idea of -- that we had
20 had before, plays very well into this sense of
21 the end result of that is your independence.

22 MEMBER PHILLIPS: But we know that once a

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1 service member is an out-patient, there are many
2 more things going on in their life. They're
3 deciding whether they should stay in or have to
4 stay in. They're in transition to many
5 different areas, to the VA, for care and so
6 forth.

7 So perhaps one of our focuses should
8 be to look for the best practices and
9 institutions, if there are any, that make that
10 transition easier or better, one of our
11 recommendations, perhaps. I mean, along with
12 standardization of certain issues and so forth,
13 and acuity.

14 MEMBER DRACH: Picking up on that,
15 I've asked myself for the last 10 years, are we
16 keeping some of these wounded Warriors on active
17 duty too long?

18 You know, we've heard some cases,
19 they've been injured three years ago, and
20 they're still on active duty.

21 Now, some of them, granted, are
22 pending further surgeries and so forth, and what

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1 not.

2 But this is just my personal
3 observation, is that the longer they're retained
4 on active duty, unless there's really a medical
5 need, the more dependent they become, and less
6 independent they become.

7 Over time, they get into a mindset
8 that, I am disabled. I am not going to be able
9 to go back to work, because the culture is kind
10 of instilling in them that you are damaged goods,
11 and the longer that I am in that medical
12 treatment facility, the longer or the more I am
13 beginning to think, what value am I. What value
14 do I have outside of this environment?

15 I don't know what kind of
16 independent living services are being provided
17 to the active duty. I know when we went up and
18 did the site visit before the actual closing of
19 the old Walter Reed and the merging, we saw some
20 very interesting facilities.

21 We saw where the rooms were very
22 accessible and so, but you know, we don't live

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1 in an accessible world.

2 When they go back to Paducah,
3 Kentucky, you know, they may not have the same
4 kind of access that they have in Washington, D.C.

5 They may not have curb-cuts. They
6 may not have access to the library, to the
7 bowling alley, to the movie theaters, because
8 you know, it just hasn't caught up with the
9 times.

10 So, I ask myself that a lot. You
11 know, I hate to reflect back, but you know, I was
12 wounded in Vietnam in May of '67, resulted in
13 amputation. I was discharged and back to work as
14 a civilian nine months after my injury.

15 You know, I turned out okay, I think.
16 Sometimes I wonder, and sometimes my wife
17 wonders, but I don't know. It's just an
18 observation and I think about it a lot.

19 MEMBER STONE: So, I throw out to
20 you this morning a very difficult question,
21 primarily because we have at the table with us
22 a number of you who have had just spectacular

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1 recoveries, and remained either in-service or
2 have gone on to really spectacular careers.

3 I think it's a question that we need
4 to ask, and clearly, what we're looking for in
5 this committee, is that all service members,
6 regardless of service, have equal opportunity
7 and equal support.

8 This is a site in which you really
9 can begin to see some of the differences between
10 our services, and I began earlier, talking about
11 service equities, and talking about service
12 uniqueness and a desire to maintain that
13 uniqueness.

14 But that doesn't mean that we can
15 accept inequality of access to services that
16 would allow you to have the maximum recovery that
17 you possibly could have.

18 I would ask you to chew on that one
19 for a while, as you think about it.

20 For me, sitting in a room out at
21 Balboa, with 10 Marines who had more than 17
22 limbs missing, who the majority had come from

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1 living in the community and driven themselves in
2 to talk to us, was a great sense of independence,
3 and morale was extraordinarily high in that
4 group.

5 I wonder if it is the same in the
6 other services, and I don't have the answer to
7 that, and I would ask you who have lived this or
8 your collective thought process in this, and as
9 we bring this one to a close, I'll turn it to you.

10 MEMBER REHBEIN: General, if I may
11 add one comment, because I want to circle back
12 to something you said about the risk of creating
13 this joint medical facility in wartime.

14 I want to take the position that I
15 think that is the best time to do it, because of
16 the intense national focus out there on making
17 sure that our Warriors were treated the way they
18 should have been when they came home with these
19 horrendous injuries.

20 Without that intense national
21 focus, if we had tried this, I don't think we
22 would be nearly as far as long as we are right

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1 now.

2 I think there have been some other
3 very important projects in the past, done during
4 wartime, that could only have been accomplished
5 in the timelines that they were, during wartime,
6 because of that intense national focus, and I
7 think that applies here.

8 I think that is what created us,
9 frankly. I think that is what has been -- I
10 think that is what has enabled us to do some of
11 the things that we've been able to do with our
12 recommendations.

13 So, I don't -- I simply want us to
14 keep -- all of us to keep that in mind, that that
15 time of intense national focus may be coming to
16 an end, that this country and the people of this
17 country may be going on to other things.

18 And so, we need to take advantage of
19 that as long as we possibly can, and do some of
20 the things like you're suggesting, where some of
21 the policies across services are different, for
22 us to try to identify which really is the best

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1 course of action, and try to get that -- and try
2 to get that standardized, so that every one
3 receives that same level of care and level of
4 service and comes to that same level of
5 independence.

6 CO-CHAIR CROCKETT-JONES: Thank
7 you, all. As long as then, we are -- all feel
8 comfortable, we can take a break of 15 minutes,
9 and then come back at that time.

10 (Whereupon, the above-entitled
11 matter went off the record at 9:26 a.m. and
12 resumed at 9:47 a.m.)

13 MS. DAILEY: Ladies and gentlemen,
14 we're now going to receive a briefing from Dr.
15 Jagger and Dr. Lederer, our research team.

16 Our 2013 Focus Group Protocols were
17 tested at Walter Reed, and we'd like to take
18 these first installation visits as an
19 opportunity to adjust or tweak them a little bit.

20 So, Dr. Lederer and Dr. Jagger are
21 going to talk to us a little bit about our
22 protocols.

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1 Also, this is -- we're going to do
2 a little reinforcement here on focus group
3 techniques, leading a focus group, bringing all
4 the members of the focus group into the
5 discussion, and these are -- these questions are
6 also -- we want to reinforce the fact that these
7 questions align with our Task Force Charter and
8 align with what Congress has asked us to talk to
9 our service members about.

10 This is kind of a standard. We ask
11 it to everyone, and that allows us to collect
12 standard information across all the services.

13 I'm going to ask everyone to turn to
14 Tab C, and I'm going to turn it over to Dr. Jagger
15 and Dr. Lederer. Thank you.

16 DR. JAGGER: All right. So, we
17 will get started with a little bit of a refresher
18 on moderating focus groups and some site visit
19 details, in general.

20 So, as you all know, the RWTF
21 collects data in several ways. One major way is
22 through meetings like this, where people and

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1 organizations come and brief the Task Force, and
2 another major way is through our site visits,
3 where you receive provider briefings to get some
4 on the ground perspective, and where you conduct
5 focus groups with recovering Warriors and their
6 family members for a consumer perspective.

7 For some of you, the last visit was
8 not all that long ago. For others, it may have
9 been Iowa in March or even earlier.

10 So, in the next hour, we'll take a
11 little bit of time to conduct a top-line
12 refresher re-orientation about site visits,
13 processes and guidelines, primarily with regard
14 to moderating the focus groups.

15 Then we'll go ahead and highlight
16 for you, some of the changes to this year's focus
17 group protocols.

18 So, tomorrow, you'll have a separate
19 discussion, in which you'll talk about the
20 specific installations where you'll be
21 traveling this year, and the dates when you'll
22 be traveling.

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1 So, the purpose of today is to just
2 talk about what you'll be doing while you're
3 there, and not specifically where you're going
4 or when you're going there.

5 As in previous years, we'll cover
6 some typical installation visits. We'll have
7 some JFHQ, Joint Forces Headquarters visits, and
8 we'll have some visits to CBWTUs, as well.

9 We also have some unique sites this
10 year, that for the purposes of this training, you
11 need to have a little heads-up about, including
12 the two headquarters visits, Navy Safe Harbor
13 and the Air Force Warrior and Survivor Care
14 visit, as well as Navy MEDHOLD-West.

15 Some of you were at Navy
16 MEDHOLD-East last year, so you'll remember that
17 that is the west coast version, and also, we have
18 a visit to the Great Lakes Naval Air Station,
19 which is a bit of a unique entity that won't
20 resemble your typical installation visit.

21 So, as you all know, there is a
22 common template for the site visit itineraries,

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1 and there are variations that occur on those
2 templates.

3 We have the subject-specific
4 briefings, and many of the questions across all
5 the different installation visits will look
6 similar.

7 Maybe you'll see some language
8 changed, like we'll go from saying nurse case
9 manager to medical case manager, because that is
10 the service-specific language we need to use,
11 but generally, questions remain the same.

12 Other times, the questions are more
13 customized to the installation or to the
14 service. Examples might include asking about
15 role delineation between section leaders and
16 RCCs at Marine Corps sites. That is not the same
17 line of questioning we'd have other -- at other
18 locations.

19 Other examples include follow up
20 questions, when you return to an installation
21 that you visited in previous years.

22 We typically do have the three focus

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1 groups. There are exceptions to that. This
2 year, we already saw at Walter Reed, there were
3 five. We'll have two at Navy Safe Harbor.

4 At the JFHQs typically, we have zero
5 focus groups, and there will be other instances,
6 Great Lakes and San Antonio, where we'll have
7 zero.

8 Sometimes, you do have tours.
9 Typically, that is family assistance
10 center-related, and then we also, at the JFHQs,
11 visit some VA facilities.

12 So, you'll have an opportunity then,
13 to speak with providers who have contact with RWs
14 and family members after the transition, and
15 these providers are able to speak to transition
16 outcomes, which are indicators of the
17 effectiveness of DoD and RW policies and --
18 DoD/RW policies and programs.

19 As a reminder, all of our data
20 collections tools, including the site visit
21 itineraries, the focus group protocols, our
22 mini-surveys, even the business meeting

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1 itineraries are informed by our research
2 questions.

3 So, let's talk a bit about the
4 instruments.

5 Like last year, there are two
6 protocols, and two mini-surveys, one each for
7 recovering Warriors and for family members.

8 These tools are designed to
9 systematically, consistently capture a customer
10 perspective on a variety of topics, topics that
11 reflect our charter.

12 The customer perspective
13 contributes an invaluable perspective and
14 balance to what we hear from headquarters and
15 from providers onsite.

16 So, the purpose of that protocol is
17 to provide targeted and consistent questioning
18 from session to session and from site to site.
19 So, no matter who is moderating, no matter where
20 you are, you have a consistent set of questions
21 to use.

22 Now, the mini-survey is

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1 specifically designed to get us some level of
2 description of the study participants, who was
3 in the focus groups. So, we put that in the
4 appendix of the report every year, and then it
5 also supplements some of what we learned in the
6 focus groups.

7 So, we have customer satisfaction
8 data in that mini-survey, and that's its
9 purpose, is to supplement what is collected in
10 the focus groups.

11 We change as little as possible from
12 year to year. If a question is working and it
13 doesn't need to be changed in the focus group
14 protocol or the mini-surveys, we don't change
15 it. Sometimes, we do have shifts in research
16 questions, based on what we've learned over the
17 course of the two years, so far. An example
18 would be, you'll see in the protocols, some new
19 questions about vocational and employment
20 services.

21 We've learned more as we've gone and
22 we've changed those questions, the research

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1 questions, which results in some changes to the
2 focus group and mini-survey protocol questions.
3 Dr. Lederer, in just a bit, will go over with you
4 some of those changes in those protocols.

5 We've seen this before too, talking
6 about human subjects protection in research, and
7 we just want to remind you that this, of course,
8 is driven by both federal policy and DoD policy.
9 We've got the National Research Act of 1974 that
10 led to some guidelines for the composition and
11 proceedings of IRBs, and as you know, the ICF/IRB
12 does approve the Recovering Warrior Task Force
13 protocols each year, and we also have a DoDI
14 3216.02, that guides how we conduct our
15 research.

16 So, when we talk about respect for
17 persons, we need to make sure that participants,
18 from the moment we kick off the focus groups,
19 have complete and detailed information that they
20 can clearly understand so that they can decide
21 how they want to participate.

22 Okay, and we know that we need to

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1 acknowledge early on in the focus groups that
2 even though participants may have been directed
3 to attend, it's their choice how much they choose
4 to participate during the course of the focus
5 group.

6 As far as beneficence is concerned,
7 we have a role early on, in crafting these
8 questions in a way that is going to consider the
9 impact on the participants of the questions we
10 ask, and we also, during the focus group itself,
11 need to think about how we conduct ourselves as
12 we moderate and how we regulate the environment
13 in the room.

14 So, you all think about how you're
15 asking questions, agreeing with some, maybe not
16 agreeing with others, if your gestures or your
17 body language is giving away any particular
18 alignment with one participant or not agreement
19 with another participant, that would possibly do
20 someone some harm or make them upset by their
21 participation in the focus groups. So, we want
22 to watch out for things like that.

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1 But we also need to watch out for how
2 the participants are treating each other, and
3 making sure that no one is getting bad
4 information or spoken over or spoken to in a
5 disrespectful way, even by the other
6 participants.

7 Justice is also an important
8 concern, giving everyone an equal opportunity to
9 participate and not hand-picking who is
10 dominating the focus group time.

11 The bottom line is that we need to
12 remember there is federal policy guiding what we
13 do and we need to ensure that there is no
14 coercion, no harm and no violation of privacy.
15 We need to be vigilant about protecting privacy
16 of our participants from the moment we enter the
17 installation, to the moment we give that
18 out-brief to the moment we issue our report,
19 we're always considering privacy.

20 You probably remember that we do
21 have a form and a process that should be used,
22 if any problems or events come up, in which

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1 you're concerned about the protection of your
2 participants, risk of injury to self, risk of
3 injury to others. We do have that form. Our
4 scribes will have that at the ready for you, and
5 they'll bring it to your attention, whenever you
6 need it.

7 It happens very rarely, so, we won't
8 spend time going over that form today, but Ms.
9 Dailey or the scribe could help you at any point,
10 if that was a concern.

11 MEMBER DRACH: Can I ask a question?

12 DR. JAGGER: Absolutely.

13 MEMBER DRACH: Could you go back to
14 that last slide, please?

15 DR. JAGGER: Sure.

16 MEMBER DRACH: On that last, on the
17 justice, participants should not be chosen
18 simply because they are available.

19 I am reading between the lines and
20 I am saying to myself, well, if you don't choose
21 them because they're available, what criteria
22 are you using?

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1 If you do it simply because they are
2 available, it's going to be pretty random, as to
3 who comes and who doesn't.

4 If you don't, you know, if you don't
5 do it on that basis, are you cherry-picking and
6 picking people that you think are going to give
7 you the right answers?

8 Could you explain that a little bit,
9 as to why you would not simply, because they're
10 available?

11 DR. JAGGER: Sure. We don't want
12 people who are able to participate because it's
13 easy for them to participate. We want a breadth
14 of experience.

15 So, people who are very busy and
16 people who are not very busy. I mean, it's --
17 if you just choose who is available, you might
18 have a different level of care, different level
19 of engagement, different level of participation
20 than if you open it up.

21 We work with the sites to give them
22 a lot of guidance about who to select, and we

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1 generally tell them to be as random as they can
2 or to avoid cherry-picking in any way.

3 But the availability piece, we want
4 to make sure we get a perspective of how involved
5 or not involved they are.

6 Did you want to add anything on that?

7 MEMBER REHBEIN: How should we
8 react when it becomes obvious that someone has
9 been directed to be part of this?

10 DR. JAGGER: Right, and we do, in
11 the focus group script, and you all do a very good
12 job of covering this, that we understand that is
13 the reality when they're there, and we want to
14 reassure them that yes, we understand that
15 reality, but how much you say is entirely up to
16 you.

17 So, there is a piece of that focus
18 group kick-off script that you all can cover and
19 you can all get familiar with it in your own
20 words, but basically, get across the message
21 that we understand that some of you are here
22 simply because you were told you have to be here.

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1 You can choose to speak. You can choose not to
2 speak. The only thing we ask of you in this room
3 is that if you hear things, what you hear in this
4 room, stays in this room, and that even if you
5 don't participate, you also don't tell anyone
6 else, what you heard in the room today.

7 MEMBER REHBEIN: Along that same
8 line then, you've got someone sitting over there
9 that hasn't said much. How much do we try to
10 draw them out? How much do we encourage them to
11 talk as opposed to respecting their desire not
12 to participate?

13 DR. JAGGER: It is a delicate
14 balance, and you just sort of -- I mean, it's a
15 little bit of reading their body language, it's
16 a little bit of -- we designed the protocol with
17 that -- if you remember, that question about who
18 is a part of your team and how helpful are they,
19 and who is the most important member of your
20 team?

21 Hopefully, anyone who is inclined to
22 participate will be inclined to participate

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1 there, because they don't have to say anything
2 negative, right off the bat. They're able to
3 talk about anyone that is important to them. It
4 can be themselves. It can be their family
5 members. You know, we're not guiding them in
6 any direction.

7 So, it's a chance for them to open
8 with a positive, but it is, you just sort of have
9 to get a feel for the room and get a feel for each
10 participant, and make some eye contact and
11 maybe, you go around the room and say at one
12 point, does anyone else want to add anything to
13 this, and you give opportunities like that.

14 Maybe once or twice, you try saying,
15 did you have anything you wanted to add to that
16 conversation? But you don't have to singularly
17 probe each quiet person in the room, just make
18 sure there is opportunities, I think, for them
19 to chime in.

20 Anybody else have anything else they
21 want to add?

22 MEMBER PHILLIPS: A broader

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1 question about the makeup of the participants.

2 I was trying to remember if in any
3 of the focus groups, I came across anyone that
4 just said, everything is wonderful. We love it,
5 and we came to tell you how wonderful everything
6 is. Obviously, most people that come do have
7 issues.

8 Is there a way of getting around
9 that? Is there another survey technique that we
10 could use, perhaps for local folks who don't
11 come, but can respond in a positive way?

12 We are looking for best practices,
13 and I'm not trying to glean over, you know, the
14 issues, but is there a way that we might be able
15 to send out an additional survey to people
16 anonymously, again, you don't have to show up,
17 you don't have to come, but it will give us a
18 broader cross-section of response to some of the
19 issues, and perhaps, we can learn some best
20 practices from that.

21 I don't know, I'm just asking that.

22 DR. JAGGER: Yes, and it's -- Denise

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1 wants to chime in, first. So, I'll let her have
2 it.

3 MS. DAILEY: Yes, sir, and we can
4 talk about that at another time. There are
5 other ways in which we reach out to individuals
6 to participate.

7 So, we're not really prepared to
8 talk about it right here, but yes, it's a good
9 idea, and there are ways that we're doing it.
10 Okay? Thank you.

11 DR. JAGGER: I'll just say, we do
12 look at secondary data, so, that is one way that
13 we try to tap into that, is to look at other
14 opportunities, other people's data, other
15 agency's data, that we can look at in more
16 detail.

17 All right, so, as Task Force
18 members, you all have many roles, and I'm here
19 to talk to you today about your role as a focus
20 group moderator. So, that is where we are right
21 now.

22 In this research capacity, there are

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1 some ideals. An ideal focus group moderator
2 would be unbiased, non-judgmental, receiving
3 information, as opposed to giving it.

4 It can be difficult, but it's
5 important to put aside your expertise and
6 influence that the focus group participants may
7 benefit from, as you are asking the questions.
8 The time to share those sorts of experiences and
9 information is after the focus group, ideally.

10 On the subject of the out-brief, we
11 encourage you to be very careful about what you
12 choose to say. You all have not individually or
13 on the whole had a chance to systematically
14 analyze what you've heard, and you also haven't
15 had a chance to compare it to other sites
16 systematically yet.

17 So, what we encourage you to say or
18 to couch your language in, is that it's
19 preliminary impressions, and to just be
20 cautious, of course, about protecting
21 participants' identity, as you are preparing
22 that out-brief and delivering it.

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1 Throughout you stay onsite, of
2 course, it's important to be vigilantly
3 safeguarding participant privacy. So, we don't
4 talk about the focus group participants openly
5 when we're out in the hallways or in the elevator
6 or around others at the site.

7 We're careful in the out-brief not
8 to share potentially identifiable information,
9 so that people don't really know who was in the
10 focus groups, and so, that they don't really know
11 what people in the focus groups said. So, we
12 don't want to say anything, you know, that guy
13 with twins, or the triple-amputee who just
14 arrived with his mom, those kinds of examples are
15 pretty clear give-aways, and we want to avoid
16 those.

17 So, what we didn't talk about on this
18 slide, but we want to mention briefly, is your
19 role as recipient of the site level briefings.
20 So, you'll hear about a day and a half's worth
21 of briefings while you onsite, and you want to
22 be able to refer to the questions that are in your

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1 binders there for you to see what was asked of
2 these particular briefers, help them to stay on
3 topic, if they need that.

4 Probe and seek clarification. That
5 helps us, when we're analyzing the data on the
6 back end to understand exactly what the words on
7 the slide mean, if you ask some probing questions
8 where it's unclear.

9 Then remember that your scribe is
10 taking notes during that time, but not as
11 detailed as the focus group transcripts. They
12 are not transcribing the briefings, but they are
13 taking some notes.

14 All right, you've all seen this
15 quote before, and I know that we've talked about
16 it in the past. We've also talked already today
17 about the careful planning and obtaining, rather
18 than giving information, et cetera.

19 So, we'll go into a little bit more
20 detail on the mechanics of the focus groups.

21 As we've already said, same as last
22 year, we'll typically have three groups per

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1 site, one of which is with family members, two
2 are with recovering Warriors, different rank
3 groups in the two groups.

4 We'll work with the site POC to get
5 about 10 to 12 participants. It seems to be the
6 best balance between having enough people in the
7 room and not having so many that the scribe can't
8 take as detailed notes, or as detailed
9 transcription.

10 On most site visits, what we like to
11 have in the room is one moderator, one or two Task
12 Force members who are observing, and a scribe.
13 Sometimes you'll have members of the research
14 team, like at Walter Reed, where we were
15 assessing how well the instruments were working,
16 and at other local site visits, we might be
17 there, as well.

18 But no one from the chain of command
19 is inside the room. No one from the
20 installation is inside the room during the focus
21 groups.

22 All right, so, how about some

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1 sequence of events?

2 So, with the focus group, you've got
3 your beginning and your middle and your end, and
4 there are some key things to hit, points to
5 consider and points to address as you work
6 through the beginning, the middle and the end.

7 As you start, the scribe can work
8 with you to ensure that participants have
9 immediate access to the consent form. If you've
10 got a table that participants are sitting at,
11 they can have that information sitting at the
12 table waiting for participants.

13 You'll have the consent form, the
14 mini-surveys, the resource forms and a tri-fold
15 brochure on the Task Force that the participants
16 need to receive.

17 You also have name tents. We should
18 collect the consent forms before we start the
19 focus group, as soon as they sign them.
20 Mini-surveys, they hold onto for a bit.

21 Scribe is happy to collect the forms for
22 you, but remember that they need to be back in

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1 their seats and ready to take notes before you
2 start any dialogue. We'll talk a little bit
3 more about how you can work with a scribe and how
4 they can help as you facilitate in a bit.

5 It's important to really focus on
6 active engagement when you're facilitating a
7 focus group, and this can be challenging. You
8 want to engage participants right as they come
9 in the door, ideally. We want to avoid some of
10 the challenges that we can.

11 We know there are challenges, like
12 the limitations of time and participants not
13 knowing what they are coming in the room for or
14 arriving late. The scripted language can sound
15 really boring or disengaging if it's just read
16 to someone, but it's important language. So, we
17 have to figure out that balance between covering
18 it all and not having people tune out from the
19 moment we start talking.

20 We can't address all the challenges,
21 but it's important to do what we can to encourage
22 participation and really get participants

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1 engaged, optimizing that 90 minutes that we have
2 with them.

3 We believe right from the beginning,
4 even pre-kick off what you do has implications
5 for how the focus group goes.

6 So, before the start, you all know
7 that someone will walk in the room saying, oh,
8 yes, they told me I was here for a class.

9 So, the first thing they're asked to
10 do then is fill out a mini-survey, and they're
11 sort of wondering, am I just filling this survey
12 out and then leaving, or am I filling it out and
13 we're having a class? What is coming next?

14 So, we think it's helpful, if you can
15 set the stage for them, manage their
16 expectations right from the beginning, and
17 engage them in small numbers one or two, as they
18 walk in the door.

19 Introduce the Task Force and the
20 fact that you're going to be doing a focus group,
21 having a discussion with them, but first, we need
22 to take care of some paperwork, and so, here is

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1 your consent form to read through, here is your
2 mini-survey to fill out. Here is some
3 information about the focus -- about the Task
4 Force, and once we've got everyone in, we'll
5 start the focus group. That kind of one-on-one
6 or one-on-two or three engagement will set the
7 tone and let them know what they're there for.

8 The scripted introduction contains
9 essential information but it's long, and it can
10 take time away from the discussion.

11 Since you are giving them the
12 tri-fold brochure, you, as the moderator can
13 highlight some key points in your own words.
14 Again, using your own words and really working
15 through that script in a more personal and
16 careful way, can help engage the participants,
17 rather than reading it to them.

18 In the middle, you've got -- you may
19 have noticed in the focus group protocols that
20 there are some introductory scripts that
21 introduce each topic as we move from medical care
22 case management to non-medical case management.

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1 There is a definition of non-medical case
2 management, right there.

3 You may or may not need this. If
4 they've talked extensively about their squad
5 leader in the who is on your team part of the
6 focus group protocol, you may not need to get
7 into the definition of a non-medical case
8 manager, if they've already acknowledged they
9 understand who their non-medical case manager
10 is. So, we leave that up to your discretion.
11 Those are there for you when you need them, and
12 you can highlight the details or you can skip
13 over it as you need.

14 The most important thing would be to
15 maintain that eye contact with participants and
16 keep them engaged.

17 We show these up here. You all know
18 them well and have been doing a great job with
19 them. So, we're not going to go over them in
20 great detail, but it's always good to just take
21 a moment to review the facilitator roles.

22 We have up here some effective

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1 behaviors and some less effective behaviors for
2 facilitators of a focus group. We've said it
3 before and you all know it: the eye contact is
4 important. Things like nodding a lot, when you
5 agree with someone, it can be important to
6 reinforce that you're listening and that you're
7 engaged, but if you're nodding too much, does
8 that send a message maybe to somebody in the room
9 who doesn't agree with the person who is talking
10 that you're nodding to? What kind of impact
11 does that have on your other participants in the
12 room?

13 It's important to ask, you'll see,
14 encouraging and checking for contrasting
15 opinions or congruent opinions, important to
16 ask, does everyone in the room -- are you all
17 having the same experience? Are there
18 different experiences in the room, giving, as
19 Mr. Rehbein said, some of those who have been
20 quieter, a chance to pipe in if they want to, and
21 also, giving the scribe a chance to capture
22 whether this is a universal sentiment or is

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1 something that only one person is really talking
2 about.

3 We want to avoid things like serial
4 questioning. So, if you're in the room, and
5 this is an example I made up, it is not from
6 anyone's transcripts, what do you think of the
7 CTP? Do you have a CTP, you know, that
8 comprehensive transition plan? Is your squad
9 leader working with it on you? That is an
10 example of serial questioning.

11 So, they don't have time to answer.
12 They don't have a chance to think about their
13 answer. Like I said, I made that up. It isn't
14 from anyone's transcripts.

15 Sometimes it's important to just
16 pause for a moment and give them time to think
17 and formulate an answer.

18 You want to also be able to follow
19 up on questions. It's a difficult balance,
20 you're trying to get through that protocol in 90
21 minutes. You're trying to keep people engaged.
22 You don't want to seem to be poking at the same

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1 issue or going too much after one participant.
2 So, follow up can be a difficult thing to manage,
3 but it can be very fruitful.

4 So, it's about that balance of
5 information quantity versus information
6 quality. If they're just scratching the surface
7 and you don't really feel like you're getting a
8 good understanding of what they mean by a comment
9 or you're seeing head nods, but you're not
10 getting any level of depth, it may be time for
11 a follow up.

12 There is a lot to consider while
13 you're moderating, and it can be difficult to
14 think critically about how you're doing in the
15 midst of facilitating that focus group.

16 So, one of the other things you can
17 do to sort of help assess your focus group
18 facilitation skills is to read through your
19 transcripts.

20 You all are reading through them, to
21 sort of get a refresher on what the participant
22 said, but it can also be very illuminating to

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1 read your own transcripts to see how you're
2 doing, as a facilitator.

3 So, you may want to take that option,
4 if you have the opportunity. You can pick up on
5 some habits, you know, some of us say like a
6 little too often. So, those kinds of things,
7 you can see those in the transcripts.

8 All right, so, please remember that
9 you and your ICF scribe are indeed, a team. They
10 are eager to help you in any way that they can,
11 and in turn, they need some cooperation from you
12 to make their job a little bit easier as their
13 fingers are flying across that keyboard.

14 One thing you can help them by doing
15 is following the protocol. Another thing is
16 checking for that congruence or disagreement.

17 So, can I see a show of hands, of how
18 many people are having this similar experience
19 or there are specific places in the protocol
20 where we ask for a show of hands, have you used
21 this survey, show of hands.

22 If you count and tally for them, they

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1 don't have to look up from their keyboard and
2 they can just move through it a lot faster.

3 Sometimes, they may need you to
4 repeat some more obscure acronyms for them or
5 slang. We had an example one year of rocker,
6 somebody said something about, they're just
7 trying to get their next rocker, and that was one
8 that the scribe, at that time, didn't know, what
9 that meant. Sergeant Major could show us.

10 So, another opportunity is that --
11 is to not start that discussion before the scribe
12 is really seated and ready. If they've just
13 gotten up to collect paperwork or anything, you
14 don't even want to necessarily start the intro
15 script until they're sitting down again and
16 ready to go. Try not to get too far into the
17 discussion while they're away from their
18 keyboard. Their primary role there is to
19 capture that discussion.

20 They can help you, of course, by
21 helping set up the room, if you need -- if you
22 want to arrange the tables differently, they'll

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1 help with that.

2 They'll help with timing. They'll
3 probably ask you before the group starts, do you
4 want a reminder at halfway through? Ten minutes
5 until end, things like that. They're very
6 welcome and open to doing that for you.

7 They'll ask you as well, if you want
8 them to remind you of any skipped items that you
9 may have gone over. That is something that
10 they'll want to discuss with you in advance, so
11 that they're not interrupting your flow if you
12 don't want them to, and they'll help with
13 tear-down, but again, recording is their number
14 one job.

15 We've had this training before, and
16 so, here are the lists of the trainings that we
17 have given in the last two years, and then there
18 are some additional materials that are
19 available. If you would like to consult with
20 any of them, we're happy to get copies to you,
21 and that sums it up for me.

22 Now, unless there are any further

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1 questions -- go ahead.

2 MEMBER DeJONG: Just one question.

3 Is there anywhere, over the last
4 couple of years of doing this, with most of us
5 being involved in multiple ones of these, that
6 we are doing particularly well in or
7 particularly poor in, that we need to focus a
8 little bit more on?

9 Any areas of the protocol that
10 you're not gathering as much data as what you
11 could be, or I am just asking collectively as a
12 group, not personally. I mean, is there areas
13 that we need to focus more on, or less on, or
14 maybe you'll get into that, Dr. Lederer.

15 But just kind of looking over the
16 last two years, as we've come through this, there
17 is a couple of different protocol changes,
18 anything that we, as a group, can do to help
19 better the data collection?

20 DR. JAGGER: I don't think, and Dr.
21 Lederer will get into the protocols a little bit
22 more, so, maybe she'll pick up on something as

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1 we go through.

2 I don't think that there are any
3 particular issues that we're trying to target.
4 We're trying to cover the bases, because we've
5 noticed even that, over time, you all have become
6 more proficient and have paid more attention to
7 certain things as we've gone on.

8 And so, we've seen that any issues
9 we might have thought in the beginning at one
10 point, may have been a concern, are really
11 alleviating themselves over the time that we've
12 all been working together.

13 So, I don't think we're seeing
14 anything in particular that is concerning. It
15 is difficult to navigate that introductory
16 script, and it is difficult to navigate when is
17 the right time to do the paperwork, and things
18 like when to start the focus group.

19 If you keep having a trickle of
20 people coming in, how to handle that.

21 So, one of the things that -- ideas
22 that we've kicked around and we talked about a

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1 little bit ago was putting the papers on the
2 table, so that participants can get in and get
3 seated.

4 That ideas of welcoming them and
5 giving them just a little more than, hi, how are
6 you doing? Come in and sit down, and fill out
7 this mini-survey.

8 But tell them about the fact that
9 there will be a discussion afterwards, that
10 managing expectations.

11 It's not that anything has been done
12 poorly, it's just that it's -- we can take
13 opportunities to do it even better, so that
14 people are more engaged right from the start, and
15 so, that when we do open up with that question
16 about, who is a part of your team and who is the
17 most important part of your team, they may be
18 even more primed to talk with you.

19 Did you want to add anything at this
20 point?

21 DR. LEDERER: Sure, sure. We
22 appreciate the question, Sergeant Major.

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1 MEMBER PHILLIPS: Let me just
2 emphasize that if there are issues related to the
3 group, please let us know. Give us the
4 specifics that we can improve on. Don't mince
5 words.

6 DR. LEDERER: Thank you for that,
7 too. I also, like Jess, nothing comes to mind
8 in terms of substantive areas that we're not
9 getting enough data for.

10 But what does come to mind are some
11 kind of some moderator practice areas that could
12 lead to even more fruitful results, such as we
13 don't -- some of our moderators, oftentimes,
14 because they're feeling time pressure, don't
15 seek to validate what one person is saying.

16 Sometimes, the moderator will say,
17 oh, I see lots of nods, very helpful, but if there
18 is no non-verbal concurrence or confirmation,
19 it's very helpful, when we're dealing -- back,
20 doing the analysis, to know if that was one
21 person's sentiment or kind of a group sentiment.

22 So, if you can pulse people, how

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1 about the rest of you, and you know, try to get
2 some very quick sense of whether this is a shared
3 sentiment: very helpful from the analysis
4 standpoint.

5 Also, the probing, sometimes, going
6 a little bit more beyond the superficial
7 response leads to richer data.

8 Periodically, there are specific
9 questions, nuances in the protocol that kind of
10 get overlooked. So, that simply speaks for it
11 becoming very, very familiar with the protocol
12 questions.

13 I guess it's my turn now.

14 DR. JAGGER: It is.

15 DR. LEDERER: My goal here is to
16 accelerate your familiarization with this
17 year's protocol, basically.

18 As Jess said earlier, it's important
19 that these questions be asked consistently from
20 session to session and site to site, but only to
21 a limit.

22 We don't want to turn you all into

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1 automaton, and you kind of need to embrace,
2 learn the material, embrace it, make it your own,
3 so, it's a natural exchange with your focus group
4 participants.

5 What I'd like to do is to re-acquaint
6 you with the structure of the protocol, and then
7 point out some differences between the RW and the
8 family member protocol, and some differences
9 between this year and last year, as well as some
10 eccentricities in the protocols, some pitfalls
11 and opportunities, again, with the goal of
12 helping you to become as familiar as possible
13 before you are in the driver's seat. Those of
14 you who moderated only recently with this
15 protocol, please chime in.

16 Again, both protocols have four
17 basic sections. We have that kick-off, those
18 key points, very important points from a human
19 subjects research policy standpoint, but
20 something that you can deliver fluidly, once you
21 are familiar with the content.

22 We have the kick off. We have those

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1 warm-up questions. We have the discussion
2 questions, and then of course, the wrap up.

3 Importantly, between the two
4 protocols, there are seven topics in the RW
5 discussion questions as compared to three topics
6 in the family member discussion questions, which
7 has implications for how you're going to pace
8 yourself as you're moderating those sessions.

9 We begin, as Jess was suggesting, by
10 engaging the participants as they file in. Do
11 remember if you are going to engage them and
12 distribute the consent form, as well as the
13 mini-survey, as they file in while you're
14 waiting for the group to kick off, if you do that,
15 there are pieces of the key points to cover that
16 will no longer apply, and I've highlighted those
17 here for you. Thank you.

18 Okay, who is driving? Thank you,
19 Steven. I'll let you do that.

20 So, just remember that some of those
21 -- we went way -- page one, still, please.

22 Some of those pieces of the script

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1 will no longer apply.

2 Then we get to the --

3 MEMBER REHBEIN: Suzanne, before we
4 get real deep into this.

5 DR. LEDERER: Sure.

6 MEMBER REHBEIN: It happened last
7 year at San Antonio. I think it will happen
8 again at Safe Harbor in a couple of days, where
9 we won't have our focus group participants in the
10 rooms.

11 So, all of the body language, eye
12 contact, head nods, raise your hands, can you
13 give us, as we go through this, can you give us
14 a little bit of guidance on how to handle -- how
15 to be effective at that kind of focus group,
16 where it's all by telephone?

17 DR. LEDERER: That is a great
18 question, and it is very challenging.

19 I, personally, don't have a great
20 deal of experience. I do know that you want to
21 clarify -- ask the participants to introduce
22 themselves each time they speak, identify

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1 themselves, however they choose, so that you can
2 keep track of who these personalities are, and
3 so, that the scribe can, as well.

4 Do you want to add anything to that?

5 DR. JAGGER: In the room, we
6 wouldn't talk about going one by one around the
7 room, but on the phone, it may be necessary at
8 times, to do that.

9 If the dialogue is flowing and
10 people are chiming in, then it's not really
11 necessary. Just remind them to keep identifying
12 themselves.

13 But if you're having long awkward
14 pauses, it may be that you want to take the
15 opportunity to say, "Sergeant Smith, do you have
16 any comments on this? Sergeant Jones, do you
17 have any comments on this?"

18 You don't want to get into a pattern
19 of doing that with every question, because that
20 then puts them on the spot to answer.

21 But it gives an opportunity to go
22 around the virtual room, and engage each

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1 participant at least once, and then see how they
2 respond to that.

3 MEMBER REHBEIN: I know the one
4 thing that I experienced in doing one of those
5 was that it was very difficult to manage the
6 time.

7 DR. JAGGER: Yes.

8 MEMBER REHBEIN: Because the
9 conversation didn't flow as efficiently as it
10 normally would have, if everybody was in the
11 room, and so, it almost felt like I needed to cut
12 off discussion, at some points, and that seemed
13 to be contrary to what you really wanted from us.

14 You know, you want as full of a
15 discussion as possible, but at the same time,
16 that sort situation -- and maybe I'm spending too
17 much time on those few that we do like this, but
18 cutting off discussion seemed to be contrary to
19 the purpose.

20 DR. JAGGER: Right, that is, I
21 think, one of the things that helps with this,
22 is to talk right from the beginning, about, we're

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1 going to be addressing several topics today.
2 I'll want to try to get to each of them, and then
3 you just have to use discretion.

4 If you hit a real sweet spot in the
5 conversation, where they're giving you really
6 great information on PTSD services, you may not
7 want to make sure that you get to vocational
8 services.

9 If that is the consequence of a
10 really in-depth discussion that is giving us
11 valuable data on PTSD, you may make that choice.

12 It's going to be a focus group by
13 focus group and participant by participant
14 decision, as far as when you need to say, "Let's
15 try to get to some of these other topics. Maybe
16 we can circle back around and finish this
17 discussion, if we get through the rest of the
18 topics," or maybe you don't do that. Maybe you
19 stick with where you're getting the most
20 feedback.

21 DR. LEDERER: The warm up
22 questions, remember that sometimes even four

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1 questions, if you ask all four at one time, the
2 participants may forget what you're asking for,
3 and it may be helpful to ask them two, and then
4 two, for example.

5 If there is a blackboard or a
6 whiteboard in the room, consider putting these
7 warm up questions there, that could greatly
8 facilitate their answering them.

9 Let's move on to the follow on
10 questions.

11 Again, with the RW protocol, we have
12 seven topics, and the first topic is medical care
13 case management.

14 What we were reminded of, just
15 recently at the last site visit, was that to ask,
16 "How does your medical care case manager
17 contribute to the CRP/CTP process," is a
18 mouthful for a variety of reasons.

19 We were reminded that before we ask
20 about the MCCM's role, we need to first establish
21 their level of familiarity with the CRP or the
22 CTP, and how do we do that?

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1 First of all, although in the
2 protocol that says CRP/CTP, please don't say
3 that. Don't read what you see here.

4 Use the appropriate acronym for the
5 service, CTP for Army and CRP for all others, and
6 then if that doesn't resonate for them, very
7 quickly, as I think you all did, a couple of weeks
8 ago, say the whole name, comprehensive
9 transition plan, comprehensive recovery plan,
10 if that is the appropriate one.

11 If that doesn't work, give them
12 those triggers like goals, scrimmage, goal
13 setting, transition plan. Give them every
14 opportunity to latch onto, to show their
15 familiarity with the concept, and then ask the
16 question if they seem to be familiar. Skip the
17 question, if they're not.

18 Moving onto non-medical case
19 management. This is one of the changes in the
20 RW protocol this year.

21 We've tried to tailor some of these
22 non-medical case management questions, to the

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1 specific service, because they deliver
2 non-medical case management differently, as we
3 have come to learn, and they have different
4 providers and use different terminology.

5 You see here, that highlighted note,
6 "Note to Moderator, many NMCM questions below
7 are service branch specific."

8 The DoDI on the recovery care
9 program describes the role of the RCC, but the
10 services vary in who they assign this role to,
11 and that is why this first set of questions is
12 specific to the service.

13 If you're at an Army installation,
14 simply ask the squad leader questions. At a
15 Navy installation, ask the Safe Harbor NMCM
16 questions. If you're talking with Marines or
17 Airmen, ask the generic RCC questions.

18 The next set of NMCM questions you
19 see, it says, "Only Army and Marine Corps focus
20 groups."

21 Those are only for those two
22 services, because they're about the Warrior

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1 transition unit or the wounded Warrior
2 detachment support, and only the Marine Corps
3 and the Army has that.

4 But the remaining questions under
5 this non-medical case management topic are for
6 all of the services, as you will see there at the
7 top of this page, all focus groups, about the
8 line or operational unit chain of command
9 support, all focus groups about other entities.

10 Let me point out, for the top one,
11 when we talk about the line or operational unit
12 support, it occurs to us that they could have two
13 different types of line units in mind.

14 They may be assigned to a line unit.
15 They may be talking about that experience, or
16 they may be assigned to a Warrior transition unit
17 or wounded Warrior detachment, and still
18 referring to support they received from their
19 operational home unit.

20 If you can ascertain which one
21 they're referring to, so much the better.

22 Moving on to PTSD and TBI services,

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1 that highlighted note to moderator, no show of
2 hands necessary.

3 Often times, throughout this and the
4 other protocol, we do ask for a show of hands.
5 That is a very helpful tool, and as Jess
6 indicated earlier, if you will count for the
7 scribe, the scribe will appreciate that.

8 In this instance, we are
9 discouraging asking for a show of hands, for
10 privacy reasons. They don't seem to balk, when
11 you all do it, but for privacy reasons, it's not
12 necessary to ask who carries a diagnosis of TBI
13 or PTSD, particularly since they have already so
14 indicated on their mini-surveys.

15 This question here, which it comes
16 under the header of 'transition discussion topic
17 number four', is the only one that refers back
18 to the mini-survey. I just wanted to remind you
19 that this is the only one that refers to the
20 mini-survey.

21 It asks them to look back at their
22 answer to question number one, and then those who

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1 respond in a certain way, are then asked the
2 following questions.

3 This is why we keep the survey at
4 their place, and we don't collect it, along with
5 the informed consent.

6 You see under five disability
7 evaluation system, I've highlighted the 'show of
8 hands', just to draw your attention to the way
9 this is a useful device in this protocol.

10 Under 'legal support', there too, we
11 have a change this year.

12 In the past, these legal questions
13 did not single out during the MEB phase. It was
14 just about legal support associated with IDES or
15 with DES, and we're singling out the MEB phase
16 because that is really the initiative since 2007
17 or so, support, legal support, as Justin is well
18 aware.

19 Prior to 2007 or so, during the PEB
20 phase has been around for decades, correct?
21 That is not of interest in this research, too
22 much.

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1 There we come to a vocational
2 support. Jess mentioned that at some time --
3 sometimes questions change as we learn more.
4 Research questions change, and that trickles
5 down into modifications to the protocol. This
6 is an example of that, where we're much smarter
7 now, about what those programs are out there.

8 And so, we actually list the major
9 programs, vocational programs that we're aware
10 of, and ask which ones they've heard of, and of
11 those that they've heard of, if they've used
12 them, how well, how effectively they serve their
13 needs. Yes, Mr. Drach?

14 MEMBER DRACH: On B, you identify
15 meeting with lawyer, meeting with paralegal and
16 other.

17 Could we add Veteran Service
18 Organization, because a lot of the DSO's provide
19 assistance and representation before the MEB and
20 more so, the PEB, I guess.

21 But I think that -- you know, some
22 of us aren't familiar with that, wouldn't

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1 necessarily know to ask that.

2 DR. LEDERER: Sure, sure, thank
3 you. Okay, I'm going to move on with the --

4 MEMBER CONSTANTINE: Suzanne, real
5 quick. Suzanne, what does E2I stand for?

6 DR. LEDERER: Employment and
7 education initiative. It's a DoD/WCP program.

8 MEMBER CONSTANTINE: Thank you.

9 DR. LEDERER: Sure. We'll move on
10 now, to the family member protocol, I hope.
11 Thanks, Steven.

12 So, a lot of the same points apply.
13 We encourage you to engage everyone, from the
14 get-go, although it seems perhaps, family
15 members don't need quite as much encouragement
16 as recovering Warriors.

17 Do engage them. Do learn this
18 protocol. Own it. Make it your own, and don't
19 repeat those instructions related to the
20 informed consent form and the mini-survey, if
21 you've already handled that from the very
22 beginning.

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1 Would like to talk with you about the
2 introductions. If you notice, and you probably
3 noticed, those of you who were at Walter Reed,
4 we have five questions, you know, warm up
5 questions for the family members participants.
6 That is a lot. It's a lot, number one, for them
7 to absorb, if you ask all five at once, and it's
8 just a lot.

9 Use the blackboard, the white-
10 board, if there is one there, and if there isn't,
11 we strongly encourage you to group them into
12 three and two.

13 For example say, "Mrs. Jones, would
14 you please tell us your relationship to your
15 service member, when he or she became wounded,
16 ill or injured, and at this point, whether he is
17 hoping to return to duty or leave the service."

18 Ask those three, get a response and
19 then follow up with the easy one, ACRC, do you
20 all live on or off the installation?

21 Easier for them to respond and will
22 probably get a little bit more cogent reply.

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1 CO-CHAIR CROCKETT-JONES: Just
2 because it makes it easier, personally, if those
3 -- if three -- not three, if two and five were
4 shifted down, and were four and five --

5 DR. LEDERER: Move the numbers.

6 CO-CHAIR CROCKETT-JONES: -- move
7 the numbers --

8 DR. LEDERER: Yes, ma'am.

9 CO-CHAIR CROCKETT-JONES: -- that
10 way, because it'd be easier to remember to do it
11 --

12 DR. LEDERER: Yes.

13 CO-CHAIR CROCKETT-JONES: -- that
14 way, and frequently, the others, the first
15 three, as you're suggesting, they're almost --
16 they almost flow out. They're easy for them to
17 answer, but the other two, you know, are
18 information that they're not always asked about.

19 DR. LEDERER: Yes, we'll take care
20 of that.

21 MEMBER KEANE: I have a quick
22 comment.

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1 DR. LEDERER: Yes, sir.

2 MEMBER KEANE: I've used the
3 grease-board, I think that's a great way of doing
4 it.

5 Instead of asking the five or six
6 family members, how hard would it be just to have
7 this at their seat, already printed off, instead
8 of having to ask those questions?

9 DR. LEDERER: A sheet of paper, that
10 is a great idea, too.

11 One of the differences between this
12 protocol and the RW protocol is that we are
13 trying very hard to get family members to talk
14 to us, you, about their own needs, and the
15 services that are available for them.

16 They very naturally slip into
17 talking about their recovering Warrior's needs
18 and what is available for him or her, and so, we
19 are trying, with our language and with our
20 bolding, to help you focus their comments on
21 their own experiences.

22 You'll see this with bolding

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1 throughout this protocol, and I've highlighted
2 it, just to draw your attention to it.

3 First topic is support for family
4 care givers, and you'll see that we start
5 generally.

6 We ask about what supports you've
7 been using, and then the next section down below,
8 is asking specifically about their recovering
9 Warrior's non-medical case manager and how
10 helpful that person has been to you, as the
11 family member.

12 Just want to point out that it's
13 going from a general line of questioning, to a
14 more specific line of questioning.

15 Would also like to point out to you,
16 under 'support for family care givers' in
17 Question A, "What supports have you been using?"
18 There is that 'note to moderator/start with top
19 of mind'.

20 What we mean by that is, to simply
21 ask them, "What supports have you been using,"
22 and let that dangle.

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1 See what bubbles up from them, in
2 their own experience, what they think of. A
3 little bit of a pregnant pause, and then if they
4 don't know how to respond or they're not coming
5 up with much, that is when you utilize those
6 prompts, these may be financial or travel, et
7 cetera.

8 That is what we had in mind, when we
9 drafted that. I don't know that we made it as
10 clear as we could have.

11 When we go down to the second, the
12 more specific line of questioning under 'support
13 for family care givers', you'll notice that we
14 say in the intro, "Your service member may have
15 one or more non-medical case managers and/or
16 care coordinators. These may include an RCC,
17 FRC, AW2 advocate."

18 Here too, we may not have been as
19 clear as we intended. Use only the example.
20 Feel free to go ahead and use the example
21 immediately, but use the example that fits the
22 service, rather than reciting the whole laundry

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1 list.

2 If you're talking to an Army group,
3 you might say, "These may include AW2 advocate
4 or squad leader," and so forth.

5 You see at the bottom of 'support for
6 family care givers', there is that CRP/CTP
7 question again. They're likely to be even more
8 confused by that term, than the recovering
9 Warriors.

10 So, very important to walk them
11 through, what you mean by it and verify whether
12 it resonates for them in any way, shape or form.

13 Under 'Recovering Warrior
14 information sources', which is the second topic
15 under this protocol, hereto, we go from a general
16 line of questioning, your experiences with
17 information resources, to more specific
18 questioning about specific information
19 resources, the NRD Military One source, family
20 assistance centers.

21 On the subject of those family
22 assistance centers, once again, try to be

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1 service specific.

2 So, if you're talking to a Navy group
3 of family members, you would say, "Have you
4 visited or used the family assistance center?"
5 I'm at C, in the first batch on the top, "Have
6 you visited or used the family assistance
7 center?"

8 This is an office or agency that
9 facilitates access to information resources
10 such as the fleet and family support center for
11 Navy. No need to recite the laundry list.

12 Services for TBI/PTSD. For both
13 here and the RW protocol, we are separating out
14 those questions this year.

15 I don't -- I didn't mention it for
16 the RW protocol, but rather than asking a
17 general, about the availability and the
18 effectiveness of TBI/PTSD services, separate
19 questions for TBI and PTSD. Very important, if
20 we can, to get distinct feedback from them.

21 Please note also that for the family
22 members, we have two additional questions.

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1 We're asking about support groups for family
2 members of folks with TBI and with PTSD.

3 I'm not sure that we noticed those
4 questions at the last site visit. So, I just want
5 to draw them to your attention.

6 That is all I had. Do you all have
7 any questions or additional comments?

8 Thank you for your attention.

9 MS. DAILEY: Okay, ladies and
10 gentlemen, our next briefer is due in here at
11 11:15 a.m. So, we have some time here for you,
12 and I will release you to that time.

13 As soon as we get our next briefer
14 in here, I'll put up here, as soon as we can, but
15 I'm not anticipating Dr. Ritchie until 11:15
16 a.m.

17 CO-CHAIR CROCKETT-JONES: Okay,
18 break until then. Thank you.

19 (Whereupon, the above-entitled
20 matter went off the record at 10:44 a.m. and
21 resumed at 11:03 a.m.)

22 MS. DAILEY: So, ladies and

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1 gentlemen, if you can get to your seats, and we
2 can introduce our next briefer.

3 CO-CHAIR CROCKETT-JONES: Okay, we
4 will now hear from Dr. Elspeth Ritchie, the Chief
5 Clinical Officer in the Department of Mental
6 Health for the District of Columbia.

7 She will be discussing the approach,
8 analysis, findings and recommendations from
9 phase one of her committee's assessment on the
10 treatment of PTSD, which was released in a report
11 in July 2012.

12 As PTSD continues to be the
13 signature injury sustained by U.S. Service
14 Members returning from combat in the Middle
15 East, it is estimated that the need for PTSD
16 services will continue to increase.

17 As a result, Congress asked the DoD,
18 in consultation with the VA, to conduct an IOM
19 study, to assess PTSD treatment programs being
20 provided by both agencies.

21 We have information at Tab D in our
22 books, and I'll turn it over to you.

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1 DR. RICHIE: Good morning. It's a
2 real treat to be here today.

3 As some of you know, I made a career
4 in the Army, as an Army psychiatrist, retired a
5 little over two years ago, now work for
6 Washington, D.C., and I was reminded, as I was
7 jogging here from the metro this morning, how
8 close we are to the site of the Pentagon, of 9/11
9 and of course, the family assistance center,
10 right down the street from us, at the Crystal
11 City and Sheraton.

12 So, this is very much a sacred area
13 right here. It doesn't have that reputation,
14 but it is one that is very, very important, as
15 we've been at war for 11 years, and it began on
16 9/11.

17 So, what I've been asked to do today
18 is talk about phase one of the Institute of
19 Medicine report.

20 I'm going to tell you in advance that
21 I'm going to disappoint you, because you have
22 some very specific questions, that I am not going

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1 to be able to answer, and the reason I can't
2 answer them is, we asked the same questions that
3 you all did, and we did not get the information
4 in time for phase one of the report, and I am not
5 allowed to speak about phase two.

6 Having said that, I think I do have
7 a lot of good information. So, perhaps, I won't
8 disappoint you, too much.

9 These are the members of the IOM
10 Committee. Sandro Galea is our Chair. I was
11 basically the only person with extensive active
12 duty experience on the committee.

13 One of the things that I tried to do,
14 and this is my personal opinion and not the
15 official opinion of the IOM, but I tried to make
16 the recommendations that came out doable ones,
17 because I am sure all of you on active duty have
18 seen times when there has been task force or
19 other reports, and there is a lot of
20 recommendations that come out, and you go,
21 "Well, can you actually do that within the
22 context of the Military?"

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1 So, that was a lot of my role on the
2 report.

3 Here is our statement of task,
4 collect data from the DoD and VA, identify
5 collaborative and duplicative efforts between
6 DoD and the VA, look at studies of innovative
7 PTSD treatments, and specifically, look at
8 physiological markers of PTSD, and you know that
9 right now, we don't have any. So, this is sort
10 of the new and innovative approach.

11 What about brain imaging studies and
12 correlation? Again, an area that there is a lot
13 lacking.

14 Effectiveness of alternative
15 therapies for post-traumatic stress disorders,
16 including use of animals, which happens to be one
17 of my personal pet interests, and effectiveness
18 of using pharmaceuticals, and most of these
19 latter ones, again, are going to be in the phase
20 two of the report.

21 So, the phase one is foundational,
22 review current science and practice, potential

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1 data sources. We did decide to include some
2 recommendations that could be implemented
3 quickly, and then phase two, building on phase
4 one, and the issues that I mentioned, and also,
5 focusing some on different populations, to
6 include minorities and females.

7 Then another issue that is very hard
8 to do, that we're grappling with, is what is the
9 cost of treatment, and I am assuming again, that
10 you've looked at some of this already before.

11 So, what we're planning to do, what
12 I can't present on today, is phase two, which is
13 cost projections, neuro-biologic findings,
14 complementary and alternative treatments.

15 We have done some further base
16 visits in phase two. We did Fort Hood in phase
17 one and phase two, we've done Fort Bliss and Fort
18 Campbell. We're going down to Camp LeJeune and
19 we're going to do some others.

20 Availability and need for programs,
21 targeted specifically again, to specific races,
22 genders, ethnicities, what are the actual

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1 numbers of service members and Veterans
2 diagnosed with PTSD?

3 That seemed like it would be very
4 straight forward information to get, but it's
5 harder than you think, and then you have the
6 population with diagnosed PTSD, and the
7 population without diagnosed PTSD, and
8 successful treatment programs.

9 Again, this seemed like this should
10 be easy to get, but a theme that you're going to
11 hear over and over again, is that there has been
12 a lot of programs that have stood up, without any
13 good outcome markers, or if there are outcome
14 markers, it's very hard to compare one to the
15 other because they're using different outcomes.

16 So, what was our approach? We
17 reviewed the literature. We heard from service
18 members, which was very, very valuable. We went
19 to Fort Hood. We requested data, and as you know
20 and are well aware, there are several places you
21 can request data from.

22 There is Department of Defense

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1 Health Affairs, where I actually worked for four
2 years, back in the late 90's, up to 2003. There
3 is a Service Surgeon General, and I worked for
4 the Army Surgeon General for five years, until
5 2010.

6 Now, there is a new entity of the
7 Defense Center of Excellence, which is where
8 many of our data requests went to, that is known
9 as DCoE here, and then we requested information
10 from the Veteran's Health Administration and
11 their program evaluation center.

12 So, a lot of data requests. Here is
13 what we actually requested, and I won't read it,
14 except briefly for you, but again, the data by
15 and large, came in late, and we got it as we were
16 finishing up phase one.

17 So, most of the specific data will
18 be in phase two, and again, I apologize if I
19 disappoint you on this, that is what happened.

20 One of your specific questions, for
21 example was, "What is the training of mental
22 health providers in evidence based therapies,"

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1 and we don't have that in phase one.

2 The list of PTSD programs, one of
3 things about this task, it was somewhat
4 duplicative of what the Defense Center of
5 Excellence is already doing, which is listing
6 all the PTSD programs.

7 I am going to go a couple more
8 slides, and then I don't know if you all want to
9 wait until the end of the briefing for questions,
10 or if you have questions so far.

11 Madam Chairwoman, do you want me to
12 pause for questions or keep going?

13 CO-CHAIR CROCKETT-JONES: No, keep
14 going. We don't hesitate to jump in.

15 DR. RICHIE: Okay, all right, so,
16 please jump in, if you have questions.

17 Okay, so, we reported on PTSD,
18 post-traumatic stress disorder, from time in
19 service.

20 Obviously, people come into the
21 service with previous traumas. In other work,
22 there has been an estimated about five percent

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1 of service members have a baseline prevalence of
2 PTSD, but we focus on combat related.

3 We did not redo existing treatment
4 guidelines. As you may know, there is already
5 a DoD/VA treatment guideline and an American
6 Psychiatric Association treatment guideline for
7 PTSD.

8 We considered related disorders and
9 comorbidities as the effective treatment for
10 PTSD. Substance abuse was a big one, traumatic
11 brain injury, suicide and then somewhat, we got
12 into the long term effects of joblessness and
13 homelessness, which of course, we saw after the
14 Vietnam War.

15 We didn't recreate the exhaustive
16 list of PTSD programs. We've relied on the
17 DCoE, and we did not look at family members,
18 except when it affected the Veterans. Sir?

19 MEMBER TURNER: Could you elaborate
20 on what substance abuse you saw?

21 DR. RICHIE: The primary substance
22 abuse that we see associated with post-traumatic

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1 stress disorders is alcohol.

2 We all know that there is drug use.
3 We don't have good numbers for that, and it
4 wasn't our task to estimate how many people had
5 comorbidities with substance abuse and PTSD, but
6 anecdotally I can say that we all think it's
7 pretty high.

8 Did you want to elaborate on your
9 question, at all?

10 MEMBER TURNER: I was just curious,
11 anecdotally again, I've heard marijuana use is
12 very high with PTSD people, and I was wondering
13 if you saw that?

14 DR. RICHIE: Again, we did not
15 specifically look at that for phase one.

16 In my personal opinion, marijuana
17 use in active duty service members, this is more
18 than my personal opinion, because we have the DoD
19 behavior surveys, and has continued to be
20 relatively low because of course, it's picked up
21 on urinalyses.

22 What I'm seeing now in D.C. and what

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1 we hear about is a lot more use of recreational
2 drugs like Spice, a synthetic cannabinoid or
3 bath salts, which is a methamphetamine, which
4 isn't picked up on urinalyses.

5 Okay, so, the scope of the problem.
6 There have actually been numerous estimates
7 about the prevalence of post-traumatic stress
8 disorder. The Mental Health Advisory Teams,
9 RAND, Invisible Wounds of War and others,
10 estimate people who have served in Operation
11 Iraqi Freedom, Operation Enduring Freedom, that
12 it's between 13 and 20 percent.

13 Differences in the current
14 conflict, you all are aware of this, more
15 National Guard and Reservists. We've got a lot
16 of blast, as my former boss General Schoomaker
17 used to say, "It's not just a signature injury
18 of the war being PTSD and TBI, the signature
19 weapon of the war is the blast, which causes all
20 of these."

21 There has been, since the beginning
22 of the conflict, the forward deployment of

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1 mental health providers, which we think is a good
2 thing.

3 If you look back at Vietnam, the
4 estimated life time PTSD prevalence was almost
5 19 percent.

6 Consistently, we've found that less
7 than half of service members who have symptoms
8 received care, and the Military specific
9 stressors include combat, combat severity,
10 wounded, witnessing death, et cetera.

11 I'm assuming you all are familiar
12 with a Mental Health Advisory Team surveys, so,
13 I don't need to tell you what they are. I'm
14 seeing some nods.

15 CO-CHAIR CROCKETT-JONES: How
16 comfortable is everyone?

17 DR. RICHIE: Maybe just very
18 briefly, I'll go.

19 So, every year since 2003, the
20 Office of the Surgeon General, in conjunction
21 with the Walter Reed Army Institute of Research,
22 has sent a team of researchers to do surveys.

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1 They're anonymous surveys, in Iraq,
2 in Afghanistan, and they ask about issues such
3 as symptoms of stress, depression and anxiety
4 and PTSD, and barriers to care.

5 It was every year for a while, and
6 they slowed down, so, it's been every two years
7 in Afghanistan. So, there is a lot of data from
8 those sources.

9 MEMBER CONSTANTINE: Ma'am, what
10 about the Congressional series you had? What
11 about that RAND survey that was closer to 25
12 percent of returning service members, or more?

13 DR. RICHIE: Are you referring to
14 the Invisible Wounds of War that was put out?

15 MEMBER CONSTANTINE: Yes.

16 DR. RICHIE: There are slightly
17 different estimates. Some of these depend on
18 how you ask the question.

19 So, the Mental Health Advisory Team
20 surveys may under-estimate a little bit, because
21 even though you tell soldiers it's anonymous,
22 they won't believe it.

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1 The RAND may have had more of a bias
2 to people answering more honestly.

3 So, I won't say it's -- I won't
4 exclude the RAND report, but the bulk of the
5 estimates are somewhere around the 13 to 20
6 percent.

7 Also, as you may know, the more times
8 you've deployed, the estimates go a little
9 higher.

10 There is also what we call the
11 Healthy Worker Effect, that if you have PTSD, you
12 may choose to get out of the service, rather than
13 go back and deploy a second or third time.

14 So, I think the bottom line is,
15 nobody knows exactly how many service members
16 have PTSD.

17 Again, there is people who report
18 for care, which is a smaller number, and then
19 there is the people who may have symptoms.
20 There is the people who may have symptoms later
21 on, that haven't -- it hasn't come out yet. We
22 certainly see that with Vietnam. But this was

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1 the official summation of all the literature
2 that is out there.

3 MEMBER CONSTANTINE: Well, it's not
4 a summation of all the literature, because we
5 just said, the RAND is significantly higher than
6 that.

7 But is the -- you said the MHAT, is
8 that -- did you say they go to Iraq and
9 Afghanistan and talk to people there, or it's for
10 people who have deployed to Iraq and
11 Afghanistan?

12 DR. RICHIE: The teams of
13 researchers went to Iraq and Afghanistan and
14 talked to the soldiers who were there, using
15 confidential surveys.

16 MEMBER CONSTANTINE: And then a
17 year later, are they talking to them back in the
18 States, or is it only immediately in theater,
19 when of course, a lot of those symptoms and
20 problems don't arise?

21 DR. RICHIE: Yes, the Mental Health
22 Advisory Team surveys are cross-sectional.

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1 They're one time.

2 One of the things that we'll come to,
3 that there was a real lack of, is longitudinal
4 studies.

5 Just about everything that is out
6 there, even the RAND survey, is at a point of
7 time, and here, I'm going to put my own opinion
8 here for a moment, but I think it will come out
9 in the recommendations too, is that we really
10 need better data, to see how the course of
11 illness changes over time.

12 One of the things, there was a study
13 by Tom Greeker with Walter Reed soldiers, which
14 showed that the people who had symptoms at three
15 months, were not necessarily the same people who
16 had the symptoms at six months.

17 So, one of the things you see is that
18 the severity and the symptoms of post-traumatic
19 stress disorder wax and wane over time.

20 Again, this is one thing that I see
21 clinically a lot, people can get triggered very
22 easily with post-traumatic stress disorder.

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1 When I was in Korea, my first
2 deployment, we had -- with the 2nd Infantry
3 Division, we had a lot of Vietnam Vets who had
4 been doing fine, until they got back to Korea,
5 and then they smelled the smell and they had the
6 same scent, and their PTSD just got reactivated
7 all over.

8 Again, that is a little outside of
9 the scope of the IOM report, but the point I want
10 to make is that PTSD symptoms do fluctuate, and
11 it's entirely possible that the prevalence of
12 PTSD is going to be much higher than this, some
13 five or 10 years down the road.

14 MEMBER DeJONG: Ma'am, are you
15 noticing any differences in the data that you've
16 collected between from DoD or from VA, number
17 differences, case load differences?

18 DR. RICHIE: Again, we did not get
19 hard data in time for phase one of the report.
20 So, I'm really not in a position, that I can
21 comment on that.

22 MEMBER DeJONG: Okay.

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1 CO-CHAIR CROCKETT-JONES: Here is
2 another question on your data collecting, and
3 you may not have this answer yet, but are you
4 looking at the correlation maybe between the
5 range of diagnosis?

6 We know that the diagnosis is pretty
7 broad. There is a lot of things that go in to
8 it, and you can have very different diagnosis,
9 markers sort of, symptom markers, that gets you
10 at the same diagnosis.

11 Is there any correlation between
12 that and maybe outcomes? Are you looking at
13 that?

14 DR. RICHIE: We do not have
15 basically, any outcome data. Most of the
16 outcome data that we're trying to collect is for
17 phase two, is really the outcome of people who
18 go through the programs, and from what I've seen,
19 there is not well-characterized, really
20 granular looking at what is one's particular
21 diagnostic picture versus how well you do in a
22 program.

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1 I absolutely think that data should
2 be collected, and let me be a little bit more
3 specific.

4 As you know, there is three major
5 types of PTSD symptoms. There is the
6 re-experiencing, there is a hyper-vigilance and
7 there is numbing and avoidance.

8 What I see clinically is that it's
9 a numbing and avoidance, which is the hardest to
10 treat.

11 The hyper-vigilance may go away over
12 time. The re-experiencing of the intrusive
13 thoughts, people learn to live with, but if
14 they're not willing to get out of the house or
15 reconnect with their family members, then that
16 can lead to divorces and other bad outcomes,
17 which adds to some of the comorbidities.

18 I'm going to talk about
19 comorbidities a little later, so, let me keep
20 going, and we'll come back to that.

21 So, neuro-biology, one of the things
22 that is very frustrating to everybody is there

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1 is no biological markers for post-traumatic
2 stress disorder, and there is a number of
3 attempts to get those, but all the attempts at
4 the moment, are in the research phase. They're
5 not able to be used clinically in a blood test
6 or in imaging study.

7 We are interested, and this again,
8 will be phase two, in looking at which people,
9 either genetically or through their background,
10 respond better to different treatments, coming
11 back a little bit to your earlier point, and we
12 really don't have that information, at this
13 time.

14 Prevention, there is a lot of work
15 out there in prevention, and you can look at the
16 three types of intervention for prevention, the
17 entire population prior to exposure, for those
18 already exposed to trauma, and for those with
19 post-traumatic stress disorder, to prevent
20 worsening of symptoms.

21 In some way, I've always thought of
22 basic training, and again, this I my personal

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1 opinion, as one of the best basic interventions,
2 because you're preparing people for battle.

3 Now, you all are also aware that
4 resiliency programs are kind of the buzz word,
5 and there is a lot of focus on resiliency,
6 comprehensive soldier fitness being the big
7 program in the Army. At the moment, we don't
8 know what works, in terms of prevention.

9 The other thing, there is -- the
10 programs for resiliency are not PTSD specific.
11 They are service specific. So, each service has
12 its own, and they haven't been formally
13 evaluated for effectiveness.

14 We do think that early intervention
15 should reduce symptoms, increase functions and
16 prevent onset of the full PTSD, and again, this
17 is one of the things that we sort of think this
18 is the right thing, but we don't have the formal
19 evaluation studies, and we are trying not to make
20 any conclusions without having hard scientific
21 evidence.

22 MEMBER REHBEIN: Ma'am?

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1 DR. RICHIE: Yes?

2 MEMBER REHBEIN: Are those formal
3 evaluation studies underway or is that just
4 something that we wish we had?

5 DR. RICHIE: My understanding is in
6 the Army, there is a formal evaluation study
7 underway for comprehensive soldier fitness. I
8 don't think I know about the other services. I
9 don't think I know about the Marine Corps. I can
10 get back to you on that, and perhaps one of you
11 actually may know.

12 MS. DAILEY: We can ask the
13 services, Mr. Rehbein, for what progress they're
14 making or what initiatives they have to evaluate
15 their preventive programs. We can pull that and
16 do a data call.

17 DR. RICHIE: And of course, one of
18 the challenges, at least speaking about the
19 Comprehensive Soldier Fitness Program, which is
20 the one I'm most familiar with, is that it's now
21 centered on basic training, and you're providing
22 some intervention and basic training, which is

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1 part of a long nine-week package of basic
2 training, and then people go to have different
3 experiences in theater. They have different
4 backgrounds.

5 Traditionally, it's very hard to
6 show the effectiveness of prevention efforts.

7 So, I don't think it's for a lack of
8 trying. It's not that the services are saying,
9 "We don't want to do this." It's just really
10 tough to do.

11 MS. DAILEY: And then real quick,
12 when the Air Force briefed us last year about
13 their intervention post-return from Iraq and
14 Afghanistan, being done at Landstuhl, they did
15 give us some data from that, relief of symptoms,
16 but it's very small scale. It's just
17 individuals going through the Air Force's
18 program.

19 So, again, as Dr. Richie said, it's
20 -- we can do this call. We can ask for this
21 information, but it might be hard for them to
22 give us something that is comprehensive and

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1 thorough, at this point.

2 DR. RICHIE: Yes, I think that's
3 what you're going to find.

4 Then the VA has a lot of discussion
5 about prevention, and some people will argue
6 where you are on the scale of prevention, because
7 generally, people in the VA system are more
8 chronic, but again, this is very little data or
9 to no data available, looking at the
10 effectiveness of the intervention programs for
11 the VA.

12 So, screening, there is actually
13 much more information about screening, because
14 screening has been a big component with the
15 post-deployment health assessment,
16 post-deployment health re-assessment, the
17 periodical health assessment.

18 In general, looking at the civilian
19 literature, as well as the Military, we believe
20 that effective screening for PTSD improves
21 health outcomes, but the caveat to that is it
22 can't just be screening. There has to be timely

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1 and adequate follow-up afterwards.

2 The Military --

3 MEMBER PHILLIPS: Ma'am?

4 DR. RICHIE: Sir?

5 MEMBER PHILLIPS: Just quick. Are
6 there any screening programs that are
7 pre-enlistment?

8 DR. RICHIE: There are screening
9 programs that are pre-enlistment. The IOM did
10 not particularly focus on those.

11 In other work that I've done
12 personally, and this again, is IOM, I've looked
13 at the session standards and screening.

14 There has been a lot of effort, and
15 this goes back to World War I and World War II,
16 to try to come up with a screening program that
17 is going to identify those who are going to be
18 at risk.

19 The bottom line is that the screens
20 are in -- not sensitive and specific enough.

21 In other words, there is too many
22 false-positives, too many false-negatives, and

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1 this is another hour-long lecture, but when we
2 were -- World War II, we were screening so much,
3 our screening -- we said so many people couldn't
4 come in that we threatened the war effort for
5 World War II, and then ended up letting a lot of
6 those people back in, after Pearl Harbor, and
7 they did just fine.

8 The other thing is that the Walter
9 Reed Army Institute of Research has put a lot of
10 effort into doing a session screening. My
11 understanding is that it tends to get very long,
12 and therefore, the sessions -- the MEPS feel that
13 they can't do it.

14 I'm a little behind, so, somebody
15 may have an update on that effort.

16 MEMBER PHILLIPS: I was just
17 wondering, just a simple question. Substance
18 abuse, if that is paid attention to by the
19 recruiters?

20 DR. RICHIE: It is. They ask about
21 substance abuse.

22 MEMBER PHILLIPS: That's a tough

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1 thing to deal with, I know.

2 DR. RICHIE: Especially as the
3 economy has gotten bad and people want to get
4 into the Military, and if they know they say
5 'yes' to substance abuse, it means they're not
6 going to get in, there is hardly an incentive to
7 be honest about substance abuse.

8 Again, in other work that the G1 has
9 done, not part of this committee, they looked at
10 substance abuse and waivers, and again, if we
11 have time, perhaps we can talk about that or you
12 can request that data from the G1, because it was
13 a nice study, done a few years ago.

14 MS. DAILEY: Yes, they briefed us
15 down at Fort Knox and gave us some of the data,
16 particularly the Army did, what waivers go
17 through, what is approved.

18 All the services have extensive drug
19 testing, prior to enlistment, required
20 urinalysis.

21 So, some offers waivers, you know,
22 for example, the Air Force, if you come up 'hot'

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1 once, that is a permanent elimination.

2 So, every service is drug testing at
3 enlistment.

4 DR. RICHIE: Okay, one of the areas
5 that we focus quite a bit on is, where is the
6 screening done, and both the VA and the
7 Department of Defense have integrated screening
8 into primary care practices.

9 In the Army, this is RESPECT-Mil.
10 In the other services, in their primary care
11 clinics, not universally, and people like it.
12 People we talked to think this avoids the stigma
13 of going into a separate mental health clinic.

14 One of the areas that we saw, that
15 there was none of this done was in the services
16 provided by TRICARE, by our purchase-care
17 providers, and we'll come back to that in our
18 recommendations, that we thought that it should
19 be accompanied by screening with the TRICARE.

20 Diagnosis, we thought that the PTSD
21 diagnosis depended on a clinical evaluation, by
22 a qualified professional. These other things,

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1 I won't read them to you. The clinical
2 interview should get these details.

3 You can use a structured interview,
4 but it shouldn't be the sole basis of the
5 interview.

6 We didn't spend a whole lot of time
7 revising the PTSD diagnosis. We used the one
8 that Diagnostic and Statistical Manual 4 used.

9 Of course, that has just been
10 updated this last weekend to the DSM-5, and there
11 is discussion about the diagnosis, but that
12 wasn't part of our charge, was to re-look at the
13 diagnosis. It was much more about how well we
14 were treating at DoD and VA.

15 So, coming to treatment, which was
16 really the heart of this phase one, there is a
17 lot of treatments available for post-traumatic
18 stress disorder, psycho-social and by
19 psycho-social, we're including psycho-therapy,
20 talking therapy, pharmacological medication,
21 complementary and alternative medicine and
22 combinations of the above.

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1 As I mentioned before, there are
2 several guidelines out there that are among the
3 most comprehensive guidelines, DoD, VA and the
4 American Psychiatric Association, which have
5 judged treatments as to which are effective.

6 The most robust evidence,
7 randomized controlled trials, have been on
8 therapies that are what we call, are manualized.

9 They're done by a manual and it's
10 fairly easy to do them, and have placebo
11 controls, and so, you can tell if they're
12 effective, and the big ones here are prolonged
13 exposure, known as PE, cognitive therapy, and
14 you usually talk about cognitive behavioral
15 therapy and cognitive processing therapy, and
16 then EMDR, eye movement de-sensitization and
17 reprocessing, which some people think of as a
18 variation of exposure therapy.

19 Do you guys need more discussion
20 about what these therapies actually are? No,
21 okay.

22 So, there is some other therapies

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1 that seem promising, but we don't have the
2 evidence, and actually, we had a fair amount of
3 dispute in our committee, as to whether we called
4 these other therapies, you know, non-evidence
5 based therapies, which sounds kind of bad, if
6 they're non-evidence based, versus we don't yet
7 have the evidence for them. It's in the data
8 gathering part, and so, calling them new and
9 innovative treatment.

10 A lot of discussion, and we'll come
11 back to, of course, need for more research.

12 Virtual reality exposure therapy,
13 that is the one where you're looking at a TV
14 screen and you see virtual Iraq or virtual
15 Afghanistan. It's probably a variant of
16 prolonged exposure.

17 It seems to be accepted by service
18 members a lot better, and one of the issues that
19 we're always grappling with is, it can be great
20 to have an evidence based therapy, but if the
21 service member doesn't go to it, or goes to it
22 once, it's not going to work.

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1 So, how can you have therapies and
2 treatments that people are willing to go with and
3 stick with, and the preliminary data is that
4 service members like these, they like the
5 ability to control it and the technology, but
6 again that is preliminary.

7 Okay, pharmaco-therapy again, there
8 is a lot of background on this. SSRIs are
9 Selective Serotonin Reuptake Inhibitors. They
10 are the ones that are commonly used for
11 depression, and FDA approves Sertraline,
12 Zoloft, Paroxetine and Paxil, and then
13 Serotonin-Norepinephrine reuptake inhibitors.
14 They're recommended as first-line treatments.
15 Effexor and Wellbutrin are an example of these
16 two.

17 However, although there has been
18 work done in the civilian world, there hasn't
19 been much research done in U.S. Veterans,
20 specifically.

21 There is a lot of other
22 pharmaco-therapies that are out there, Prazosin

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1 and others. Unfortunately, we don't have the
2 research base yet, and again, you'll hear us
3 circling back to it in the recommendations.

4 Lots of issues about whether people
5 are willing to stay on medications.

6 In my experience, in talking to
7 folks, young men, young women don't really like
8 to be on medication. All these medications have
9 side-effects. The SSRIs, the side-effects are
10 generally mild. Some of the side-effects
11 though do include sexual dysfunction and my
12 opinion, young -- the cameraman has now gone, put
13 the things away.

14 My opinion, Marines and soldiers,
15 the Air Force Airmen, Sailors, none of them like
16 to be on medications with sexual side-effects,
17 and this isn't just my opinion, there has been
18 a lot of research out there, as well.

19 Then the question about combining
20 psycho-therapy and pharmaco-therapy. Again,
21 further study needed.

22 But we do have good evidence about

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1 pharmacotherapy, and then there is emerging
2 therapies, and as I said, we discussed quite a
3 bit, with these, couples, families,
4 complementary and alternative medicine, and let
5 me spend a minute or two on these.

6 There are a number of programs which
7 use complementary and alternative therapies.
8 There is one at Fort Bliss, which is now called
9 the Warrior Resiliency Center, used to be six
10 months and it's now a month, out at Balboa and
11 San Diego, here and at the Bethesda and the
12 National Intrepid Center of Excellence.

13 They're using a lot of these, and
14 they're beginning to gather the data, especially
15 the NIKO, but it's in an early phase, and was not
16 in a way that we could look at it and say, "This
17 works or this doesn't," and in addition, in many
18 places, you've got multiple alternative
19 therapies being used, so, it's really hard to
20 tease out.

21 You might get that the people are
22 better after six months in a program, but is it

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1 the cohesiveness of the band of brothers that
2 goes through the program? Is it the yoga? Is
3 it Reiki? And every service member, actually,
4 that you talk to and we did talk to them, will
5 say something different that helped them
6 specifically.

7 There is a number of other somatic
8 therapies, and by somatic that means basically
9 physical. Electro-convulsive therapy, we
10 would not use for PTSD per se, but PTSD is often
11 comorbid with depression and certainly,
12 electro-convulsive therapy does help with
13 severe depression.

14 Transcranial magnetic stimulation,
15 hyper-baric oxygen, vagal nerve simulation, all
16 of these have been proposed, and again, we don't
17 have the research basis, and as you know,
18 hyper-baric oxygen has also been discussed a lot
19 for traumatic brain injury. The recent reports
20 that I've seen have been disappointing, on that.

21 MEMBER CONSTANTINE: Ma'am, with
22 the alternative medicine or the yoga and

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1 medication and acupuncture, what kind of access
2 do you folks have to those who aren't MTF?

3 DR. RICHIE: What kind of access
4 does the service member have? Poor, and that is
5 one of the things that we will be probably
6 commenting more on in phase two, but here -- and
7 I've got to be very careful not to talk about
8 phase two.

9 I do a blog on time battle-land site,
10 and I've written in my blog, about the unequal
11 access to care, in general, and certainly, to the
12 alternative medicines.

13 So, you've kind of got Cadillacs and
14 you've got kind of broken down Chevrolets, and
15 it's not -- I think it's not that the services
16 aren't trying, but when you're out in the bottom
17 of Texas, you know, there is just not that many
18 yoga therapists around.

19 MEMBER CONSTANTINE: But if there
20 is a yoga therapist or a place that offers
21 acupuncture, can a service member, whether he's
22 still maybe Reservist or if he's moved on and the

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1 VA care says to him, "go ahead and utilizes
2 those" easily, or is it a very, very tough road
3 to hoe, to get that through TRICARE or whatever
4 it is?

5 DR. RICHIE: The best access is when
6 the Military offers it in their Military health
7 clinics because then they're not going to charge
8 for it. TRICARE doesn't reimburse for yoga and
9 acupuncture, to the best of my knowledge, and I'm
10 pretty sure that is correct.

11 In terms of Guard and Reserve, it's
12 probably going to depend on what their treatment
13 is.

14 So, these complementary and
15 alternative treatments are very unequal
16 throughout the system.

17 The other piece of that is, again,
18 without good research support, it's hard to
19 mandate that they need to be. Why? It's
20 something -- you don't know whether something is
21 effective yet, then it's a hard road to hoe, to
22 say it should be a benefit. Sir?

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1 MEMBER TURNER: I assume that these
2 programs that -- the complementary, are locally
3 initiated. There is no programmatic
4 service-wide or larger program. These are all
5 initiated locally by people that want to use
6 these, is that accurate?

7 DR. RICHIE: That is basically
8 accurate. That certainly happened at Fort
9 Bliss, for example. You have a champion there,
10 who stood up the Warrior Resilience Center, John
11 Fortunato.

12 At NIKO, it's more, you know, that
13 is a -- you all are familiar with the NIKO?
14 You've been up there?

15 Okay, so, you've got service members
16 who come in from all over, to come to the NIKO.

17 One of the challenges is when they
18 leave to go back to wherever they are, there may
19 or may not be something available back where they
20 are.

21 MEMBER TURNER: And since these are
22 locally initiated, are -- so, we actually have

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1 locally initiated Reiki, Military Reiki
2 providers, or how is that done?

3 DR. RICHIE: We do at Fort Bliss,
4 and again, when I was on active duty, there was
5 a lot of discussion about trying to export the
6 package from Fort Bliss to Fort Carson, to other
7 places, and people liked it in theory.

8 But in my experience, it takes a
9 champion and a lot of energy, and then the other
10 -- the challenge, and I'm sure you've seen this
11 too, is there is a lot of people who have great
12 ideas, so which great idea do you go to?

13 MEMBER PHILLIPS: Question about
14 TMS.

15 I mean, the civilian population
16 seems to be exploding, jumping on this because
17 it's lucrative. Do you have a personal opinion
18 as to the effectiveness?

19 DR. RICHIE: I don't think the
20 research is out there. It's anecdotally, some
21 service members like it. Some will take it home
22 and use it on themselves. It gives them a sense

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1 of control. I think it's technical, so, they
2 like it.

3 But I haven't seen any research that
4 would make me say, "We should be doing this on
5 the Military," and you're hearing a theme, I
6 think, which is all these ideas.

7 We all -- we're all very attracted
8 to these, and again, in terms of the service
9 members liking these therapies, they like them
10 but does that mean we have the evidence to
11 support them yet, and the answer really is no.

12 MEMBER CONSTANTINE: And along
13 those lines, the hyper-baric oxygen, I know Dr.
14 Green has just said that has been a long -- last
15 year, has said it's a long time in the works, the
16 studies --

17 DR. RICHIE: Could you put the
18 microphone on?

19 MEMBER CONSTANTINE: Sorry, yes,
20 with the hyper-baric oxygen, Dr. Green, who was
21 here last year has said that has been ongoing,
22 a lot of research going into that, and I know a

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1 Marine who have severe TBI and it wasn't until
2 he had the hyper-baric oxygen that he saw real,
3 sustainable progress.

4 But you said that really hasn't
5 proven out in the grand scheme of things, I
6 guess, is that accurate?

7 DR. RICHIE: So, specifically for
8 TBI, I think the research is equivocal. There
9 has been a lot of excitement about it, but the
10 studies I was just looking at and I can send them
11 over to Ms. Dailey, if you want to look at them,
12 soldiers were -- service members were not doing
13 better in a degree that really supported the
14 treatment.

15 There has been less work on that with
16 post-traumatic stress disorder. The people who
17 are promoting hyper-baric oxygen have
18 postulated that it should be useful.

19 But when I looked at the research,
20 the study design was not very good at
21 distinguishing what was TBI and what was
22 post-traumatic stress disorder and what was a

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1 placebo effect.

2 Sir, you had a point?

3 MEMBER DRACH: Yes, Doctor, two.
4 One, on their animal assisted therapy, I'm
5 familiar with the service animals, which are
6 typically dogs. Are the animal assisted
7 therapies, are these specially trained animals
8 for therapeutic purposes as opposed to assistive
9 purposes?

10 The second question is unrelated to
11 that --

12 DR. RICHIE: Let me answer your
13 first, if I may.

14 MEMBER DRACH: Okay.

15 DR. RICHIE: And I will say, again,
16 that I have an hour lecture on this, and in the
17 interest of time, Ms. Dailey, you pull me.

18 Actually, we published the first
19 literature on this last April, which was in the
20 Army Medical Department. We've talked about
21 the use of canines in animal medicine -- excuse
22 me, the use of canines in Army medicine, and

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1 there is a range.

2 You've got the service dogs, which
3 are the traditional ones given to people with
4 physical disability, who by the way, also seem
5 to improve on their PTSD symptoms.

6 You have the animal assisted therapy
7 dogs, which are the ones that we sent into Iraq
8 and Afghanistan to work with our combat stress
9 control units, Sergeant Zeke, some of the other
10 dogs that are over there.

11 We also have a variety of dogs that
12 may belong to Walter Reed, to say, the
13 occupational therapist at Walter Reed, that come
14 in and bring and help people with mobility but
15 aren't traditional service dogs in that they
16 don't belong to the provider.

17 Again, there is a lot of anecdotal
18 research. I've talked to so many service
19 members who say, "You know, without my dog, I
20 couldn't do anything. I'd be at home all day,"
21 and that's one of the reasons I got really
22 interested in the subject, but the research is

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1 just beginning.

2 The National Intrepid Center of
3 Excellence is looking at some research there.

4 One of the things -- my personal
5 opinion of that, I think we should do, is just
6 look at the medication use of people who have
7 been issued a dog, either a service dog, because
8 what I've heard anecdotally is, "My use of
9 Risperdal, which is an anti-psychotic, got cut
10 in half. My use of benzodiazepines went way
11 down."

12 Of course the other thing about
13 dogs, you know, I mentioned before how the
14 numbness and avoidance, people not getting out
15 of the house was such a problem.

16 Well, if you have a dog, you've got
17 to get out of the house, and so dogs are really
18 social lubricants.

19 The flip-side is there is a lot of
20 policy that still needs to be developed around
21 the use of animals. Who gets an animal when?
22 Who takes care of it if they go back into the

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1 hospital? Their living situation.

2 There has been some -- how well the
3 dog needs to be trained. There has been some bad
4 outcomes, where dogs have bit people and yes,
5 that is not good for anybody, much less pooping
6 in the bathtub in the occupational therapy
7 clinic.

8 So again, Ms. Dailey, you can put the
9 hook around my neck for dogs right now.

10 But I think it's a great subject, but
11 needs work.

12 MEMBER DRACH: Just real quick. I
13 saw over the weekend a report that there is some
14 experimental -- experiments going on with using
15 Ecstasy to treat PTSD, and are you looking into
16 that at all?

17 DR. RICHIE: Not for this. Not for
18 the IOM report at this time, or we haven't yet.

19 Actually, people were looking into
20 Ecstasy and LSD used to treat depression and
21 PTSD, mainly depression in cancer patients back
22 in the 50's and 60's, if you remember Timothy

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1 Leary and some of the things that were happening
2 there.

3 So there is a tradition of the use
4 of psychedelic medications in the treatment of
5 mental disorders, however, I'm going to just be
6 -- keep repeating my refrain, there is not enough
7 research at this time.

8 Okay, so rehabilitation, and ma'am,
9 coming back to your point, what were some of the
10 co-occurring conditions that were common,
11 substance abuse and depression, and by the way,
12 in the definition of PTSD there is not --
13 depression isn't in there, but we see depression
14 and we see irritability all the time, and anger,
15 and when I talked to civilian providers about
16 working with patients with PTSD I emphasize
17 these points.

18 Medical comorbidities,
19 psycho-social ones, all the ones that we saw
20 after Vietnam, and that we're worried and are
21 beginning to see again, and that a lot of the
22 studies that are out there are done on "pure

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1 PTSD", but there is very little "pure PTSD" in
2 our service members. It's comorbid with
3 everything there and what we need is a
4 collaborative approach.

5 So, the PTSD guidelines for those
6 with "pure PTSD", they don't address depression
7 and substance abuse. So we need more treatment
8 guidelines in that area.

9 One of the questions is whether you
10 first treat the PTSD and then the substance abuse
11 and then the depression, or whether you treat
12 them all at once, and we don't have -- we don't
13 have comprehensive guidelines for comorbid
14 treatment, little outcome data.

15 Our mission was not to look at
16 suicide, but certainly suicide is an enormous
17 issue, and there -- we think, and there is some
18 evidence, that treatment for PTSD reduces
19 suicide attempts, but again the data is pretty
20 soft right now.

21 I did a paper on -- where I looked
22 at all Army suicides. It was published August

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1 2011, and what we found is that -- and the data
2 looked at suicides from 2001 and 2009, and it
3 looked at what was known about their medical
4 conditions.

5 So in 2001, essentially none of our
6 suicides had PTSD, and in 2009 it was up to about
7 nine percent of completed suicides had a
8 diagnosis of PTSD.

9 Do I think that it's actually much
10 higher than that in suicides? Yes, I do, but it
11 wasn't in the data available to the people who
12 were looking at the suicides.

13 So the nine percent figure, I
14 suspect it will go up, especially around this
15 issue of numbing and avoidance, which leads to
16 the relationship break ups, which is a big factor
17 for suicide.

18 The other thing we see a lot of is
19 people getting in trouble at work, which is
20 another enormous risk factor for suicide.

21 Comments or questions?

22 MEMBER CONSTANTINE: It seems

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1 almost obvious, if they're not getting care, if
2 they're not getting treatment, they're not
3 falling on the radar of someone who has been
4 diagnosed with PTSD and seems to me as a
5 layperson, that type of person is probably more
6 inclined to go all the way and commit suicide
7 because they're not on anyone's radar and
8 they're suffering on their own.

9 DR. RICHIE: I agree. The other
10 thing that you often have with people who have
11 been in the theater of war is, they develop a
12 little bit of a fatalistic attitude. This
13 doesn't quite count as post-traumatic stress
14 disorder.

15 But certainly, I've seen a lot of the
16 -- and I won't use this language in here, but oh,
17 you know, "F it. I don't care. I won't do this,
18 you know, relationship is over."

19 So it's kind of a fatalistic, angry
20 attitude, and if you have to go in to a clinic
21 which is marked 'Army Substance Abuse Clinic',
22 and walk into that door where everybody is seeing

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1 you, and sit down in a room, a waiting room, this
2 again my personal opinion, but we heard this a
3 lot from soldiers, a lot, you know, and you sit
4 down in the waiting room and you're
5 automatically a sleazebag for being there.
6 Soldiers, service members are not going to walk
7 into that door.

8 So, what are some of the PTSD
9 programs? Well, there are a lot of them.

10 In the DoD, they're very seldom
11 delivered in PTSD programs, per se. The VA has
12 a lot more programs, but the -- for the soldier
13 this is kind of the venue that you go through.

14 You either get treatment on base or
15 off base. On base, primary care, mental health
16 specialized programs, in-patient or
17 out-patient. Again, this is rare in the
18 Department of Defense.

19 Off base, you can go to a TRICARE
20 provider, either primary care or mental health,
21 to a VA facility, and to Military One Source or
22 to a private practitioner that is not part of the

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1 TRICARE network.

2 Now technically, Military One
3 Source is not suppose to provide treatment.
4 They're providing counseling, but there has
5 certainly been the line there and I've got the
6 30 minute sign, so I'll try to run through this.

7 In the VA, there is lots of PTSD
8 programs and they know very easily, very
9 clearly, how many Veterans are receiving care
10 for PTSD.

11 The VA is also very good at knowing
12 who has been trained in evidence based
13 treatment, and they are better than the Military
14 in knowing whether people are receiving evidence
15 based treatment, although that is still a little
16 soft.

17 So again in the VA, it's mainly
18 treated in out-patient clinics, but there are 41
19 specialized intensive PTSD programs, and of
20 course there is the Vet Centers that also offer
21 counseling.

22 Access to care, barriers to care.

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1 We've touched on this. This is a really big
2 issue. There are a ton of barriers to
3 high-quality PTSD treatment. We have broken
4 them down by individual, if you can't get child
5 care, you can't park.

6 Provider, even if you've received
7 training in evidence based care, you have time
8 to do it, and then institutional things.

9 So you're doing all these
10 screenings. You have time to provide
11 treatments. You're revising your medical
12 boards and adding addendums, if you have time to
13 do treatment.

14 So active duty service members have
15 all kinds of reasons that are hard for them to
16 get to appointments.

17 Now, the Military has recognized
18 this. They're not sitting back and admiring the
19 problem, but what they have done is embed mental
20 health treatment in primary care settings.

21 This again, the RESPECT-Mil program
22 is one of them. There is now the Army -- the Army

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1 is pushing very hard on what they're calling
2 embedded behavioral health providers, so
3 they're going out to the brigade level. That,
4 like everything, has its pros and cons.

5 So, there is a lot of screening out
6 there, but again, the challenge becomes how to
7 get them from screening to access to care.
8 Again, less than half of veterans who need PTSD
9 care get it.

10 Tele-mental health, been a lot of
11 emphasis on that recently. My own personal
12 experience is tele-mental health can be very
13 helpful in some settings, but it's not a fix-all.
14 It takes a lot of care and feeding because you
15 usually have to have a provider at each end, and
16 the equipment to maintain.

17 There is internet based
18 interventions that the soldiers like, but the
19 providers are a little less keen on and need for
20 more data.

21 Again, some of the barriers, this is
22 really a recommendation that snuck into here.

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1 We need to be training practitioners
2 for delivery of evidence based care. The VA
3 tracks PTSD training not done so much in the DoD.
4 The VA use qualitative interviews with patients
5 and providers, we haven't done so much of that
6 in the DoD, and then there has got to be feedback
7 loops.

8 It's not enough to train Dr. Richie
9 on how to provide CBT. Somebody has got to be
10 monitoring Dr. Richie, to make sure Dr. Richie
11 is getting it, and how many times does that
12 soldier come in?

13 Here is a challenge. Again, most of
14 the evidence based treatments are 12 to 20
15 sessions.

16 When I was on active duty, the
17 typical length of time for everybody in the
18 system to get treatment was three sessions, and
19 that included people who were in the medical
20 board process, and most sailors and soldiers and
21 Marines went in once.

22 So, how do you provide therapy that

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1 works, in either one or two sessions, or how do
2 you make it attractive enough to the service
3 member, that they're willing to come back?

4 Okay, so, getting into findings, and
5 the findings will then be kind of repeated in the
6 recommendations, which is good. You shouldn't
7 have a recommendation without a finding.

8 Most of these programs lack long
9 term data outcome. PTSD is highly comorbid.
10 Although the VA/DoD guideline exists, we don't
11 know how often people use it, and although many
12 providers are trained, we don't know how much the
13 therapies are actually used, and I'm going to go
14 through these quickly, because I think I've
15 touched on most of these before.

16 More programs need to be evaluated
17 and results disseminated. Evaluation methods
18 have not been standardized.

19 Both the DoD and VA have made the
20 one-stop shops, mainly primary care, mental
21 health care, and we're using new technologies.
22 We don't have good research on this yet, and

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1 additional data are needed.

2 So recommendations, and we've broke
3 the recommendations down to analyze, implement,
4 innovate, overcome and integrate.

5 One of the questions that you all
6 had, I think was why is this our first
7 recommendation, and this recommendation was not
8 first as the most important, it was just under
9 the general stream of analyze, implement, et
10 cetera.

11 We don't have a way right now to sort
12 of look at all the patient records and see which
13 treatments are effective. We can -- you see, I
14 still say 'we'. I still think I'm in the Army.

15 We can look at the ALTA system and
16 say how many patients have post-traumatic stress
17 disorder, but at the moment we don't have a way
18 of saying how many people who were started on
19 Paxil or Paroxetine did better, much less, back
20 to your question about specific shades of the
21 diagnosis doing better.

22 So there should be a way for the

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1 researchers to be able to pull out that
2 information.

3 The DoD and VA should institute
4 programs of research to evaluate all their PTSD
5 services. The effectiveness of DoD prevention
6 services should also be assessed, back to the
7 point over here.

8 You know, there is not a single place
9 that you can look and go to, where all the DoD
10 and VA research on PTSD is being done.

11 Probably the best location is up with Carl
12 Castro at MRMC, Medical Research and Material
13 Command, but that is principally Army. So there
14 is no belly-button that you can say where
15 everything is. Again, the services have been
16 working on trying to do that.

17 We did say that PTSD screening
18 should be done at least once a year, because
19 remember not everybody is caught by their
20 post-deployment health assessment and
21 re-assessment since those are related to
22 deployment.

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1 There is beginning to be a mental
2 health assessment done pre-screening, and then
3 we think it should be done at the TRICARE
4 provider locations.

5 So these specialized programs need
6 to be evaluated.

7 You're going to ask, "Well, why
8 haven't they been evaluated?" You know,
9 they've been going for four or five years and we
10 asked that same question.

11 Well, why not? You've been putting
12 this money into these programs. Why not have an
13 evaluation arm, and what I've seen is that people
14 attempt to do that but they say they don't have
15 the research analysts or they don't have
16 somebody, and I think most of the time people are
17 just swimming as fast as they can trying to keep
18 their head above water, and as the money is
19 coming in, you know, they're just seeing
20 patients. So we need to be more rigorous about
21 this.

22 We looked -- we should support

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1 neuro-biology research here. Didn't have too
2 much on that in phase one. We'll have more in
3 phase two.

4 There is a lot of the emerging
5 technology, and I've mentioned virtual reality,
6 internet based therapy, tele-medicine and I
7 think we all thought that there was a lot of
8 promise in these therapies but we need to --
9 broken record again, we need to evaluate them
10 better.

11 Then we need to have an evidence base
12 that is supported by the DoD and the VA. We need
13 to include comorbid conditions, concurrent and
14 sequential care, as I mentioned before, and then
15 as we learn we need to be updating the VA/DoD
16 clinical practice guidelines.

17 MEMBER EVANS: Just a question.
18 So, a lot of emphasis on Army. I know such as
19 at San Diego, we have an NC-cost program that is
20 doing.

21 So I assume we're reaching out to all
22 the programs that are involved with PTSD studies

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1 and pre-imposed, because NC-cost looks at the
2 pre, they do a pre-study, then when they return
3 from overseas or from theater they try to
4 capture, although predominantly west coast, we
5 have not expanded that out to the east coast
6 Navy. But just a lot of emphasis on Army
7 programs.

8 So I was just wondering, are we
9 capturing -- I hear DoD, but are we making sure
10 that we capture all of the programs out there?

11 DR. RICHIE: We have -- that is a
12 very good point and I think it's Army centric
13 when I talk for two reasons. One is that is my
14 personal experience. The other is that the Army
15 has -- is -- has been the lead in many of these
16 programs, and the Army provided the best data.

17 So we asked the Navy and we asked the
18 DCOE about the Navy programs, and we didn't get
19 a whole lot of information back.

20 Hopefully, again, we'll have more on
21 that in phase two. Sir?

22 MEMBER TURNER: Just two quick

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1 questions.

2 From earlier, we've all been hearing
3 about the integration of mental health into
4 primary care since the 90's.

5 DR. RICHIE: Right.

6 MEMBER TURNER: And something like
7 that, and since you've been out there and seen
8 it, is this also just a local initiative? Are
9 there any enterprise-wide moves to push mental
10 health into primary care, and do you think it
11 should be done?

12 DR. RICHIE: Wow, that is not a
13 quick question. So, let me take it in probably
14 three parts.

15 First of all, this has been an effort
16 since the 90's at least, and often my experience
17 has been mental health is pushing it because they
18 want to reduce the stigma, and primary care, who
19 is actually fairly resistant, either because
20 there is not room enough in the clinic or they're
21 worried these patients will take too long.

22 I do think that there have been good

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1 programs stood up, both in the Army and the other
2 services.

3 The Army has been the RESPECT-Mil,
4 the other service is Navy and Air Force model,
5 have been more putting a psychologist into the
6 primary care clinic, and now, there is more moves
7 to have both of them there, which again, people
8 like the idea of, but then you get into the
9 shortage for providers and the shortage of space
10 issue.

11 Now, were you also asking in my new
12 role as not being in the service anymore, because
13 I am seeing the same thing out into the civilian
14 world, that there is a lot of discussion, it
15 should be great to have diabetes in my world
16 right now in Washington, D.C., which is
17 chronically mentally ill, it would be great to
18 have diabetes managers in the mental health
19 clinic.

20 But what we find is, we put them in
21 there and patients don't show up for them.
22 They're under-utilized.

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1 So, I think it's something that the
2 enterprise as a whole, the healthcare enterprise
3 is struggling with.

4 MEMBER TURNER: And again, thank
5 you very much, and again, just one quick
6 question.

7 As a mental health provider, based
8 on your experience, what are your thoughts on
9 credentialing and certification of
10 complementary therapy providers?

11 DR. RICHIE: I think there is two
12 ways to approach that.

13 One is, there is program, there are
14 several programs that train people who are
15 already physicians in how to do acupuncture, and
16 in that case they could be credentialed, kind of
17 as an additional technique that they can use,
18 just like I used to be credentialed to do
19 electro-convulsive therapy, if I took the
20 acupuncture course I could be credentialed to do
21 acupuncture.

22 I think it's a lot stickier when

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1 you're talking about people who don't
2 necessarily have that level of training, to
3 develop a certification method for them to do
4 something.

5 Having said that, all the healthcare
6 disciplines that are sort of in main stream, have
7 done that.

8 So, you have various ways to certify
9 credential, other disciplines.

10 Did you have a thought about that,
11 sir?

12 MEMBER TURNER: Well, just again,
13 just when you mentioned that they're providing
14 Reiki, which to me is a real fuzzy --

15 DR. RICHIE: Yes, I wouldn't call
16 that a health --

17 MEMBER TURNER: Right, so that is --
18 you know, if you're getting -- if you're reaching
19 into, you know, maybe eastern medicine and those
20 types, which I'm not saying anything bad about.
21 I mean, there might be a place for them.

22 But you know, where do you go to get

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1 certification or where -- who actually, do you
2 choose to provide them, and again, I agree with
3 you, that you have to see if there is some kind
4 of outcome measure on this as well.

5 I was just curious as a provider, did
6 you see that there was a rigor, as far as the
7 credentialing of the people that provide these?

8 DR. RICHIE: Again, I think it's a
9 range. Acupuncture, which is probably closest
10 to what we do, I think is the easiest because
11 there are credentialing programs for that.

12 Reiki, massage therapy, where I'm
13 not -- I know there are things that do improve
14 mental health, whether they're technically
15 mental health interventions is another story,
16 and if we're going to start to get to dogs, again
17 the whole issue about certifying dogs as being
18 PTSD dogs is a really hot topic out there.

19 MS. DAILEY: Excuse me, real quick.

20 The evidence based or semi-evidence
21 based treatment, such as the virtual reality
22 pieces, there are barriers to bringing that to

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1 the table because who is certifying someone who
2 is administrating a virtual reality event for
3 our service members?

4 So, it's not just about the more --
5 the more non-medical pieces. The very
6 promising practices in virtual reality, which
7 you listed are also experiencing barriers
8 because who is going to train? Who is going to
9 certify the people administrating them?

10 DR. RICHIE: Yes, I'm actually
11 feeling encouraged by the virtual reality,
12 because they've got some good researchers,
13 including Skip Rizzo, who is leading the effort,
14 and they are doing research on that.

15 So, that -- and again, that is probably a
16 variant of exposure based therapies. That is
17 going to be an easier one. Some of the others
18 are much harder.

19 Sir, you had a comment?

20 MEMBER PHILLIPS: Just, when will
21 phase two be ready?

22 DR. RICHIE: It will come out two

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1 years from the last one. So, that would be July
2 2014, and I'm really hoping that phase two will
3 be a lot more granular.

4 Phase one, in many ways, I thought
5 was a pretty vanilla. It was telling you what
6 is already out there, but there wasn't a whole
7 lot of new data in it.

8 Do you have copies of the book for
9 phase one? If you don't, I think the IOM would
10 be glad to send the committee members.

11 It's a nice summary of what is out
12 there in the literature, but there is not that
13 much new and different.

14 MEMBER PHILLIPS: It's probably
15 online. I mean, you can --

16 DR. RICHIE: It is.

17 MEMBER PHILLIPS: -- go on for the
18 IOM. Without revealing any results which
19 you're not supposed to, what sort of things did
20 you look at in phase two?

21 DR. RICHIE: Well, again, we
22 finally got the data on how many people are being

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1 treated. We got -- we've asked again, for
2 program evaluation data.

3 Phase one was really more focused on
4 the DoD, than the VA, and one of the challenges
5 is -- anybody here work for the VA?

6 Okay, so I'm frequently told there was 144
7 VAs and there is 144 VAs and it's very hard to
8 generalize about the difference between VAs.

9 So I think we're going to have more
10 of a focus. One of the things I really want to
11 see in phase two is more focus on the Guard and
12 Reserve.

13 So, you notice that this is pretty
14 active duty centric. Another thing that we
15 didn't do enough of in phase one is, how is care
16 delivered in theater of operations, so, that, I
17 think, is also an important piece, and we've had
18 -- we had some discussion which I didn't go into
19 here, on what can you do in a forward operating
20 base in Afghanistan, on a hilltop in
21 Afghanistan, in terms of treatment versus what
22 can be done at Walter Reed or the NICOE or the

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1 VA, and how does the care change depending on the
2 environment that you're in?

3 MEMBER REHBEIN: The word "prevent"
4 is right up front in your purpose, but yet as I
5 listen to the presentation I see -- I hear very
6 little. Prevent gets not even its own sentence
7 in the recommendation.

8 Do you see more emphasis being
9 placed on assessing prevention, in assessing
10 effectiveness of prevention? Where does that
11 come into all of this?

12 We can -- we have a large population
13 out there to treat, and if we get too deeply
14 involved in spending all our money on treatment
15 and none on prevention, and I understand it's
16 tough. It's a, "Did your flu shot work,"
17 question. You really have trouble
18 understanding what did prevention do.

19 But do you see more emphasis being
20 placed on prevention effectiveness?

21 DR. RICHIE: You know, sir, you're
22 right, I hadn't noted that before, but we don't

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1 actually do talk about prevention in the
2 recommendations. We do in the findings.

3 I think one of the challenges is that
4 it's very hard to give an easy recommendation
5 about what to do to improve the efficacy of
6 prevention, and I'm not sure if I agree with your
7 'flu shot' because it's fairly easy to say who
8 has flu shots and who gets a flu.

9 I think one of the things that the
10 field of public health has struggled with is
11 things like stop smoking campaigns, and how many
12 of them work and what percentage, and how many
13 people actually either stop or decrease, and
14 then how does that relate to the number of heart
15 attacks 40 years later?

16 So I think there is a good
17 observation, but I think it's hard to have an
18 easy recommendation.

19 MEMBER MALEBRANCHE: What role does
20 resiliency, because I know the resiliency
21 program has been kind of started and now, it
22 seems, I've heard a couple of presentations on

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1 it and it seemed to be really impressive in some
2 of their work.

3 But is that playing into any of the
4 research that you're doing now, or have you --

5 DR. RICHIE: I think you may have
6 come in a little late, because I think I
7 mentioned --

8 MEMBER MALEBRANCHE: I missed that?

9 DR. RICHIE: Let me go back to this.

10 So, under prevention, we listed the
11 DoD resiliency programs. The problem is,
12 again, we don't have good data to show what
13 works.

14 There is actually a little bit of
15 data that is related to the Battle Mind program,
16 which proceeded comprehensive soldier fitness,
17 like in Mental Health Advisory Team 2, we found
18 that those who had received Battle Mind training
19 had -- 12 percent had symptoms of anxiety and
20 depression. Those who hadn't received Battle
21 Mind training, 20 percent had symptoms. Sounds
22 good, 20 percent versus 12 percent. Battle Mind

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1 works.

2 Except that if you looked at it, this
3 was before Battle Mind was mandatory, and Battle
4 Mind training may have been a marker by a unit
5 that was focused on what can we do to get our
6 people ready to deploy, and get them ready to
7 deploy back?

8 So it wasn't an independent variable
9 that we were able to tease out, and that is true
10 with a lot of the other prevention.

11 Now the comprehensive soldier
12 fitness say they're working very hard on doing
13 this. My understanding is that they have not
14 gotten any data that really supports the
15 prevention program yet. It may well be that two
16 years from now, hopefully, we'll be able to say,
17 "Yes, this works," but we're not there yet.

18 MEMBER TURNER: I was at a medical
19 meeting earlier, and one of the concerns of the
20 new Surgeon General for the Air Force was,
21 perhaps we are over-aerovacing psychological
22 casualties from the field, not to belie my great

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1 age, but we've moved from three hots and a cot,
2 to everybody goes.

3 Do you see any of that? Do you think
4 that we're bringing too many people back or are
5 short-changing local treatment in the field?

6 DR. RICHIE: Again, I am going to
7 answer that from not the IOM perspective,
8 because that is not something that we've
9 specifically looked at.

10 I do think at the beginning of the
11 war, there was the three hots and a cot
12 mentality, the combat stress control or the
13 OSCAR.

14 I think it's service specific and
15 area specific, and it's also how many troops you
16 need.

17 So now that we're drawing down, what
18 I hear from my colleagues who are providers in
19 the field, is that there is much more of a -- you
20 know, if we're having problems with somebody,
21 get them out of there, as opposed to four or five
22 years ago when we were in the surge and we really

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1 needed everybody there.

2 As I'm sure you're aware from your
3 reading of history, one of the things we find is
4 when we evacuate somebody out, they don't do well
5 in the long run and usually end up discharged
6 from the Military.

7 So the emphasis that we went into the
8 war with in 2001, 2003, 2006, was keep people in
9 theater.

10 But again, we're winding down, and
11 if somebody is causing more problems, at least
12 from the perception of the unit I think there is
13 a lot of perception to evacuate.

14 The flip-side is, one of my
15 colleagues tells me that he has wanted to
16 evacuate a lot and the unit says, "Well, no, I
17 really need that person."

18 So there can be pressures from both
19 sides. There are also issues about escorts and
20 that you have to send escorts back with somebody,
21 which may make a unit more reluctant to evacuate
22 as well.

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1 How am I on time, Ms. Dailey? Do we
2 have time for a few more questions?

3 MS. DAILEY: We do. You're doing
4 good on time.

5 DR. RICHIE: Good.

6 MEMBER CONSTANTINE: I don't want
7 to beat a dead horse, but since you have a couple
8 of minutes, getting back to the alternative
9 care.

10 I used to be on the Warrior Group for
11 Cause, and they through grants from the Wounded
12 Warrior Project and significant grants from the
13 Wounded Warrior Project and Warrior Foundation
14 operate a number of organizations around the
15 country, and one thing that -- one service they
16 provide is the Reiki, is the massage therapy.
17 They don't do acupuncture but other groups do
18 that.

19 Everyone there is certified. That
20 is mandatory, and they're invited by a number of
21 Base Commanders to come and set up an office on
22 their base, because the rave reviews they

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1 received from the leaders who saw the effects and
2 the individual service members who went through
3 it.

4 I think the DoD has -- you know, in
5 many things has a very conservative outlook. I
6 think outside the DoD, though, these alternative
7 medicines, that almost has a pejorative sound to
8 it, anyway, the way of the alternative
9 medicines.

10 But these other techniques are much
11 more successful in the medical field, and I hope
12 that they are being truly investigated by your
13 group and looked and considered and thought
14 about because there are a lot of positive results
15 out there.

16 DR. RICHIE: You're not beating a
17 dead horse. I am firmly convinced of the
18 benefits of animals, personally, but when you go
19 out and look at the scientific literature, which
20 is what the IOM bases some of its findings on,
21 then there is not much.

22 That is part of the reason if you

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1 Google online, and maybe Ms. Dailey can send this
2 to all of you, as I mentioned, we published the
3 first comprehensive use -- the use of canines in
4 Army medicine in the AMED Journal, which is the
5 magazine devoted on the different use of dogs,
6 people said, "Why not horses," and I sort of
7 said, "Once you start getting into dogs you get
8 deeper and deeper."

9 Somebody else has to do the
10 scientific research on horses. There is
11 clearly, to me, benefit there, and what we need
12 to do is probably have more public/private
13 partnerships.

14 There are some organizations out
15 there, especially vet schools, that are
16 interested in looking at this. Again, this is
17 -- we need to get the research.

18 Big pharmaceuticals don't sponsor
19 research on puppy dogs. They sponsor research
20 on pharmaceuticals.

21 MEMBER CONSTANTINE: Right, I agree
22 with that canine stuff. I was talking more

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1 about the other medicine, you know, Reiki or
2 something. It all falls in the same category.

3 DR. RICHIE: It all falls in the
4 same thing, yes.

5 MEMBER CONSTANTINE: Also, when we
6 -- again, getting back to sending your research
7 teams in theater, for those PTSD service, seems
8 odd to me, that in the middle of the war scenario
9 is when you're going to be testing people.

10 When I was there, the last thing I
11 would have wanted to do was take time out from
12 the mission to do that. I can't really even
13 imagine doing that.

14 But that being said, someone has
15 decided that while they're on active duty, while
16 they're in the midst of that environment, that
17 is the best time to test them.

18 Yet, we've seen from your
19 presentation, the DoD offers very little, when
20 it comes to PTSD care and you said the VA tracks
21 on the certifications and things like that with
22 PTSD providers, but DoD doesn't really do very

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1 much with that.

2 So, it sounds like a mixed message
3 to me, that the DoD is getting involved very
4 early -- or someone is getting involved very
5 early on in the process, but while they're active
6 duty, not very much is being done for them.

7 DR. RICHIE: Okay, let me take that
8 slightly differently.

9 First of all, I think in survey, in
10 the theater of war surveys, this is the first
11 time we've done them, and I think they've been
12 very, very useful, mainly in terms of looking at
13 barriers to care, and again, this is independent
14 of the IOM report, but maybe -- and maybe I'm
15 being defensive because I've been involved on
16 one level and just about all the MHAT's.

17 But one of the things the first
18 Mental Health Advisory Team found was that
19 soldiers could not get to providers. Providers
20 were concentrated at the larger FOBs and the
21 soldiers were out there.

22 So, as a result of the first MHAT,

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1 they moved more providers outside the wire, and
2 that is kind of the way the MHATs have been used,
3 is really focusing on access to care and delivery
4 to care.

5 I also think that there has got to
6 be a range of different surveys. I think having
7 one in the theater of war was useful, and there
8 also has to be the ones after they get home, and
9 there has to be the independent ones that the
10 RAND and others have done to look at that.

11 Did I answer all of your question?
12 I think I got part of it.

13 MEMBER CONSTANTINE: Well, I
14 appreciate that, and I know you have a wealth of
15 experience here, so, I'm very glad we have a
16 chance to ask you these questions.

17 It's just, it just seems to me, it's
18 a lot of effort to send someone over there. I
19 thinks it's worthwhile, especially with
20 soldiers who are there for a year, or then 15
21 months, to have someone to talk to on that FOB.
22 That sounds like really hard work to do.

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1 It would be a lot easier to me, in
2 conjunction with that, is to provide those very
3 necessary services when they're back here, six
4 months later, when they're coming back and
5 having to re-adjust to what is going on, and they
6 really start to get hit with the post-traumatic
7 stress, and I'm just, I guess, a little surprised
8 to hear that we're putting such an investment up
9 front in theater, but here, there isn't 10 times
10 that investment while they're still on active
11 duty.

12 DR. RICHIE: Well, there is data
13 available from the post-deployment health
14 assessments, and post-deployment health
15 re-assessments, and to remind you all, in the
16 beginning of the war, we just had the
17 post-deployment health assessment done, as
18 people were coming back, which grew out of the
19 First Gulf War, remember, in 1990.

20 Then people realized that people
21 weren't going to tell the truth, as they were
22 coming back. So, the re-assessment was put into

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1 place.

2 That has actually been fairly
3 useful, most of the time, for the health
4 assessments over time, this is generalization,
5 about five percent of soldiers returning have
6 said they've got any mental health problems.

7 For the re-assessment, it
8 traditionally has gone up overall, to about 12
9 percent, with marked variability between units.

10 So, especially if you may have a
11 Reserve unit or Guard unit that was hit
12 especially hard, you'll see it very, very high.

13 So, I think the bottom line answer
14 is there needs to be a range of times where you
15 do an assessment of the health of the force in
16 theater, after return and then, five, 10, 30
17 years later.

18 Personally, and I suspect I'm going
19 to get the hook, so let me just say, I don't think
20 this war and the effects of the war are going to
21 be over any time soon.

22 You look at Vietnam and you see

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1 people who are newly diagnosed with PTSD, what,
2 40 years later, now.

3 So, you're -- you know, yes, data in
4 theater is one window, but there is a lot of other
5 times, and then to repeat that we need to have
6 longitudinal data and we need to know which
7 treatment and preventions work.

8 Most of our data is just snapshot,
9 just look at what is out there now, and we
10 absolutely need to do more.

11 The good news is that Congress gave
12 the Military some money a few years ago, to do
13 some of that research, and hopefully, that will
14 bear fruition in the next few years.

15 MS. DAILEY: And we do need to wrap,
16 but one more question and we're --

17 CO-CHAIR CROCKETT-JONES: Do you
18 want to -- yes, I know, and it will be quick.

19 I just want to say as a layperson,
20 that I'm hoping that there is some nuance
21 understanding whether treatment is effective
22 for a small number of people, but not, you know,

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1 as a different assessment then, not effective,
2 and that if we were looking at the variations of
3 diagnosis in comparison to those, we might have
4 an idea of -- a better idea of what actually is
5 effective for very specific cases.

6 But that is the last thing I'll throw
7 out there, and thank you.

8 DR. RICHIE: Well, I --

9 CO-CHAIR CROCKETT-JONES: Very
10 much, for speaking to us.

11 DR. RICHIE: I absolutely agree.
12 So, hopefully, phase two, you know, I briefly
13 mentioned gender differences. There is almost
14 nothing out there on gender differences, nothing
15 out there on ethnicity, and race, very little.

16 Some of that is going to get into the
17 neurobiology, we hope, because if you know a
18 little bit more about the genetic make-up, then
19 can you target the intervention?

20 Having said that, I'm not going to
21 hold my breath. We've been talking about that
22 for a while, but I do think there is some low

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1 hanging fruit there, that can really improve,
2 especially in the areas around barriers to care,
3 because that is enormous.

4 Well, thank you all very much. I
5 really appreciate the chance to come and talk to
6 you.

7 CO-CHAIR CROCKETT-JONES: Thank
8 you very much, Dr. Richie, and now, we are
9 breaking for lunch. Thank you.

10 (Whereupon, the above-entitled
11 matter went off the record at 12:18 p.m. and
12 resumed at 1:02 p.m.)

13 CO-CHAIR CROCKETT-JONES: We will
14 be hearing now from Mr. Michael Conner, the Chief
15 of the Office of Warrior Support for the National
16 Guard Bureau.

17 Mr. Conner will be discussing the
18 services offered through the Warrior Support
19 Office, and updating us on the transition
20 assistance advisory program that he briefed us
21 on back in March 2011.

22 We have some information at Tab E in

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1 the briefing book, and I'm going to turn it over
2 to you, Mr. Conner.

3 MR. CONNER: Thank you. What I
4 started out with was the first slide that was
5 probably the longest one-second you've ever
6 experienced on there.

7 The slide show you're going to see
8 today, as soon as we get this thing up and running
9 here, I'm going to start out by giving you a small
10 glimpse of the same briefing slide, briefing
11 show that the TA -- that our wounded Warriors
12 get, and our recovering Warriors.

13 The TAA Program is a program
14 underneath the Warrior Support Office, in NGB,
15 and what I'm going to try and do is paint a
16 picture for you, on how that all fits together
17 and who does what, exactly.

18 First, I need to tell you that we're
19 a non-medical/non-clinical type program. So,
20 it's basically administrative support.

21 The slide show you're seeing is
22 based on a study that we did, that took a year,

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1 actually, going to the different CBWTUs and
2 WTU's, and watching most of the service members,
3 and if you've been there, a lot of times, it's
4 because they're hearing briefing, after
5 briefing, after briefing. Sometimes, they're
6 hearing the exact same thing after every
7 briefing.

8 We sat through all those briefings
9 and realized, we're talking about Veterans'
10 benefits because that is one of the programs we
11 offer back in the States, but so is the VA
12 briefer. The difference is, he is the local VA
13 guy from Virginia, if he's at that CBWTU, or New
14 York, if he's at that WTU there. So, what we
15 said was, "Let's quit boring our soldiers."

16 So, basically, what we started out
17 with is, I'm Mike Conner, a transition
18 assistance advisor. My role and my mission in
19 life is to provide direction to you, to the
20 benefits you've earned, and I do that with
21 compassion, because I am someone has been there
22 and been through that myself.

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1 A little side bar to that is, 85
2 percent of our TAAs are Veterans, 68 percent of
3 those are disabled Veterans. The remaining
4 balances are spouses of Veterans, and we
5 intentionally did that because we wanted that to
6 get -- to get that credibility from our service
7 members that we're taking care of.

8 The other interesting part for us
9 is, the oldest person is 78 years of age, the
10 youngest is 26 and our average is 54 years of age.

11 So, to get a little bit of that
12 fatherly/grandfatherly relationship going on
13 with the service members they're helping, and
14 that helps tremendously, rather than someone in
15 uniform, and they're looking at their rank
16 versus the guy that supports that.

17 Now, this is what we tell the service
18 members. Again, the study, it sounds strange,
19 it's not about making fancy charts, but it's
20 about connecting with the audience.

21 This is exactly how most of our
22 recovering Warriors feel, when they get put into

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1 this system. There is just so much out there,
2 and they're not sure how to get through it.

3 Our organizations collectively
4 provide the best quality of service of any other
5 organization worldwide, but somehow, we just
6 never seem to be able to communicate that to our
7 service members, and they're finding out about
8 something by two other service members talking.

9 The way our TAAs can help that
10 individual is they cut through the red tape,
11 because they've been there, they know it, they
12 know what it's like, and they know who to call,
13 when they're running into a problem.

14 Some of the challenges we run into
15 at the CBWTU is, they know the network there, but
16 when they go back to their state, that is a
17 different network, and that is where we come in,
18 because we know that network there, and we know
19 how to link them together.

20 As we brief them, we talk about each
21 one of the different services we provide. The
22 order of these things that were in the chart are

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1 based on the survey we did over the past year,
2 what is the most important service that that
3 recovering Warrior wants to know about, and they
4 ranked health and life insurance number one.

5 Most of us in uniform, most of us as
6 Military civilians, were floored by that. We
7 just couldn't understand why they would want to
8 know about that.

9 When we dug a little further, what
10 we found out was, the Affordable Care Act,
11 remember that was all over the news about a year
12 or two ago.

13 So, our Veterans, as they were
14 coming back, they're looking at now, they were
15 in TRICARE while they were deployed. Now,
16 they're at the CBWTU, collecting TRICARE, but
17 what is going to happen to my family, when I get
18 back, and how does the Affordable Care Act impact
19 on there?

20 This was astonishing. I mean, it
21 sounds like a little thing, but it was
22 astonishing to most of our networks, and again,

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1 putting them in the order of how the service
2 members requested it, made it more important to
3 the individual, because now, we're addressing
4 their needs.

5 The second one was Veterans'
6 benefits. The third one then was education and
7 training, and what the biggest interest our
8 individuals have there is, how do I transfer my
9 benefits to my family member? Whether they had
10 a degree or not didn't matter. Most didn't, but
11 still wanted to take care of their family,
12 usually their children they were asking about.

13 The next thing we talked about for
14 them is financial assistance. That seems to
15 have gone by the wayside, I shouldn't say by the
16 wayside. It's not as important as what it was,
17 at one time.

18 About four or five years ago, the
19 financial impact was really the most stressful
20 for that recovering Warrior, and now, it doesn't
21 seem to be that stressful. I can only equate
22 that to the services training those folks before

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1 they actually deploy. So, they're prepared for
2 those financial changes.

3 Then finally, disabled Veterans
4 briefed -- benefits, you'll see this in a later
5 slide, but most of the folks really didn't want
6 to talk about this, because they didn't want to
7 admit that they're disabled Veterans. That
8 takes time for them, while they're at the CBWTU
9 or the WTU, to really kind of face that.

10 The last was employment assistance.
11 They really don't seem to be that concerned about
12 that. They just figure they'll find a job,
13 everybody does in their mind. I know that has
14 changed now.

15 A career change, this has impacted
16 a number of our folks, because they're
17 wondering, what am I going to do next? This is
18 what I did before I left. This is what I did for
19 the last year in combat. This is what I did for
20 the last year, or whatever, I did CBWTU. Now,
21 how do I make that apply to the civilian world,
22 going back, in a meaningful way?

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1 Legal assistance was down towards
2 the bottom. Most of the folks have kind of
3 reduced their legal challenges they've had,
4 during deployments, and the last thing was
5 relocation assistance.

6 There are a few service members,
7 Guard and Reserve, that do look to relocate,
8 especially if it's based on their medical needs.

9 Single service member might need to
10 go back to mom and dad, because of their
11 injuries, or they just want to move the whole
12 family near their family because of their
13 injuries, and then they have that family support
14 network.

15 Then we close, or we finish up a
16 little bit by telling them that we have TAAs
17 located all the way through the United States.
18 There are 65 of them. Some states have two.

19 The reason we talk about this is, at
20 those CBWTU musters, there is folks from seven,
21 eight, maybe 12 different states, and that way,
22 when they see me standing up there and saying,

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1 "I'm from Virginia," they know that there is
2 other folks out there.

3 And then we close again by reminding
4 them who we were, what we can do and of course,
5 we thank them for their service.

6 This is a five to seven minute
7 briefing, and that is it, and then we break out
8 into small groups, where everybody from Illinois
9 over here, Indiana, here, and that TAA from that
10 state is there, and they sit with their group and
11 talk about their specific issues, and how that
12 state can actually help them.

13 Now, if we can do a little quick
14 switch over there.

15 This has proven very successful to
16 us. Part of our surveys were, do they like the
17 briefing or do they like the briefing with the
18 one-on-one, the small groups, and they seem to
19 like that mix, because they get a quick overview
20 of some things, and then they get to talk to their
21 -- like I said, their state one-on-one, and find
22 out what is going on.

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1 Most other briefers stand up there
2 for an hour, go through a series of slides that
3 are just too busy, too much information. The
4 nice thing about having the topics, we can
5 address any changes.

6 If there is changes in the GI Bill,
7 which does happen regularly, we can address that
8 there, rather than having the pre-printed slide
9 without those changes, and you see that a lot.
10 You end up confusing the service member.

11 The other nice thing is, we talk
12 about those nine benefits that we offer. Keep
13 it simple. Those are the nine things we can help
14 you with.

15 Now, I did it backwards. Let's turn
16 that around.

17 I talk briefly about this maze of
18 confusion. One thing that the Office of Warrior
19 Support really appreciates, and just can't talk
20 kindly enough about, is having a CBWTU, because
21 our Guardsmen, our Reservists are not like the
22 active component.

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1 Everybody kind of acknowledges that
2 and nods their head, but the CBWTU is showing it
3 in practice, where that service member can go
4 back home and get the need -- the medical need
5 they have, and still be with their family.

6 That is tremendous, and Dr. Goedde
7 did some of our studies. We talk about this, you
8 know, you just can't fix community based issues
9 with installation based solutions. It doesn't
10 work, in the community. It works well in the
11 installation.

12 How do we find our recovering
13 Warriors? First and foremost, we do that at
14 musters. There has been talk to try to cut that
15 back, you know, for funding reasons, for us to
16 not go, but that is too critical because that is
17 when they get to meet the folks face-to-face, and
18 there is folks that just kind of sometimes bounce
19 out of the woodwork, or you never even knew
20 existed.

21 The second is, in the National Guard
22 side, we communicate with -- they have a medical

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1 staff that usually follows that line of duty,
2 follows the injuries, takes care of all that, and
3 they normally have a roster that shows who is in
4 the CBWTU or WTU.

5 So, we first start there, then with
6 them, and make sure we find them at the muster.
7 Not all service members will go to the muster.
8 I know they're required to attend at least one
9 or two in some cases, but somehow, they tend to
10 slip through the cracks, for all sorts of
11 reasons.

12 This gives us that checks and
13 balances by going to both organizations, to see
14 where that soldier is at.

15 Then for the United States Army
16 Reserve, we either see them at the muster, and
17 there are some active duty folks at that muster
18 also. Those numbers seem to be decreasing, but
19 there still are USAR folks there, and that's when
20 we see them, either at that muster or a lot of
21 our TAAs will support them in their state, at
22 their yellow ribbon events.

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1 Sometimes, they have a demob, family
2 days, whatever it is, and then they also go work
3 with the USAR full-time staff, and say, "Do you
4 have anybody out there that we need to be looking
5 after for you?"

6 So, that is how we find them. Our
7 goals while we're there, the first thing is to
8 identify any issues they have before it
9 escalates.

10 That seemed to be our biggest
11 success right now, because sometimes, when they
12 first get in there, they're kind of afraid to say
13 things to the medical staff because that is the
14 guy that may not let me stay in, or might give
15 me some kind of profile, and when they first have
16 those injuries, that is the last thing they want
17 to talk about, usually.

18 It helps establish a rapport, rather
19 than waiting for the service member to come back
20 to the state, in whatever condition, whether
21 they're being discharged or being returned back
22 to duty, we contact them beforehand.

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1 The last -- the next thing is the
2 state specific program benefits. That is the
3 one uniqueness for us, in the Guard and the --
4 well, more so, the Guard, and some in the
5 Reserve.

6 Some state benefits will say, if
7 you're a resident of Iowa, this is what you get.
8 Other things are, if you're in the Guard, this
9 is what you get. Do you have a question, sir?

10 MEMBER DRACH: What do you use as a
11 base for identifying your state specific
12 benefits?

13 MR. CONNER: I am not sure what you
14 mean.

15 MEMBER DRACH: Well, each state has
16 different benefits.

17 MR. CONNER: Correct.

18 MEMBER DRACH: So, you mentioned
19 Iowa. So, if you're looking at Iowa, what is the
20 nucleus of your information? Where does it come
21 from?

22 MR. CONNER: Each state TAA is

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1 responsible to find out the resources in their
2 state, and they do that through what we call a
3 community coalition, and they go out basically,
4 networking, and they start finding out what is
5 going on out there.

6 Most of the time, as I said, these
7 guys are -- well, 90 percent of the time, these
8 guys are Veterans, and they usually are a Veteran
9 from that state.

10 So, they kind of already know about
11 those things, and then sometimes, they're
12 involved, not in the legislative process, but
13 sometimes, the State Legislature will ask
14 questions of the Adjutant General, "What can we
15 do," and then they kind of fish things up that
16 way. Does that answer your question?

17 MEMBER DRACH: Well, yes, part of
18 it. Do they use the National Resource Directory
19 at all?

20 MR. CONNER: I'm glad you brought
21 that up.

22 Yes, they do, in fact, what we really

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1 like about the National Resource Directory,
2 because it's Google-based, when you do your
3 searches, in the past two years, our TAAs have
4 been the top three, when you start looking for
5 state resources.

6 So, they come up quite regularly,
7 and that -- you know, you pay for that on Google,
8 on the National Resource Directory, it's free,
9 and what we're finding with the younger
10 generation is, it's the, "I need the answer
11 quick," the Google search, type in the word or
12 three words. They don't want to read a website.

13 So, what they do is, they tend to go
14 the National Resource Directory, and then they
15 start looking at some of the data, and say, "You
16 know, it's just as easy to pick up the phone and
17 call somebody," and that is what happens for us.

18 MEMBER REHBEIN: Sir, some of our
19 National Guard soldiers and more so, Army
20 Reserve live in one state and drill in another.

21 MR. CONNER: That is correct.

22 MEMBER REHBEIN: Which state

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1 benefits do you use?

2 MR. CONNER: That varies, by state,
3 actually. It depends on how the legislature
4 writes those laws for those benefits. They
5 might say, all residents of Illinois, for
6 instance.

7 So, you could be drilling in the
8 Indiana Guard, doesn't matter. You're in New
9 York, excuse me, you're in Illinois, so, you get
10 Illinois benefits.

11 Other ones will say, you must -- it
12 applies to all Indiana Guardsmen. So, then it
13 doesn't matter where you live.

14 So, each benefit could vary greatly,
15 as far as the requirements. Does that answer
16 your question?

17 One thing I will say is, our TAAs
18 work very closely with each other. So, a lot of
19 times, you have those border states, they'll
20 pass people off, so to speak.

21 Sometimes, they'll find, we had one
22 where somebody was driving from one state to

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1 another and along the way, ran into some
2 problems, and that state took care of them, and
3 then found out who the TAA was, you know, what
4 state they were from, and connected them with the
5 state, and then got that state to give them some
6 more resources.

7 So, and then overall, we're just
8 kind of that safety net. I know everything is
9 suppose to work perfect. We all know that
10 sometimes we have challenges. Sometimes,
11 they're self-inflicted. Sometimes, they're part
12 of the organizational challenge. But that is
13 what we look at ourselves as, that safety net,
14 and we have a pretty good success rate at -- at
15 finding those resources for them.

16 Now, how do you measure that? Three
17 ways. We started last year, customer
18 satisfaction surveys.

19 The studies and research, we have a
20 lot more going on, kind of a sidebar to this.
21 The VHA offers free healthcare for five years,
22 for combat Veterans, and we're at an 89 percent

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1 rate of usage on that, for the Guard. But we
2 measure that by name and if you're not enrolled,
3 we get you enrolled.

4 So, these studies and the research
5 we go through, finding out who is slipping
6 through the cracks and how, we're able to fill
7 in those cracks, and that is one of the things
8 we did with this CBWTU muster, and then
9 testimonials.

10 We tend to get emails back, and when
11 you're a safety net, it's easy to become kind of
12 lethargic because you're always hearing good
13 things, because by the time we get somebody,
14 they're so frustrated with everything else, it's
15 easy for us to look really good.

16 But fortunately, our guys just move
17 onto the next one and say, "Let's treat that one
18 the same way." But those testimonials go a long
19 way for us.

20 The satisfaction surveys, from the
21 recovering Warrior, this is just a one-year
22 glimpse, it's ending in December. We did this

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1 for one year. When the report is done, I'll turn
2 it over to Ms. Dailey, and then I'm sure she'll
3 get that to the committee.

4 But then you'll see all the
5 statistics, and we're looking at like the 15th
6 or the 20th of January, where that will be
7 actually published.

8 From the Guard and Reserve staff,
9 remember I said we go back and work with the
10 full-time staff for the Reserves and for the
11 Guard. We do it with their medical staff. They
12 seem to be pretty pleased with us.

13 In many cases, we help them with
14 their workload. So, that is why there is such a
15 high number. Yes, ma'am?

16 MEMBER MALEBRANCHE: Just because I
17 am not sure of the data and percentage, it's 95
18 percent are satisfied of what kind of a return
19 rate on your surveys?

20 MR. CONNER: What we did was, we
21 gave a three series of one, two and three rating,
22 one, obviously being the highest, and 93 percent

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1 said one. I apologize for not being clear on
2 that. Thank you.

3 MEMBER MALEBRANCHE: I'm just
4 wondering, because you know, when you do
5 surveys, you get that percentage, but what was
6 your return rate on all the surveys put out?

7 MR. CONNER: The return rate? I'm
8 sorry. I think we were around 78 percent on
9 average, between all the CBWTUs.

10 But keep in mind, you have a
11 collective audience there. It's not -- we're
12 not sending out a survey in the mail or an email.
13 We're all sitting here and we hand these out, and
14 then there is somebody sitting in the back,
15 collecting them.

16 We do have a pretty good rapport,
17 where we -- I know no one likes doing surveys,
18 and we're being surveyed to death, but we explain
19 to them why, and then we follow up to say, we
20 changed this because of what you said.

21 So, it seems to get some validity
22 there, when we do it that way, and then

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1 sometimes, the WTU's, CBWTU staff aren't real
2 fans of ours, and I say this in the nicest way
3 possible.

4 They have their mission they need to
5 do. They want to get each of those service
6 members through the stations, what they have to
7 take care of that weekend.

8 But when you starting saying, "Okay,
9 your hour briefing is now 15 minutes, because we
10 have to do this or this," then it just takes the
11 whole thing and throws it in to, you know, little
12 quagmire there.

13 So, we get a little frustrated. Our
14 guys kind of push back. We do have one CBWTU
15 right now, that all they want us to do is have
16 a booth and stand back in the corner somewhere,
17 and we're kind of negotiating that back and forth
18 with our leadership, either you want us or you
19 don't.

20 We don't want to see ourselves are
21 fillers. Not just because of ego, but because
22 of -- we have a service, a valuable service we

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1 can provide.

2 So, sometimes we do argue a little
3 with them, so, I think that is why our rating is
4 a little bit lower.

5 On our study, I came in here about
6 two years ago in the job, and what I looked at
7 was, what is our purpose? What is our
8 objectives at the CBWTU musters, and it varied
9 by state, because they all kind of did their own
10 thing at one time. It wasn't really uniform.

11 So, the first thing we did was
12 identify what our objectives are, and that is
13 what we measured. We did a Warrior in
14 transition survey with them and said, "Okay,
15 what are our objectives, and are we meeting
16 them?"

17 The second thing we looked at, the
18 presentation, so, standardization. We have one
19 gentleman from Wisconsin. He is an excellent
20 presenter. He is extremely entertaining. If
21 you looked at his slides, without hearing his
22 presentation, you had no clue what he was talking

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1 about.

2 A lot of football logos on, things
3 like that, and I'm not picking on the individual,
4 but that is how we've been trained over the
5 years, in the Military, do it -- different ways
6 to get someone's attention.

7 So, what happened was, when we took
8 all the presentations and put them together, we
9 started to realize, what is our message, and it
10 needs to be standardized, and that is what you
11 saw in my first presentation, and I took it, you
12 know, went quick there, five minutes or so, but
13 it took us a while to get to that point.

14 The slide with the red tape, that
15 thing, as soon as you put it up, and we did the
16 surveys of those studies there, as soon as you
17 put it up, everyone could relate to that, because
18 we all talked about that in the Military one
19 time, either waiting in line or cutting through
20 the red tape.

21 So, each slide, we went into
22 meticulous measurements for, and then the

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1 learning was out last measurement.

2 If we talked about those services we
3 offered, how did we know if it reinstated or if
4 the individual retained that, or was it just
5 another briefing, and then walked away?

6 So, we did, from the old Army side,
7 and from my background, we did the pre-test and
8 the post-test. We asked them up front, what
9 they knew about, and then we ask them at the end,
10 what they know about now, and that was like a 99
11 percent increase in their knowledge.

12 They couldn't name all nine services
13 right up front, by the end, they could name at
14 least seven of them.

15 So, it showed a lot of retention of
16 what we were talking about.

17 You'll see on -- I laid on your --
18 I think I had everyone, the business cards we
19 use. You'll notice, it's not my name on there,
20 because I don't use those. I have a different
21 one, since it's our TAAs.

22 But if you remember that slide show

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1 I did in the beginning, when I had my name, it
2 was a dog-tag. So, again, that branding, if you
3 will, where they start seeing that, their name
4 tags look identical to that, and it draws their
5 attention in.

6 All the things we need to do, to
7 retain their knowledge that they get, and who to
8 call when they need help.

9 I'm sure you're aware that some of
10 the CBWTUs now are going through a transition
11 where it used to be one central location. A lot
12 of them now, seem to be going to each state CBWTU.
13 They'll have their musters that way.

14 I think they're looking at a cost
15 factor. It's cheaper than bringing everybody in.

16 That is becoming a challenge for us,
17 because figuring out who is where, when, because
18 even though it says the State of Indiana,
19 sometimes, they'll send guys from Illinois,
20 because it's a border state.

21 So, then we didn't have our Illinois
22 guy there, because we thought it was just going

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1 to be Indiana, that kind of thing.

2 So, we're just working through that.
3 That is a little bit of a challenge we have, right
4 now, and their delivery methods are changing.

5 What is happening is, because
6 they're moving them out to the states, they're
7 not right -- right now, they are not as closely
8 structured, as they were before, because they
9 did it the same way at the CBWTUs they had
10 established.

11 When they put it out in the states,
12 sometimes the state leadership wants to get
13 involved and suddenly, the Adjutant General
14 wants to talk for 20 minutes, and that really
15 throws their structure into a little quagmire,
16 too.

17 The expectations of the Warrior,
18 recovering Warrior, that is a big challenge.
19 They hear a lot of things when they're injured
20 from each other. They hear things while they're
21 at the CBWTUs. They read things.

22 So, what is their expectation? How

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1 are they -- how do we manage that, and that is
2 basically, just talking to them and finding out
3 what it is, and some guys think they're going to
4 get a big check somewhere, and it doesn't happen
5 that way.

6 So, we need to let them know that,
7 what the rule book says, and then competing
8 activities, and that is what I was talking about
9 where we're in here doing a briefing, talking
10 about programs, and at any given time, people are
11 coming and going because they're going to meet
12 with their counselor.

13 That is important. Don't get me
14 wrong, but we need to find that balance on where
15 that is, and some CBWTUs, it becomes a
16 distractor, and for instance, in California, the
17 idea is well, if you don't have anything else to
18 do, go to the briefing. Well, they find other
19 things to do, obviously.

20 Okay, the common request. The
21 first that they -- it's a phase level thing, and
22 you've probably heard something similar to this.

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1 The first thing is, they want to know
2 how they go back into the service. They don't
3 want to get out. They don't want to be put out.
4 They want to stay in.

5 At some point, they start realizing
6 that may not be the case for some of them.

7 They also talk about unresolved unit
8 issues. This sounds strange, but one of our
9 most common requests are, equipment.

10 The service member was injured.
11 They were EVACED out. Their equipment was taken
12 by different people. They're worried that
13 they're going to have to pay for that equipment,
14 and I know that is in the big picture, the
15 services are saying, "Relax," but because of our
16 conditioning and our training, that soldier, the
17 airmen, that sailor, that is what they're
18 thinking of, all of them. Marines too. They
19 want to know what is going to happen? Where is
20 it? Am I going to have to pay for it?

21 What our guys tend to do for the
22 Guard folks and the Reserve, when we get back to

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1 our state, we'll contact their leadership, find
2 out what went on. You can usually trace it, and
3 then go back and put that service member to ease,
4 that look, you're okay, no matter what it is.

5 I already talked about the health
6 insurance. That was a big issue for the folks,
7 from the service members, from their family
8 benefits. Then they want to know about VA
9 benefits. They start to learn about the VA very
10 quickly.

11 The challenges we're running into
12 is, like any large organization, the VA's
13 communicate differently.

14 So, if I talk to you as a VA
15 counselor, you're telling me one thing, or I'm
16 hearing -- but the way you say it, I'm hearing
17 it differently than the way you tell me.

18 So, because they're at the CBWTU,
19 they'll get a briefing from let's say, Alabama,
20 because that is the muster they went to.

21 Then when they go back to their state
22 in Florida and talk to the VA there, then the VA

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1 says, "Well, that is not quite true," and what
2 also can get confusing is, then you have your
3 state VA benefits, and the service members can't
4 delineate between the two, at first. They just
5 don't understand it. They thought VA is
6 everything.

7 So, that is the one thing I told you
8 earlier, about the education and training
9 benefits, and most of it has been, "How do I pass
10 it on to my family?"

11 Interesting story with the Marine
12 Corps. The Marine Corps was looking at trying to
13 save some funds. So, they were looking at doing
14 away with the benefit, the tuition assistance
15 benefit. You get that while you're on active
16 duty, and their logic was, "Well, yes, but you
17 have the GI Bill, so you still get the
18 education."

19 Well, that quickly -- that changed
20 because obviously we -- they want the best of
21 both worlds. I can still use the tuition
22 assistance and get my degree and then take the

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1 GI benefits and give it to my family.

2 Then like I said, financial was the
3 last one. It hasn't been as significant as it
4 was couple years ago. It seems to really kind
5 of backed down a little bit, and all I can do is
6 commend the services for the training, because
7 I'm sure that is what is helping them before they
8 deploy.

9 Our staffing and our case load, 65
10 transition assistance advisors, under a
11 contract. I know that sounds like, how do those
12 so few guys, do so much?

13 Remember, I told you the age
14 category? They work smarter, not harder. They
15 really do, and because they know the folks to
16 call, it goes a lot quicker, than some young
17 soldier running around, trying to find the right
18 guy to talk to.

19 Four of the states actually have a
20 state employee or ADOS people. They're on
21 active duty orders, basically for that time
22 period, or active Guard and Reserve, and that

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1 varied by state. That is a state initiative.
2 That wasn't done by the national level. State
3 just said they needed to, for whatever reason.

4 The case load, it has gone down.
5 The one to 64 for recovery Warriors, you'd ask
6 for a break down of the three components there
7 that we deal with, primarily deal with. We
8 think it went down. It seems like there has been
9 a -- kind of a cleaning up, so to speak of the
10 CBWTUs.

11 They're looking a little closer.
12 That could be because you guys are visiting, but
13 they're starting to kind of say, "Okay, this guy
14 has been here a little bit too long. We need to
15 start managing a little better," or it could be
16 because their ratios have gone down a little bit,
17 so, it's easier for them to manage that way.

18 So, I think that is why our numbers
19 went down. We don't know any other reason why.

20 Our separating members actually
21 went up from last year, and the reason that went
22 up, with all the additional funding that was

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1 available, the services put a lot of people on
2 orders, temporary orders.

3 September came along, and all that
4 went away. Those are separating service
5 members, and they're entitled to benefits, and
6 since we do transition, not just for the
7 recovering Warrior, that increased our
8 workload.

9 Then you ask how many of the workload
10 we have, at this -- if I understood that
11 correctly, at the CBWTU, the recovering
12 Warriors, being on Title 10, that is about 75
13 percent of our workload. Does that make sense,
14 for the Title 10 folks? Okay.

15 One of the -- the last question, I
16 think, or one of the end -- ending ones, was
17 basically, when does it start and when does it
18 end? When do we kind of close the book, so to
19 speak on that recovering Warrior, and basically,
20 we don't, because what we're finding is, folks
21 that we may have assisted six or seven years ago,
22 or didn't assist, suddenly are coming in, with

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1 the same issues that other folks had, when they
2 came back, and I think from the medical side,
3 you're seeing the statistics there.

4 I know that my -- the previous
5 presenter was talking about Korea, they were
6 fine, until they went back to Korea. They started
7 smelling the Korean food, and then they had some,
8 you know, memories back there.

9 Well, I think the same thing
10 happens. Once they settle down, they get home,
11 and they start thinking about things, we're
12 seeing more and more guys come back in around the
13 six or seven year mark, saying, "We need help."

14 So, we just -- because we're part of
15 the State Guard organization, the Adjutant
16 Generals and the Governors say, "Look, they're
17 always ours, so, we'll always do whatever we can
18 to help them."

19 Any questions?

20 MEMBER MALEBRANCHE: How do you
21 coordinate with the yellow ribbon program, you
22 mentioned up there, that go to yellow ribbon

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1 events, because if you're in some states that are
2 large states, and you have one, how do you
3 coordinate to get out to those different events?
4 Is it with the National Office, or how does that
5 work?

6 MR. CONNER: What happens is, at the
7 local -- each state, when they know there is a
8 yellow ribbon event going on, according to the
9 National Guard anyway, the TAA must attend a 30
10 day event. That is a mandatory event. The
11 other ones are optional, but that is mandatory.

12 So, what they do is, they coordinate
13 in most cases, they're in the same room.

14 So, the yellow ribbon coordinator is
15 sitting across from the TAA, and then they're --
16 the leadership there have operational boards,
17 and they say, "Okay, these are the dates that
18 we're expecting coming back. These are the
19 projected dates for the 30 day, the 60 day, the
20 90 day."

21 That is how they do it internal in
22 the Guard. Then when it comes to the other

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1 Reserves, that is where we go out to that
2 community coalition, and when we go visit the
3 Navy Reserve Center, for instance, we'll find
4 out from them, when their 30 day event is, and
5 then make sure our schedule can -- we can fit
6 that.

7 MEMBER MALEBRANCHE: Do the states
8 -- does each state then have a relationship with
9 the National Yellow Ribbon Office?

10 MR. CONNER: They do.

11 MEMBER MALEBRANCHE: The
12 re-integration program office?

13 MR. CONNER: It's the same thing.
14 The yellow ribbon person, just like I described
15 at the state level, she sits across from me, and
16 we're constantly going back and forth on how we
17 can help each other.

18 The same with ESGR sits across from
19 us, and we all coordinate our resources and our
20 efforts, and then they do that in more detail,
21 obviously at the state level.

22 MEMBER MALEBRANCHE: And the

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1 training for the TAAs is provided by whom?

2 MR. CONNER: The training now, is --
3 when I came onboard -- there is a pre-separation
4 training count -- or counselor training, that
5 DoD operates through the Office of Warrior Care
6 and Transition Policy. Dr. Kelly is going to be
7 here, I think tomorrow, to talk to you about it.

8 They conduct the training. It's --
9 they contracted with the University of Colorado,
10 Denver.

11 It's a four and a half day event,
12 where they go through the whole -- all of those
13 nine benefits in much greater detail, and we have
14 all but 10 of our guys trained, and those 10 are
15 going to be trained January 7th, is the next
16 training event for us.

17 MEMBER MALEBRANCHE: Thank you.

18 MR. CONNER: You're welcome.

19 MEMBER REHBEIN: You said there is
20 no structured end date. Does that tell me then,
21 that for the rest of their lives?

22 MR. CONNER: Yes.

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1 MEMBER REHBEIN: Whether they're in
2 a Guard or Reserve unit or not?

3 MR. CONNER: And we've -- you know,
4 everybody likes to talk about that one guy they
5 helped, or the one situation.

6 Idaho, when I went out to visit with
7 her, she's a retired nurse. Her big story was
8 a picture of a man who was 94 years old, a World
9 War II Veteran, and they got him, his benefits
10 that he didn't ever apply for, and got him
11 actually in the nursing home. He was very ill,
12 and then took care of the burial. It all happened
13 kind of quickly.

14 So, and I don't even think he was in
15 the Guard or Reserve. I think he was, you know,
16 from World War II. He was just drafted.

17 So, anyone -- that states are really
18 good about this, and these are the Governors and
19 the Adjutants General, anybody in that
20 perimeter, that border, they take care of.

21 CO-CHAIR CROCKETT-JONES: Do you
22 have a system for once you've helped someone, do

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1 you go back and check in on them or is that sort
2 of up to the TAAs themselves?

3 MR. CONNER: We just -- the way we
4 do this is, the TAAs, at one time, didn't do the
5 follow up. They kind of relied on the service
6 member. Again, I think it was the ratio. They
7 just couldn't follow up with everyone. It's the
8 old 90 percent/10 percent thing.

9 Our customer satisfaction surveys,
10 we do that at our level. We reach out to the
11 individuals and say, "Hey, you just -- so-and-so
12 just did this. How did it go for you," and then
13 we have their standard questions.

14 But that seems to be giving us the
15 good feedback, and now, it -- rather than telling
16 the TAA, "You must go do this," they know that
17 is a report card.

18 So, on their own, they'll make sure
19 that they're taking care of it. I mean, because
20 they know that now, they're being followed up.

21 Before, if somebody gets to be a
22 pain, and some service members can keep coming

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1 at you, and it can get overwhelming, now, they
2 know that somebody up there still may be sending
3 out a survey and that guy's opinion counts like
4 everyone else.

5 MEMBER MALEBRANCHE: I think
6 because so often, Guard and Reserve are
7 Veterans, active duty Veterans, active duty,
8 they're back and forth, we at the VA, have
9 records in our electronic.

10 How do you track -- do your TAAs,
11 first of all, I guess do they track
12 electronically or have any kind of records from
13 the state, on any of your members? Do they? Do
14 they keep any kind of records, like they
15 counseled them, so, they could go back and find
16 out what they know or --

17 MR. CONNER: That is kind of --
18 that's been a challenge for us, because of the
19 Privacy Act and HIPAA, in certain areas.

20 So, there are some things that the
21 service member will tell the VA medical staff
22 that is treating them, and then there are some

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1 things they'll tell the Military staff, medical
2 staff it's telling them, and right now, those
3 don't talk to each other, unless the individual
4 is applying for some kind of medical benefits
5 from the VA, benefits and compensation, and then
6 packets are shared back and forth, the actual
7 medical records are shared.

8 Admiral Hunter, she is a public
9 service nurse in the -- she's actually assigned
10 to the National Guard. She has kind of taken
11 that under her wing, right now.

12 We have an issue in Wisconsin, where
13 it was something like that, where an individual
14 was telling the VA, some medical things that
15 would have precluded them to be doing certain
16 Military duties, and needed for the safety of
17 others, that information needed to be shared,
18 but because of HIPAA, it was not.

19 Now, she is working on trying to
20 figure out, how do we do -- like a duty to warn
21 type concept.

22 Other than that, as far as sharing

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1 records, it's only if the -- if the VA doctor
2 would sign a request saying, "I need to see your
3 dental records, medical records," whatever, and
4 vice-versa.

5 MEMBER CONSTANTINE: I have a very
6 specific question, and maybe you -- you may not
7 know the answer.

8 But you talked about the GI Bill.
9 I've had some recovering Warriors recently ask
10 me, how easy it is for them to transfer their GI
11 Bill benefits to their family members, if
12 they're going to be medically retired, because
13 they don't really have time to incur anymore
14 service.

15 My understanding was, it's pretty
16 easy, and they don't have that same requirement.
17 Do you know if that is accurate or not?

18 MR. CONNER: It is very easy, and
19 typically, what our guy will do, or the Guards,
20 have a state education officer, and they'll walk
21 you through on a website, either while you're at
22 home on the phone, or if you're in the office,

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1 and it's very simple to go into the website, and
2 just transfer it.

3 It is one of the more user-friendly
4 databases or systems out there, yes.

5 The challenge for us is, just for
6 them to know that window that they need to do it
7 before they get discharged, that actual
8 transfer, and that is where we sometimes get a
9 little, you know, sketchy.

10 MEMBER CONSTANTINE: Thanks.

11 MR. CONNER: You're welcome. Did I
12 finish my time early? Look at that.

13 MS. DAILEY: I got Mr. Conner in
14 here for an hour, ladies and gentlemen. This is
15 the safety net, as applied to the National Guard.

16 Tell me if I'm stepping wrong here,
17 Mr. Conner, and just not only the National Guard,
18 but as Mr. Conner says, he's also doing Navy,
19 re-deploying and de-mobilization units that
20 come back to a state, TAAs attend their -- their
21 30 day yellow ribbon.

22 And so, they are not just covering

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1 in a state, the Army National Guard or the Air
2 National Guard, but when there is a Reserve unit
3 and active duty, former active duty, too, if they
4 come and they retire in the state, and live in
5 the state and they reach out, the TAAs are
6 providing them services, also.

7 So, I just -- I wanted to -- I've had
8 Mr. Conner in here before. He goes out on -- he
9 comes with us to the Joint Forces Headquarters.
10 He has in the past, and came to us with one
11 Massachusetts community based Warrior
12 transition unit.

13 MR. CONNER: Most recent.

14 MS. DAILEY: Yes, and then I moved
15 one around on him, and I think he arrived and we
16 didn't, but be that as it may.

17 I just want everyone to get a good
18 feel for this safety net that is out there. It's
19 a national contract. It's run out of the
20 National Guard. You function a lot out of the
21 family support centers, correct? Is that where
22 most of your TAAs --

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1 MR. CONNER: Yes, and that is
2 primarily because there were so many contract
3 positions put out for ESGR and all these other
4 benefits that were coming up.

5 The only Government employee,
6 rather than the personnel colonel RSO, was the
7 state family program director.

8 So, you had to have some Government
9 official in charge. So, that poor guy is
10 getting overwhelmed with all these different
11 contracts. But yes, that is why they're under
12 that.

13 So, and I need to just -- did you have
14 a question?

15 CO-CHAIR CROCKETT-JONES: I do have
16 a question.

17 If you're -- do your TAAs have a
18 group or a regional like sharing sessions, at any
19 intervals? Do they come up with like a best
20 practices kind of thing that they share amongst
21 themselves?

22 Because I am wondering, state to

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1 state, I know that the variation on some basic
2 issues, Massachusetts has check the box on your
3 state tax return, to fund state, you know,
4 Veteran's benefits.

5 I'm just wondering if those kinds of
6 ideas are -- since these people are such experts,
7 are they getting transferred best practices, or
8 is any of that kind of generated and happening?

9 MR. CONNER: It has, in a number of
10 cases. But I need to first qualify best
11 practice, because as an organization, we tend to
12 throw that term out there a lot. What works in
13 one state may not work in another.

14 Connecticut, for example, I went up to
15 visit with the TAA there, very nice gentleman,
16 took me all around, showed me everybody in the
17 headquarters he is in.

18 They all knew him, really, which was
19 amazing, and then in a conversation over lunch,
20 he says to me, "I used to do everybody's OER in
21 that whole building."

22 Now, he is a retired General. So,

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1 of course, they know him, and of course, when he
2 walks in the door and says, "We need to help this
3 service member," everybody says, "Yes," even
4 though he's wearing civilian clothes.

5 You can't copy that in Pennsylvania.
6 I mean, it's just, that is different
7 relationships that they have.

8 Wisconsin has a great relationship
9 with the TAG and the Governor, our TAA there from
10 a previous life.

11 So, they can do a lot more. So, the
12 first thing we do when we talk about a best
13 practice is, we identify the measurements, and
14 we go through and say, "Can I replicate this in
15 another state?"

16 If it's based on relationships, then
17 it's just a sharing of information, you may want
18 to think about this.

19 If it's truly a best practice, where
20 this can be replicated anywhere, then we can say,
21 "Okay, we're going to start doing this," with
22 minor modifications for that local state or that

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1 local area, and then it seems to work out much
2 better that way.

3 The musters, the other big plus
4 about the musters, it gets everybody together.

5 So, typically, the states that get
6 together for that muster, in Illinois, for
7 instance, they're in the same region. So, they
8 actually go to dinner, and to be honest with you,
9 I thought this was just a show for the boss,
10 because they said we'd go to dinner Friday night,
11 before everything starts.

12 I go in there, and they have dinner,
13 they're laughing, having a good time, and then
14 somebody says, "Okay, I have an issue with this,"
15 and then they sit there and just share whatever
16 has gone on, and they come up with some ideas,
17 and I honestly asked them afterwards, you know,
18 "Was this a show because I was here," and
19 honestly, they said, "No, we do this every single
20 time."

21 So, those musters allow that
22 informal sharing of information, and problem

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1 solving. So, that is from a hidden benefit for
2 us, participating in the muster.

3 MEMBER MALEBRANCHE: One thing you
4 mentioned, like one was a retired General, one
5 is a retired nurse, but what is the basic
6 qualifications for a TAA? Isn't it
7 significantly variable?

8 I mean, what is the -- as far as the
9 level that they're coming in?

10 MR. CONNER: It is, and we take all
11 kinds, so to speak.

12 Mainly, everybody comes in with a
13 different set of skill sets, whether it's an
14 education. We have a number of folks that have
15 advanced degrees, in counseling, even though
16 that is not what we do, but that gives them a
17 background that normally wouldn't have.

18 We do look for Veterans, number one.
19 Any other qualification, it's just a passion for
20 the Military. I mean, there is no written, you
21 must have this type of degree, or this level of
22 a degree.

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1 MEMBER MALEBRANCHE: So, they all
2 have degrees?

3 MR. CONNER: Not all of them.

4 MEMBER MALEBRANCHE: So, the
5 variation state by state is significant --

6 MR. CONNER: Yes.

7 MEMBER MALEBRANCHE: -- I guess, is
8 what I'm getting at.

9 MR. CONNER: It is, and typically,
10 they're recommended by the state.

11 So, the state -- we'll say we have
12 an opening in Delaware, and the state will say,
13 "We have three or four people we'd like you to
14 consider."

15 They get their resumes together.
16 They're submitted to the contract company, and
17 then that program manager will contact each one
18 of them and interview them and make the
19 selection.

20 MEMBER MALEBRANCHE: So, it's a
21 contract at a national level or state by state?

22 MR. CONNER: It's at the national

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1 level, yes.

2 MEMBER MALEBRANCHE: A national
3 level contract, state by state?

4 MR. CONNER: Right.

5 MEMBER REHBEIN: So, you have just
6 one contract company then, that you deal with?

7 MR. CONNER: When it first was
8 announced, or first awarded, about five or six
9 years ago, it was three different contracts.
10 There was a prime and two subs.

11 I'm not sure why that was done, to
12 be honest with you, but over time, it just kind
13 of morphed in to one contract company.

14 MEMBER DRACH: You mentioned that
15 you get referrals from the state. Who in the
16 state? The National Guard people?

17 MR. CONNER: Yes, it's usually the
18 personnel guys, because they fall under the
19 personnel section or the J1 in the Guard case.

20 So, they're usually saying, "You
21 know, I know three guys, four guys," whatever,
22 and then they say, "What is the process," and

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1 that is when the contract company gets involved,
2 and I don't, but they'll say either, send a
3 resume or however -- letter, or whatever.

4 MEMBER DRACH: Do you do any
5 external outreach to find candidates?

6 MR. CONNER: They do. I don't.
7 The contract company goes on those -- the job
8 search sites, I don't know all the different
9 names, Monster and all of those, and they're
10 always putting positions out there and have like
11 a -- in their back pocket, so to speak, folks they
12 could pull up, if they need it.

13 MEMBER EVANS: I guess that's the
14 same question, on the line of the same question
15 I have.

16 Are you working with the non-profit
17 organizations at the local level, because we --
18 to connect our service members with those
19 benefits that --

20 MR. CONNER: We do.

21 MEMBER EVANS: Okay.

22 MR. CONNER: That is when I

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1 explained, typically in the office, they have
2 all those support, or the services type folks
3 there, the family program person, ESGR, the TAA,
4 yellow ribbon, and they'll say, "I know of a VA
5 benefit from the local VA," but this person
6 doesn't qualify, "Anybody know anything else,"
7 and the family program person might say, "Well,
8 I know they have unmet needs from one of the VFW
9 friends."

10 And so, our county has something,
11 so, the trustees, for instance, some states have
12 trustees, and they can write a check.

13 MEMBER EVANS: Okay, so, you have a
14 list out, because what we found is that -- or what
15 we hear, a lot of the National Guards or the
16 returning Warriors, they don't, when they go
17 back to the state level, they really don't have
18 a list or a good sense.

19 Like here, if you're here in the
20 Capitol Region, it's a plethora of non-profit.

21 But back at the state level, we find
22 that it's a disconnect, as to getting those

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1 members connected directly to a non-profit that
2 probably could provide more service than the
3 Government.

4 MR. CONNER: What many of the --
5 that usually falls under the family program
6 arena, and what they tend to do, is give one of
7 these binders, excuse me, one of these binders,
8 and it's usually about three-inches thick, and
9 there is a tab in there that has that. It just
10 gets lost with all of the other things that are
11 in here.

12 You know, I always kid with the folks
13 at -- you know, who bought a new car in here
14 recently? You know, you see hands go up.

15 Did you look at the owner's manual?
16 No, you put the key in and turned it, and now,
17 if you buy a car, they even have a little fold-out
18 thing that is the cheat-sheet, because no one is
19 taking the time to read these, and that is just
20 that commercial society, that 30-second burst
21 that all of our guys are used to. They want the
22 answer now.

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1 I know that is not the answer you're
2 looking for, but I know we are trying to minimize
3 this just dumping of information on them, and
4 they feel overwhelmed. If we build that
5 relationship, they know who to call to get the
6 help. That has been our focus, anyway.

7 MEMBER CONSTANTINE: I've got a
8 related question.

9 I had a Marine call me last week, a
10 guy I served in Iraq with, and he is on his way
11 out from Lejeune, going down to college in
12 Alabama, and he said that he is not going to have
13 enough money to make it the next two months, and
14 asked what I could do, where I could point him.

15 I didn't know about the TAAs. I
16 wish I had. So, I put him in touch with a couple
17 other -- well, a couple non-profits, including
18 -- I told him about 'unmet needs' as an example.

19 MR. CONNER: Right.

20 MEMBER CONSTANTINE: If I had known
21 about the TAAs and if I had put him in contact,
22 I assume the TAA could have provided him a

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1 notebook and one section of that probably has to
2 deal with financial assistance, or at least
3 could have talked to him about groups that will
4 provide micro-grants or something along those
5 lines.

6 Is that accurate? Is that a good
7 place for someone to turn to?

8 MR. CONNER: That is a -- you're
9 right on par for your observation, and
10 basically, that gives me my chance to beg for
11 forgiveness, because I personally think that is
12 my fault.

13 When I hear that leaders, and I know
14 that, I've been focusing on this, and we don't
15 have a strategic communication plan. I don't
16 have one yet, at this level, you know, with my
17 own organization.

18 Some know, some don't, and that is
19 my hope to get to this -- starting in January,
20 because I had to get these guys in order first,
21 in my mind.

22 But you're absolutely right, there

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1 is just so much out there, and we don't know which
2 way to turn them, in some cases.

3 MEMBER CONSTANTINE: On the little
4 business cards, I don't see a website. How
5 would I -- because I get calls from guys all the
6 time, because I've been doing this for a number
7 of years, now.

8 How do I know where to tell them to
9 turn to, if one guy is in Alabama, some guy is
10 here?

11 MR. CONNER: This guy had the answer
12 earlier.

13 MEMBER CONSTANTINE: Is it a
14 national resource structure?

15 MR. CONNER: Absolutely, either the
16 --

17 MEMBER CONSTANTINE: But no, I want
18 to introduce, you know, one person, to talk to.

19 MR. CONNER: I can give you the list
20 of names, and that is fine. That is the other
21 thing we do.

22 All of these different services I

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1 mentioned earlier, provide each other rosters,
2 like a national level, each state and who is in
3 there, with phone numbers and emails.

4 I mean, that is what we do to the
5 other service providers, so, we know if we don't
6 have -- we can't fix it on our issue, maybe this
7 person can, because they have that list.

8 MEMBER CONSTANTINE: But if I'm
9 talking to a guy in Alabama, I'd say, "Oh, I just
10 heard about these TAAs," and he says to me,
11 "Where do I find them online, or how do I get in
12 touch with them?"

13 MR. CONNER: Okay.

14 MEMBER CONSTANTINE: I don't know
15 that.

16 MR. CONNER: If you -- that guy,
17 that is -- that guy works for me in my office
18 there, give him a call and he'll connect you with
19 a name, or I can do that before I leave. You're
20 talking about a specific --

21 MEMBER CONSTANTINE: Well, I am,
22 but I'm also --

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1 MR. CONNER: Okay.

2 MEMBER CONSTANTINE: -- thinking --
3 I've gotten these calls, every month, probably
4 until the day I die, and so, I want to make sure
5 I can put them in touch with you, and not just
6 send them to the National Resource Directory.

7 MR. CONNER: Okay, I misunderstood.

8 Yes, if you have a specific case, by
9 all means, give Chuck a call, let him know, email
10 him, whatever, and we'll connect you.

11 MEMBER CONSTANTINE: And I will do
12 that. Thank you. That is great for this guy,
13 but looking down range a little bit, knowing I'm
14 going to get --

15 MR. CONNER: Right, and that's why
16 I said, that's me, I don't know, I've got to come
17 up with marketing devices to get out to the
18 leadership to say, "Here we are and this is what
19 we do."

20 MEMBER CONSTANTINE: But can you
21 tell me right now, put yourself in my shoes, and
22 the Warrior is going to be calling and saying,

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1 "Hey, I need some transition assistance."

2 What can I tell him, how to get in
3 touch with someone from your organization? You
4 don't have a website, right?

5 MR. CONNER: No, well, the National
6 Guard has a joint support -- joint service
7 support website, and we're on there. Those some
8 five services, ESGR, Yellow Ribbon,
9 psychological health, ourselves and one other
10 one, I can't think of. But all of us are on that
11 website. That is another option.

12 MEMBER MALEBRANCHE: Well, not to
13 put you on the spot, but I am, maybe a little bit
14 here.

15 MR. CONNER: That's all right.

16 MEMBER MALEBRANCHE: Do you have,
17 like the National Guard Bureau, one number that
18 somebody can call, because you don't know what
19 state all these people are from.

20 MR. CONNER: No, that, we don't
21 have.

22 MEMBER MALEBRANCHE: Because you

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1 know, then you'd have to know each state, and
2 honestly, even though we have the National
3 Resource Directory, someone has got to be able
4 to maneuver, a lot of times, these directories,
5 that are not easy.

6 So, if you had one number, and if
7 this is a contract out of the National Guard
8 Bureau here, is there one number that someone can
9 call, to get this list of different state people?

10 MR. CONNER: Yes, actually, on that
11 website, there is a phone number that they put
12 out on their marketing stuff, and that -- what
13 happens, when you call that number or go to that
14 one email site, it will direct you to one of the
15 five different services that apply.

16 That is the only thing. I think
17 they have it on Facebook or something too. That
18 is the only thing that I know of, that the
19 National Guard has, as a central number to kind
20 of farm-out who goes where.

21 MEMBER MALEBRANCHE: And are you
22 considering, what I'm thinking is, each state

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1 has so many different things. I know some give
2 free licenses or some do different things for
3 universities and your kids.

4 Is there any one site that tells you
5 all the differentiation --

6 MR. CONNER: No.

7 MEMBER MALEBRANCHE: -- and the
8 different states, because I have to tell you,
9 when you're Military, you don't always have a
10 home state.

11 MR. CONNER: Right.

12 MEMBER MALEBRANCHE: And maybe that
13 would be of interest to people of choosing one.

14 I mean, you know, too, if you're --
15 I mean, I know if you're Guard and Reserve,
16 you're coming out of there, but some people work
17 from different places and like we say, are
18 assigned to different places.

19 MR. CONNER: Yes.

20 MEMBER MALEBRANCHE: But the
21 variations from state to state, and maybe a
22 little friendly competition would be good --

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1 MR. CONNER: Well, I can tell you,
2 it's been attempted a number of times. You just
3 can't keep up, is what -- the maintenance of
4 that, then you end up putting out bad data,
5 because that program is no longer there, or
6 something, and no one told the national level,
7 and then you're back to calling.

8 I don't mean to be negative, but I
9 know we've tried that a number of times, when the
10 National Resource Directory came out. We were
11 saying the same thing, "Good luck," because the
12 maintenance part of that is just a nightmare.

13 I got to tell you, when I was Deputy
14 Chief of Family Programs, we told them to call,
15 I think it's '411' or '211' in each state,
16 because the states know their resources. That
17 is -- states take care of their people, for the
18 most part. They do.

19 MEMBER DeJONG: There was a
20 website. I don't know if it's still up and
21 functioning, that would show the whole United
22 States. You could click on the state, it would

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1 then give you the benefits of that state.

2 I don't recall what it was. I don't
3 even know if it's still up and functioning, but
4 as of two years ago, there was a website out
5 there.

6 MR. CONNER: Yes, I think that was
7 previous to the National Resource Directory. I
8 know what you're talking about, and I don't know
9 if they ran out of funds or what happened. I
10 know that just went away, yes.

11 MEMBER DRACH: Years ago, the
12 Congress, the Senate, excuse me, the Senate and
13 the House Veterans Affairs Committee used to
14 publish, I'm sorry, used to publish a directory
15 of state benefits, and it was -- this is back in
16 the old days, you know, when it was nothing but
17 hard copies.

18 I don't think that they publish that
19 anymore, but that was a very, very resourceful
20 -- very good --

21 MR. CONNER: I'm familiar with what
22 you -- and then they did it one time, put it on

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1 their state websites, and then it just -- like
2 I said, I think it just became a maintenance
3 issue for most organizations, and I know that is
4 not the right answer, I just don't know what the
5 answer is, at this point.

6 Okay, I think that's it, then.

7 CO-CHAIR CROCKETT-JONES: Thank
8 you, Mr. Conner. I just wanted to thank you.
9 We met in Massachusetts, and you're always a
10 great resource, lots of information, and I think
11 we'll be interested in seeing how you now go
12 forward with some more of the marketing of your
13 services.

14 I kind of like how this worked out.
15 Thank you, again.

16 MR. CONNER: Well, that's how I was
17 going to close.

18 I can't tell you how significant
19 what you're doing, you know that. You all hear
20 that, but I -- we see it in the soldier's faces,
21 and in the Airmen's faces, in the Navy and the
22 Marines.

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1 I mean, you're sitting here, running
2 papers, going places, coming back, writing
3 reports, but that paper, those reports really
4 translate to the service members out there, and
5 you are helping us, too. I've got to tell you
6 that.

7 The visits, you know, gives the
8 attention where it needs to be. So, for all of
9 you and all of your efforts, I didn't get to meet
10 all of you on all the visits yet, but thank you,
11 also.

12 I think you can get your 10 minutes
13 for your break.

14 CO-CHAIR CROCKETT-JONES: Yes, we
15 get -- well, no, I think we at least get a 20 --
16 let's call it 20 instead of a 15 minute break.

17 MR. CONNER: But they're already
18 trying to figure that out, now.

19 CO-CHAIR CROCKETT-JONES: Yes, I
20 know, quick before they stop.

21 MS. DAILEY: Okay, and my staff is
22 rushing to tell me that my next briefers are

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1 here, and we are having -- we have a little extra
2 minute here, yes.

3 They are staff, they are -- I know
4 my briefers are here, Mr. Holdeman and Colonel
5 Faris are in the back there. You've seen at
6 least one of them before.

7 So, 2:15 p.m., you have a break.
8 It's five-til right now, and we'll start again
9 at 2:15 p.m.

10 (Whereupon, the above-entitled
11 matter went off the record at 1:55 p.m. and
12 resumed at 2:15 p.m.)

13 CO-CHAIR CROCKETT-JONES: Okay,
14 we'll now receive a briefing from Mr. Raymond
15 Holdeman, the Deputy Division Chief for
16 Personnel Army National Guard G1. Colonel Jill
17 Faris, the Deputy Surgeon Army National Guard
18 briefed us last October 2011 on the National
19 Guard Medical Management Processing System.

20 We learned how the system was a
21 decision making process to provide case
22 management direction for the Army National

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1 Guard.

2 In addition to the MMPS, Mr.
3 Holdeman will also discuss today, the Reserve
4 Component Managed Care pilot, which was also
5 mentioned in October 2011.

6 This briefing is meant to be a follow
7 up from the previous presentation provided by
8 Colonel Faris. Mr. Holdeman's information can
9 be found under Tab F in your briefing book. I'm
10 going to turn it over to you all.

11 COL. FARIS: Thank you. We feel
12 honored to be back again. I don't feel like it's
13 a redo. I feel like you're excited about what
14 we're doing in the Guard, and we want to share
15 with you, the successes that we've had over the
16 past year, since we've been together.

17 So, at any time, if you have
18 questions, feel free to ask. I hate people that
19 wait until the end, because then all they do is
20 think about that one thing and they don't listen
21 to anything else you say. So, feel free to ask
22 questions.

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1 All right, this is our agenda. In
2 your intro, you heard we're going to be talking
3 about, we have a system that we call MMPS, the
4 Medical Management Processing System.

5 This is a formal process in which we
6 manage our soldiers in the Army National Guard
7 through medical case management.

8 And so, we're going to talk about all
9 the roles, rules and responsibilities, who makes
10 up MMPS and we're going to talk about how MMPS
11 works in with all the different ways we can fund
12 soldiers to have care and treatment, as it's duty
13 related.

14 Then Mr. Holdeman is going to talk
15 quite extensively about the pilot program we had
16 over this past year, and then put a plug in for
17 assistance in getting our signature, as it's
18 sitting in the staffing process to be a full
19 implemented process in the National Guard.

20 All right, so, without further ado,
21 okay, so, just a little overview, for those of
22 you who weren't here last year, I'll give you a

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1 definition on MMPS, and it is a process where we
2 can monitor and facilitate what is happening
3 with soldiers from a medical perspective.

4 Often times, what happens, and I've
5 even seen it here in the National Capitol Region,
6 here you can throw a softball and hit some sort
7 of Military treatment facility.

8 That doesn't necessarily equate to
9 good care, because it's multi-services. We
10 have people within the TRICARE network.
11 Sometimes, it's hard to negotiate through the
12 system, access to care standards, and we don't
13 necessarily have an advocate looking out for us,
14 unless we have multiple modalities going on, and
15 then we get assigned a case manager from a
16 medical treatment facility.

17 So, what we've done in the Guard is,
18 it's even more complicated with us. I think
19 last year, I talked about the type of care we get
20 in the Guard.

21 In the Guard, we have a patchwork
22 quilt. We have early eligibility. We have

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1 eligibility while we're deployed. We have
2 post-deployment TAMP eligibility. We have
3 TRICARE Reserve Select. We have our civilian
4 insurance. We have LOD care.

5 We have all kinds of care, and it's
6 all patched together, and that equates to our
7 blanket, as opposed to the active component that
8 has TRICARE throughout the time and duration
9 while they're on active duty.

10 And so, because of that, any time you
11 have a stitch, you have the possibility of a
12 stitch to come loose and a gap to happen.

13 And so, bringing on a case
14 management team helps facilitate less gaps in
15 getting those stitches put back together.

16 So, what we have on our team of case
17 management support, and I'll talk to a minute,
18 in great detail, is we have something called a
19 Medical Readiness NCO. We have something
20 called a case manager. We have people that are
21 called care coordinators.

22 Obviously, we also have the

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1 leadership of Commander and First Sergeant that
2 are involved in this process of MMPS.

3 Okay, Battalion Medical Readiness
4 NCO. These are people that are relatively new
5 to the force structure in the Army National
6 Guard.

7 So, about two years ago, in the
8 Surgeon's Office, we identified that we didn't
9 -- okay, so, there is -- when you have a person
10 who is Ms. Jones, who is your case manager, and
11 she calls Sergeant Holdeman on the phone, and
12 says, "Sergeant Holdeman, I need for you to
13 provide me some supporting medical
14 documentation," because it's Ms. Jones, he may
15 not necessarily listen to Ms. Jones.

16 But when it is Sergeant First Class
17 Jones calling Sergeant Holdeman, who is in his
18 organization, and says, "Soldier, you need to
19 bring in the supporting documentation, so we can
20 figure out what is going on with you," he is more
21 apt to comply.

22 And so, we came up with these Medical

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1 Readiness NCO's. They were funded to 80 percent
2 fill within the Army National Guard at Battalion
3 and Brigade levels, E6's at battalions and E7's
4 at brigades.

5 Now, just like anything, when it's
6 a voucher validated requirement and it goes into
7 the 54 states and territories, each one of them
8 will do it differently.

9 That is the strength of the Guard and
10 sometimes, that can be our Achilles heel, as
11 well.

12 So, sometimes what happens when
13 you're a Chief of Staff, because you managed all
14 the full-time resources, that new funding comes
15 in and they're like, "Wow, but I really need an
16 aviation mechanic, and I really need a supply
17 Sergeant."

18 And so, a Chief of Staff will say,
19 "Well, you've given me the authorizations.
20 Rather than having them be Medical Readiness
21 NCO's, I may re-purpose them to do something
22 else."

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1 So, some states did that, and as a
2 result, they didn't do so well in this process,
3 and they're in the process now, I have many
4 states that are going back and as people atrit
5 out, they're bringing Medical Readiness NCO's,
6 because they see the importance of having a
7 uniform person in this process of case
8 management, and being the voice and looking out
9 for that Commander and First Sergeant. Yes?

10 MR. HOLDEMAN: I think it's also
11 important to note that when we looked at this
12 problem years -- a couple of years ago, we
13 realized we weren't going to get any additional
14 funding to support this new mission that we were
15 -- that we were levying on the states.

16 This was all taken out of organic
17 resources and organic to the units and soldiers
18 that needed access to care and quality care for
19 the Guard, because with the Surgeon and the G1,
20 we recognized very quickly that the long pole in
21 the tent was medical readiness for sustaining
22 and maintaining the force and its capability,

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1 with regard to the Army mission.

2 COL. FARIS: So, what this
3 individual does is help facilitate, and from a
4 Guard perspective, cares associated with line of
5 duties.

6 We have a system, an electronic
7 system that we talked about last year with Mr.
8 Scott called eLOD, which is now called eMMPS, and
9 they go in and electronically route and do a line
10 of duty, because the soldier is not eligible for
11 care, unless they're in a duty status, and if
12 they're in a duty status, then they require a
13 line of duty.

14 And so, this is the system. The
15 Medical Readiness NCO helps facilitate getting
16 that completed.

17 They also work with the soldier in
18 obtaining temporary profiles greater than 30
19 days. They actually also work with ensuring
20 that soldiers are showing up for an appointment,
21 following through with the soldier, being a
22 conduit.

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1 Sometimes it's easier for a soldier
2 to talk to a soldier than it is to talk to
3 somebody who is a contract civilian, one of our
4 care coordinators or nurse case managers.

5 So, we take care of things in the
6 close fight, if it's a little thing. Faris
7 steps off the curb, twists her ankle. That is
8 going to be resolved within 90 days. All that
9 can be done locally with that Medical Readiness
10 NCO.

11 These positions are filled with 68
12 whiskies, primarily. I will put a caveat and
13 say we do have some 42 alphas, some
14 administrative folks that fill the positions
15 because we have to have force structure in that
16 MTO unit, to be able to support the position, and
17 if there isn't one, then it's a 42 alpha that
18 fills the position.

19 All right, case managers. So, back
20 in about 2005 -- yes, ma'am?

21 MS. DAILEY: Tell them what a 42 alpha
22 is.

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1 COL. FARIS: I'm sorry, a 42 alpha
2 is a personnelist, a paper-pusher, yes. That's
3 what I do. I'm a Staff Officer. That's what
4 Ray does.

5 So, case managers. Back in 2005, we
6 were in the thick of the fight of the War, and
7 literally, this was what was going on. We were
8 robbing Peter to pay Paul, but this is what would
9 happen.

10 We would bring in a unit that we
11 identified that was going to mobilize and we
12 would go through a soldier readiness processing,
13 and we would determine, do they meet all of their
14 medical readiness requirements, because like
15 Ray said, the long pole in the tent of building
16 personnel readiness to get a soldier out the door
17 to support the war fight is medical readiness.

18 When we identified that they had a
19 deficiency, we put them in the deficiency pile,
20 and we were so busy, we didn't really have people
21 to focus on what was going on, and we said, "This
22 is an issue."

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1 We need to have somebody to help
2 figure out, because maybe it's just a twisted
3 ankle, maybe it's just they need to be on high
4 blood pressure medication, or maybe they're a
5 Type II diabetic, but we need to have somebody
6 looking out for these people and getting them
7 into some sort of status.

8 So, hence, we created, because we
9 weren't going to grow in force structure on the
10 AGR technician side, hence, we created a
11 national contract for case managers and care
12 coordinators.

13 We hired people into that initial
14 contract in 2006, and you can see a direct -- I
15 wish I brought that slide. Next time we come
16 when you invite us, we'll bring the slide to show
17 you our ramp-up of readiness.

18 So, you can tie it to the fact in
19 2006, we had case managers, and we started doing
20 PHA's, touching every soldier, every year, and
21 we had follow through and when we found
22 deficiencies, and you can watch how the angle of

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1 our readiness went from 36 percent in 2006 up to
2 77-point-something percent. It's on my last
3 slide, and I directly tie that to the fact that
4 we have people following through with what is
5 going on with soldiers that have known
6 deficiencies.

7 The people that we have, that serve
8 in the role of case managers are clinical
9 professionals. They're either a licensed
10 nurse, a social worker, and in some cases, we
11 have some PA's that work within this contract.

12 Their job is to coordinate. It's
13 just like in a hospital. That person
14 coordinates all of the information together,
15 puts together the compelling medical
16 description of what is going on with the soldier,
17 and then gives that information to the provider,
18 so they can make their clinical assessment on the
19 way ahead for that soldier, and that is their
20 role.

21 MEMBER EVANS: Are these civilian
22 contract Reservists?

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1 COL. FARIS: They're civilians.
2 Some of them also serve within the Guard and the
3 Reserve, that are in these roles, but they are
4 civilian contracted. They work within their
5 own credentialing, within the jobs they do.

6 They're not covered under Federal
7 tort. They work within the national contract
8 that we have, that supports this effort.

9 MEMBER EVANS: Okay.

10 COL. FARIS: Another player on the
11 team is a care coordinator. We used to call them
12 administrative assistants, and then we decided
13 they needed a better name, or something, and so,
14 we came up with care coordinators, because that
15 is really what they're doing.

16 You know, we wanted soldiers to
17 understand that they weren't not just -- they
18 weren't just a paper-pusher. They were helping
19 coordinate the care.

20 However, what they were doing is
21 coordinating the paperwork that supported that
22 soldiers' care.

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1 So, care coordinator gets all that
2 paperwork together and organizes it in a
3 fashion, so the case manager can take a look at
4 it and make an assessment. So, they're like the
5 worker-bees.

6 They're the ones -- because a lot of
7 times, our care in the Guard and Reserve comes
8 from the civilian network, and so, we don't have
9 access to that. It's not ALTA.

10 So, then we have to ask the soldier
11 for the medical documentation. We have to take
12 that documentation. We scan it, upload it into
13 the health readiness record, index it within
14 that electronic medium that we have in the Guard,
15 and that is their job. They take care of all of
16 the paperwork.

17 When the soldier signs the medical
18 release of information, that care coordinator
19 takes that piece of paper and sends it to the
20 applicable provider, where the soldier sought
21 care and treatment, to get that medical
22 documentation. Very important.

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1 MEMBER EVANS: At any time, do you
2 feel like you have an overlap between your case
3 managers and your care coordinators?

4 COL. FARIS: No, they have very
5 different roles. You don't see a nurse case
6 manager faxing something to an MTF, to get
7 documentation. Clearly, that is what the care
8 coordinator does.

9 The case manager, rather, looks at
10 that medical documentation and makes a clinical
11 assessment to make some direction and guidance
12 to the provider on what kind of temporary profile
13 needs to be written, if they meet retention
14 standards.

15 MEMBER EVANS: Okay.

16 COL. FARIS: So, yes, so, they
17 definitely have different functions. They all
18 support each other, but they're very uniquely
19 separate.

20 MEMBER EVANS: Okay.

21 COL. FARIS: So, in the National
22 Guard, we have these people, these champions,

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1 these heros. They were the first medical people
2 that we had on a full-time manning documents
3 within the Guard, health system specialists.

4 They fall within the G1 community.
5 Their sole function in life was to support line
6 of duties, incapacitation pay, as it related to
7 line of duties, board actions, all the G1
8 processes. They were the go-to person.

9 These people still exist. They're
10 still very busy. They've just been able to get
11 some of the stuff off of their plate and focus
12 on G1 actions.

13 And so, this is also part of our
14 one-team-one fight, when it talks about MMPS.
15 They have very definitive role, not a replicated
16 role. They focus on all the G1 touch points.

17 So, if a soldier meets retention
18 standards, but has a permanent profile, they may
19 go through what was formerly known as an MOS
20 Medical Review Board, now a MAR2. They support
21 the INCAP packet. They support getting the
22 packet together, to go down to Pinellas Park, to

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1 be reviewed before it goes into the medical board
2 process. They do all those G1 activities, and
3 so, they're definitely a part of the team of
4 MMPS.

5 Then obviously, we have our Military
6 healthcare providers.

7 Now, one of the struggles for us in
8 the National Guard is, we used to have a whole
9 bunch of OCO funds, and so, we could bring
10 providers on ADOS orders to support us, because
11 here is what happens.

12 Care coordinator gets the
13 documentation, it gets uploaded and scanned, it
14 gets organized. The nurse case manager reviews
15 it, looks at it. He or she makes a determination
16 and then we turn to the provider and, "Oh, yes,
17 we don't have any full-time providers on our
18 TDA's or MTO's."

19 And so, we were bringing people on
20 ADOS, because we need that person to be able to
21 write a profile, to clear a soldier, and so,
22 before we had people in ADOS, we would have to

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1 wait until the State Surgeon came in, or another
2 person split out of drill, to be able to clear
3 these soldiers.

4 So, one of the things we learned,
5 it's very important to have a full-time
6 provider.

7 So, what have we done to support that
8 effort? We've gone through a manpower study.
9 We're in the process of going through a manpower
10 study, and we're very confident at the results
11 of that manpower data capture that we're going
12 to realize that we're going to have to have a
13 full-time provider on staff, and then we're
14 going to have to make some decisions internally
15 as a Guard, on what is more important, having a
16 full-time provider or whatever the other
17 positions are that we're looking to choose from.

18 So, very much -- it's kind of obvious
19 there, we're part of the team. But they help
20 resolve or push forward a soldier throughout
21 this process.

22 Okay, I'm a visual person. I like

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1 maps. I deal with lots of combat arms people,
2 and so, maps and pictures are kind of good.

3 So, what this tells you is what I've
4 kind of talked about.

5 So, we go through the medical MMPS
6 system. We have this kind of rule in the Army.
7 The rule is, after 12 months of a known
8 identified medical deficiency, we have to come
9 to what's called 'Mr. DP', your medical
10 retention decision point.

11 So, that is the point where either
12 Faris needs a permanent profile in her lower
13 back, she has a bulged disk, and so, she can no
14 longer do sit-ups, or it's Faris has that, along
15 with planter fasciitis, chronic knee problems,
16 and now, I don't meet retention standards.

17 And so, I need to either go through
18 a board, if it's duty related, or go through a
19 non-duty PEB.

20 Those decisions have to be made.
21 Twelve months is the mysterious time frame.
22 Sometimes, we extend it by exception, if we've

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1 took a while to make a diagnosis and treatment,
2 but for the most part, we're at the 12 month
3 point.

4 So, if you look through this thing,
5 remember, I talked about the fact that once we
6 get to a 90 day point, that is where we have to
7 do battle hand-over from the Medical Readiness
8 NCO, over to the care coordinators and the case
9 managers, and we preemptively follow.

10 A rule in the Army is, when you're
11 coming up onto one year's time and you've had a
12 temporary profile for the same type of
13 condition, we have to make a determination. Is
14 it now a permanent condition, and if it is, is
15 it duty-limiting, you know, what are those
16 constraints.

17 And so, this model talks to you about
18 what people do, what their roles are. You talked
19 about, do we have any duplication? They have
20 very defined roles, and every month, that
21 medical readiness NCO is having a conversation
22 with his Commander and his First Sergeant about,

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1 "Here is what's going on in our unit, sir. This
2 is someone that's on a profile," because all this
3 stuff ties to readiness, which ties to the USR,
4 which is our report card to Congress.

5 Every time I have a person that has
6 a temporary medical condition, guess what?
7 They count against your USR. They're not a
8 ready soldier.

9 So, our task is try to get our
10 soldiers ready as quickly and as efficiently as
11 we can, and MMPS has been able to help us with
12 that.

13 So, what ends up happening, the sort
14 of -- the happenings behind the curtain, as we're
15 doing MMPS is that we're having meetings. We're
16 having the case manager gets together with the
17 medical readiness NCO, care coordinator.
18 They're going through the process, and the thing
19 that is important that you take off of this
20 slide, is the fact that it is not just medical
21 that's involved in this process.

22 It's medical, with the soldier's

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1 leadership. The Commander needs to be acutely
2 aware of what is going on, and that First
3 Sergeant, and they can help assist. Sometimes,
4 we have soldiers that really like being in the
5 Guard, and they know that if I provide this piece
6 of information, in all probability, I may not be
7 retained anymore, and I want to stay in the
8 Guard. So, maybe they won't turn the paperwork
9 in, in a timely fashion.

10 The way we help support timeliness
11 is getting Commanders, First Sergeants involved
12 in the process, and so, this is -- so, trigger
13 points to starting MMPS.

14 It could be as simple as Faris
15 walking up to her First Sergeant and saying,
16 "Hey, I was in a track meet and I tore my
17 Achilles, and here is my medical documentation.
18 What do I do?"

19 Okay, that is a touch point. "Go
20 see the medical readiness NCO. Got to make sure
21 we get a profile started on you, and we can start
22 this process."

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1 It could be that self-reporting.
2 It could be, Faris is coming in to do her annual
3 periodic health assessment, and during that
4 periodic health assessment, when I'm having a
5 conversation with the provider and filling out
6 my questionnaire, it's disclosed that I am
7 having an issue with a hernia, and that will
8 start the MMPS process.

9 It can happen when a soldier is
10 coming back from deployment, and they're at the
11 demob station and they talk about that they have
12 a medical condition. Now, it's not significant
13 enough to stay on active duty, and they decide
14 they want to come home, and they have an LOD and
15 they're going to follow that up with LOD care.
16 That is what starts case management.

17 So, it's any time we have an
18 opportunity, where we lay eyes or hands on a
19 soldier, or they self-report, that can initiate
20 MMPS for us.

21 You want to start on this one, Ray?

22 MR. HOLDEMAN: I'll jump in here.

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1 I just want to say thanks again, for having the
2 opportunity to come and address the Task Force.

3 We talked a little bit about RCMC,
4 Reserve Component Managed Care, the last time we
5 met.

6 At that time, it was just a pilot
7 program. By the report, we got to kick that
8 pilot off. It was extended through August of
9 2012, and we recently have experienced a gap in
10 our ability to continue to run this program.

11 It's important to remember that this
12 was just 14 states initially, that we really only
13 had 12 states that lit the fire and took off with
14 this program, and exercised the authorities that
15 we built around this access to care, this active
16 duty care program, that really serves the
17 recovering Warrior, that leads the mob station,
18 maybe doesn't identify or self-report right
19 away, that they had a problem or injury or
20 illness that was occurred while on active duty.

21 There was a gap in our ability to
22 provide care or access to care, without

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1 expending INCAP funds to cover pay and
2 allowances and resources, make sure the
3 financial resources were available to the
4 soldier and their family, while they were
5 struggling through these patchwork of care
6 issues, that there Reserve component soldier
7 often experiences.

8 So, we kicked off RCMC. We focused
9 on two groups, and then the focus of those two
10 groups, training and mobilization was extremely
11 narrow. We made sure we kept it limited to those
12 low-risk/low acute cases, that we could easily
13 manage through treatment, care and recovery.

14 The 180 days was the max target for
15 this program. We did experience a couple of
16 extensions.

17 It wasn't for those soldiers that
18 should be assigned to a WTU behavioral health,
19 more intensive care requirements or complex care
20 requirements.

21 So, we left those populations that
22 normally applied for ADME or MRP2 alone, with

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1 regard to our implementing guidance and policy.
2 Question?

3 MEMBER TURNER: Just real quickly.
4 Maybe I missed this, but I heard that this
5 program when through all the different --
6 perhaps, if you could just clarify.

7 When you were talking a moment ago,
8 you said this program went through August 2012?

9 MR. HOLDEMAN: Yes, it did.

10 MEMBER TURNER: And what has
11 happened since then?

12 COL. FARIS: Staffing.

13 MR. HOLDEMAN: Staffing, we'll get
14 to that in just a second.

15 MEMBER TURNER: Okay.

16 MR. HOLDEMAN: I am going to address
17 that. So, next slide. Any other questions on
18 the basic framework of the program?

19 All right, next slide. So, there are
20 other options for care, obviously. LOD is the
21 document that the Department of the Army and the
22 Army National Guard uses to verify and validate

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1 access to care for an injury or illness incurred
2 in the line of duty.

3 If it's not in the line of duty,
4 there are other options that the soldier has.
5 One of them is TRICARE Reserve select, down at
6 the bottom.

7 If a soldier purchases that care
8 coverage, healthcare coverage for themselves
9 and their family, obviously, they have the
10 benefit of one of the best low catastrophic cap,
11 low premium insurance programs available today,
12 in my mind, for a soldier.

13 We also have used and continue to use
14 INCAP pay to bridge gaps where there are problems
15 with a soldier's ability to go back to their
16 civilian job, perform their Military duties.
17 INCAP pay is an option.

18 In most case -- in every case where
19 a line of duty is approved for soldiers, when
20 they're looking for a lengthy application for
21 ADME, they're looking at a lengthy application
22 process for ADME, or MRP2 or they're waiting for

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1 their approval for RCMC.

2 PARTICIPANT: Can you talk about how
3 it's part of the contract?

4 MR. HOLDEMAN: Yes, incapacitation
5 pay is akin to workmen's compensation, if
6 everybody is familiar with that.

7 What happens is, a soldier has to
8 prove the loss of income in almost in -- in the
9 majority of the cases, and they are only
10 reimbursed 30 days in arrears.

11 So, it's for the previous month lost
12 wages. They're paid after their claim for the
13 previous month is adjudicated by the state, and
14 sometimes that can be 10 or 12 days into the
15 following month.

16 So, payments for INCAP pay are
17 always paid in arrears. That often creates more
18 problems for the soldier, with regard to
19 continuity of income and financial -- meeting
20 their financial responsibilities.

21 But since Congress, how they wrote
22 the legislative language that supports INCAP

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1 pay, that's what we suffer through, with regard
2 to implementing guidance and policy.

3 MEMBER DeJONG: Sir, if I may?

4 MR. HOLDEMAN: Sure.

5 MEMBER DeJONG: Are we still -- is
6 INCAP pay still readily being used for Title 10
7 injuries?

8 COL. FARIS: Right now, we do.

9 MR. HOLDEMAN: Yes.

10 MEMBER DeJONG: Okay, and again,
11 and depending on your interpretation of INCAP
12 pay --

13 COL. FARIS: Tag.

14 MEMBER DeJONG: Understood, but I
15 mean, truly, INCAP pay was designed for the IDT
16 weekend.

17 COL. FARIS: Sure.

18 MEMBER DeJONG: The ATE injury, not
19 for Title 10 injuries.

20 COL. FARIS: That is correct, and
21 right now, we're able to talk about the fact that
22 we're in a staffing hold right now, to make this

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1 a permanent program, and so, as a result of that,
2 we've had to go back to using INCAP pay.

3 So, what we've done in INCAP pay,
4 this is in the last two years, we've been
5 tracking whether it's related to deployment or
6 whether it's related to -- so, we had two
7 different fund sites.

8 So, we can track that as an Army, to
9 find out how we were using funds that were
10 supposed to be used for something else.

11 MEMBER DeJONG: That was my next
12 question, was if --

13 MR. HOLDEMAN: Let me say this.
14 The Guard never did anything inappropriate. We
15 ask and received permission from the Secretary
16 of the Army to utilize INCAP pay, as a bridging
17 strategy to support those soldier's financial
18 needs, whether they were warranted and
19 validated, with an approved LOD.

20 Now, it is controversial, and that
21 is why we've been -- that's why we've garnered
22 and obtained the authority to do things like

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1 RCMC. That is why the Department of the Army
2 HQDAG, one, DMPM is publishing, they're in the
3 throes of publishing AR-600-XX, which gives the
4 Reserve components the authority to publish ADME
5 orders, when soldiers are injured or become ill
6 on active duty.

7 So, we're -- the Army, I think, I
8 addressing that issue, the utilization of INCAP
9 pay, and the perceived misuse of INCAP pay, but
10 there is no misuse.

11 We asked for and got the authority
12 from the Secretary of the Army, to use INCAP pay
13 for those soldiers were LODs were approved, and
14 their inability to perform their Military duties
15 was a fact based on their condition.

16 COL. FARIS: So, sometimes what
17 happens is, you qualify for INCAP pay, but you
18 don't meet the criteria to come back into the WTU
19 unit, to come ADME or MRP2.

20 Another reason why we created RCMC,
21 because it's the low-risk/low-acuity. We have
22 lots of soldiers that have bad knees, bad elbows,

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1 bad ankles, bad shoulders, it's all ortho kind
2 of stuff.

3 And so, it was a quick win for us,
4 to be able to bring them on these type of orders,
5 to be able to have them in a steady state of pay.
6 Their primary mission in life is to get well, and
7 that is what they focus on.

8 Then if they work within the
9 confines of their profile, and when there is time
10 that they're not at a medical appointment, then
11 we're finding uses for them within the
12 constraints of their profile.

13 They're getting full pay and
14 allowances, where INCAP pay is only paying for
15 the loss of wages.

16 MEMBER DeJONG: Correct, that was
17 my next point.

18 COL. FARIS: Yes, yes.

19 MR. HOLDEMAN: Okay, so, and then
20 again, we have PDHRA, which allows the
21 individual to be seen for their claimed
22 condition, and then once that

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1 diagnosis/prognosis is codified, we can look at
2 other options, RCMC, ADME, MRP2, to get them the
3 care, the access to care that they need.

4 COL. FARIS: So, PDHRA is
5 post-deployment health re-assessment.
6 Normally, in the Guard it happens at our 90
7 yellow ribbon event.

8 So, sometimes it happens is
9 HOLDEMAN, Sergeant HOLDEMAN is coming back from
10 deployment and his knee is kind of bugging him,
11 but you know, he just wants -- the horse sees the
12 barn. He just wants to go home. It's not so
13 bad, okay.

14 So, now, but Holdeman works on an
15 assembly line. So, he's on his feet all day, and
16 after 35 days of being eight hours a day on the
17 cement floor, that knee is now the size of a
18 grapefruit.

19 And so, we're at our post-deployment
20 health re-assessment, Holdeman discloses, "Hey,
21 my knee is bad," and so, as a result, we have to
22 determine what is wrong with it. We have up to

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1 seven appointments that are covered.

2 If it's determined in the line of
3 duty, a line of duty is initiated and then we look
4 at our different courses of action, to get
5 Holdeman the type of care that he needs.

6 So, this is a summary of slides.
7 So, and then I could do the really busy slide,
8 which is this slide of all the things that we do,
9 monitoring, communicating, assigning, and then
10 we can put Holdeman's overlay, which is the
11 different things that you're eligible for, INCAP
12 pay, ADME, MRP2.

13 Now, the quick win, which Ray didn't
14 reveal to, because he is kind of a humble guy,
15 but as a result of being so methodical in this
16 pilot program, we have demonstrated full
17 disclosure.

18 They can look at all the orders that
19 have been generated. We were doing monthly
20 reports to the Pentagon, and they were so
21 impressed with what we were doing, as a result
22 of that, Ray alluded to the fact that the Guard

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1 is going to eligible to be able to do the same
2 kind of criteria. I'm going to show you another
3 slide, to be able.

4 So, if Faris is applying to go use
5 Reserve component managed care orders, we do an
6 assessment at my office and the Surgeon's
7 Office, and we go, "Wait a minute, this is a bit
8 complex. This is going to exceed 180 days, but
9 you know what? You qualify to go on MRP2 orders
10 or ADME," depending on how long it's been since
11 your time on active duty.

12 We can generate at that point, those
13 orders, and that is a win for us, to be able to
14 have the authority to be able to do that on behalf
15 of the Army, to do Title 10 orders.

16 MR. HOLDEMAN: Actually, Jill,
17 under the 600-XX authority, that is in the -- in
18 the final stages of being approved for
19 publication as an Army regulation.

20 MRP2 actually goes away, and then
21 there is the Guard/Reserve authority to order a
22 member to active duty, because they have an

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1 approved LOD.

2 It essentially takes our RCMC pilot
3 program and turns it into Army policy. They
4 took our idea and turned it into a Department of
5 the Army program, a policy for the Reserve
6 component. It's not quite there yet.

7 COL. FARIS: That is where you guys
8 come in. You can send your cards and notes to,
9 who is it, Ray, that needs to sign this?

10 All right, so, this is just an
11 overview of what we talked about.

12 So, the golden ticket rule is, it's
13 low-risk/low-acuity. So, Faris has a bad knee,
14 but she is also dealing with PTSD. I am not a
15 candidate for this program, because remember,
16 we're taking this out of hide in the state. We're
17 using our case management team that is case
18 managing the force through normal MMPS, and now,
19 we're giving them an additional responsibility
20 to go above and beyond, to case manage people,
21 in the state.

22 It's kind of like, if you remember

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1 back in the day, we stood up community based
2 healthcare organizations. It's a little bit
3 like that, and then that morphed into CBHTO's.

4 So, it's kind of taken
5 low-risk/low-acuity type people and managing
6 them in the states. So, that means we've taken
7 people who have one-million things to do, and
8 having them do one more thing, to help supervise
9 and coordinate the soldier's care, doing those
10 case management meeting touch points, ensuring
11 that if they're not at medical appointments,
12 they're at their prescribed duty location and
13 doing work within the confines of what their left
14 and right limits are, of their profile.

15 MR. HOLDEMAN: Okay, we're going to
16 move through these -- this next slide, kind of
17 quick, because this is redundant. It already
18 talks to the fact that the pilot program only
19 went through August.

20 One thing I want to tell you is that
21 we went back from the Director of the Army
22 National Guard, the Secretary of the Army, and

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1 asked for an enduring, enhanced authority to
2 continue the program and expand it across the 54
3 states and territories, for those that are
4 ready, willing and able to take on the additional
5 administrative burden of this intensively
6 managed program.

7 Again, we have 14 states, about 12
8 of them really took off with it, and used the
9 resources and the authority that we gave them.
10 The other two kind of stumbled and stuttered and
11 only got one or two folks into the program.

12 But next slide. If you look at
13 this, it kind of gives you a real quick snapshot.
14 Again, she likes working with combat arms and
15 combat aviators, and we need pictures and
16 diagrams.

17 But if you look at the circle on the
18 left, that adds up to 14 days. From the time the
19 packet is compiled and entered into the system,
20 and keep in mind, we built this in a totally
21 transparent automated system that the
22 Department of the Army has purview over, so they

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1 could see every single order we publish.

2 They have confidence and trust in
3 our program management controls from the -- from
4 day one, because we built it that way. But it adds
5 up to 14 days.

6 So, we can get a soldier who has all
7 the documentation, their case manager has worked
8 with them, their care coordinator has worked
9 with them. They've got the documents together.
10 Two weeks, we get them orders. They've got
11 their care program already locked in, and
12 they're getting the care and recovery that they
13 need.

14 We published the time line. Yes, go
15 ahead and go to the next slide.

16 We published 183 orders, with
17 amendments. Some with amendments.
18 One-hundred-ten soldiers have come off of orders
19 and already returned to active duty, ready to
20 fight again. They've been cleared, medically
21 cleared.

22 COL. FARIS: Well, not active.

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1 They were returned back to Title 32 status, yes.

2 MR. HOLDEMAN: Yes, they were
3 REFRAD from active duty, returned to their Title
4 32 status, as a drilling Army National Guard
5 member.

6 Average tour length was only 89
7 days, not 179 days. We had in our policy, if the
8 order could be curtailed early, it would be, and
9 soldiers were fully counseled, and made aware of
10 this.

11 COL. FARIS: Almost everyone,
12 through the time that they were on orders, went
13 back to full duty. We just had -- if you see like
14 four percent, so, a handful of soldiers that came
15 off of orders, that had a temporary profile with
16 some limiting conditions.

17 MR. HOLDEMAN: Right, and the
18 bottom line, we saved about \$2 million in the
19 first year of the pilot program in INCAP funds,
20 that we didn't have to use for those Title 10
21 injuries that were identified later, where
22 soldiers really needed follow on care and

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1 treatment.

2 That is what this program was
3 designed to bridge. That was the gap, the
4 program was designed to bridge, and it did.

5 Here are the data numbers and
6 elements that we reported to the Department of
7 the Army each month, and as they looked at these
8 numbers, I can tell you that just with 12 states
9 participating, Mr. Rutherford was -- he was
10 somewhat shocked and surprised. Sam Rutherford
11 is -- works in the Assistant Secretary of the
12 Army Manpower and Reserve Affairs Office.

13 He was somewhat shocked and
14 surprised that they were so low, that we had this
15 few people qualify and apply for the program
16 through the state policies and guidance that we
17 published.

18 But you have to keep in mind, it was
19 only really 12 pushing hard. It's extremely
20 complex, the paperwork that we required in the
21 document management that we demanded was not
22 easy, but that led to the trust and confidence

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1 that the Army needed to give us this authority,
2 because you have to also remember, this is the
3 first time ever that the Director of the Army
4 National Guard had the authority to order a Guard
5 member to active duty pursuant to Title 10.

6 COL. FARIS: Other than being
7 mobilized for combat operations.

8 MR. HOLDEMAN: Well, even
9 mobilizations are at the direction of the Army,
10 through First Army for deployment, and that is
11 -- any questions about RCMC?

12 MEMBER DeJONG: When do you
13 anticipate -- that signature, and correct me if
14 I'm confused, but you're waiting on that
15 signature to make this --

16 COL. FARIS: Go live 54.

17 MEMBER DeJONG: -- go live 54.

18 COL. FARIS: If they want to
19 participate.

20 MEMBER DeJONG: -- in 54 states, two
21 territories, okay, got it.

22 MR. HOLDEMAN: We ran into a small

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1 problem with folks changing over, because this
2 program was a year long, the pilot was a year
3 long.

4 When we went back with the request
5 in July, for an enduring enhanced authority to
6 continue the program and spread it out across
7 those states that were ready and able, it met up
8 with some new attorneys and new personnel that
9 had to be spun up and now, we're currently
10 experiencing a gap in our authority to publish
11 these orders.

12 The last I heard, it was on Secretary
13 McHugh's desk, awaiting final signature.

14 COL. FARIS: So, this is our bottom
15 line slide.

16 Now, granted, it was 110+ people.
17 That doesn't equate to a lot of force structure,
18 but you get the idea. You know, we had to get
19 our foot in the door. We had to prove that we
20 could manage big Army's money, that we could do
21 it transparently, that everyone could see what
22 is going on, and so, we've demonstrated that.

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1 But this is what our readiness
2 report card, I call this the underwear chart,
3 because we have a lot of Type A in the Military.
4 So, if you put up, you know, like every state has
5 its competitive states.

6 So, the Chiefs of Staff look at this
7 and they're like, "Georgia is higher than me."

8 So, I love this slide, because
9 competition breeds really good readiness in the
10 Guard.

11 So, you can see we have some
12 challenges with some of our states, and but Ray's
13 program, because the GI and medical have worked
14 so closely together, we see this as a mechanism.
15 If we take it times 54, we have a lot of soldiers,
16 injuries as related to mobilization or even
17 training.

18 We get soldiers that come back from
19 AIT that are injured, and they just come back,
20 and they wait to go back to school, and you know,
21 so, there are many different applications that
22 we could use and potentially, you know, go to the

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1 Army and ask if we can expand this program. We
2 first have to get our first signature first,
3 though, to be able to happen.

4 Are there any other questions?
5 That completes the Holdeman/Faris tag team.

6 MEMBER REHBEIN: Colonel, I am
7 about to do what you asked us not to do, and that
8 was hold my question, because I --

9 COL. FARIS: Excellent.

10 MEMBER REHBEIN: -- because I
11 wanted to --

12 COL. FARIS: Did you write it down?

13 MEMBER REHBEIN: Yes, I did.

14 COL. FARIS: Excellent.

15 MEMBER REHBEIN: Because I wanted
16 to be able to refer to the graph here.

17 COL. FARIS: Okay, let me go back.

18 Can we go back to the map?

19 MEMBER REHBEIN: The map there.

20 COL. FARIS: Okay.

21 MEMBER REHBEIN: The MMPS system,
22 to me, looks like a good system, as long as the

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1 population is spread across the time line, but
2 then we run into situations like we found in Iowa
3 a year, when several hundred to 1,000 people all
4 enter at the same time, and it totally
5 overwhelmed the system.

6 COL. FARIS: Yes.

7 MEMBER REHBEIN: And I'm seeing
8 numbers here in Idaho now, where their medical
9 readiness is down 14 percent. I'm guessing it's
10 the same kind of thing.

11 How does the system --

12 COL. FARIS: Sure.

13 MEMBER REHBEIN: How does the
14 system respond to that kind of extreme
15 circumstance?

16 COL. FARIS: Yes, so, what this
17 chart reflects to you, for those of you not
18 familiar with the medical readiness categories,
19 this measures medical readiness category one and
20 two.

21 One and two means that a soldier will
22 be ready to go within three days, to move out

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1 smartly.

2 So, let's pick on Idaho. So, Idaho
3 is sitting at 67 percent. Idaho just had -- all
4 readiness expires after 15 months of PHA, after
5 12 months for dental.

6 So, a big formation came back in Iowa
7 -- Idaho, and they haven't had an opportunity to
8 appropriately reset them. So, that is what
9 impacts that.

10 But another thing that does and
11 follows suit, it was like I planted you in the
12 audience.

13 So, last year when we talked about,
14 we had 100 case managers and 156 care
15 coordinators. We expanded our contract. So,
16 the ratio that we have now is one to 250.

17 So, for every 250 soldiers in our
18 Army National Guard, I have either a care
19 coordinator or a case manager that is there to
20 support that soldier.

21 It's still high, but it's a lot
22 lower, because we had some states where we had

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1 one to 650, and so, we were able to increase the
2 contract, to be able to provide more resources
3 --

4 MEMBER REHBEIN: Can you move those
5 people around to address situations of people --

6 COL. FARIS: Another great
7 question.

8 MEMBER REHBEIN: -- of brigades
9 coming off deployment?

10 COL. FARIS: So, absolutely. So,
11 we have in the hold, some case managers and care
12 coordinators that we can surge to states, when
13 we have large force structure coming back.

14 Our preference is to move them to the
15 demob platform, so, we know what we know, and we
16 can kind of be proactive and productive.

17 Now, the beauty too, of the money
18 that we get to build medical readiness, the
19 NG6-Hotel money is that I can do personal
20 contracts.

21 If I want to, I can augment, I only
22 have so much money in NGB. But I give money to

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1 the state. The state decides how they want to
2 build readiness. They may decide to do another
3 personnel contract within their state, to bring
4 on another behavioral health person or another
5 case manager, or maybe a PA. It just all
6 depends.

7 You look at the states, I can tell
8 you by state, who has got a new DSS, who has got
9 a new G1. Whenever there is change, there is
10 always a hiccup in readiness, because it really
11 is a tandem thing. Those states that work
12 hand-and-foot with the G1 community and the
13 medical community, yield much better readiness
14 than those states that don't.

15 MR. HOLDEMAN: To answer your
16 concern about those states that have surge
17 requirements, or have re-deploying units, we
18 look at that in a G1 through our medical
19 readiness cell, and I send about \$2 million each
20 year, to those states that have re-deploying
21 formations, for additional administrative
22 personnel, for medical actions only. That is

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1 all they do, is help manage the LOD requirements,
2 the PDHRA boards, and usually they hire between
3 two or three people, and that is all they do is
4 the paper piece. That keeps their medical
5 numbers from really tanking, because everything
6 has a shelf life, with regard to the data we
7 report.

8 COL. FARIS: Any other questions?

9 MEMBER MALEBRANCHE: Did I hear you
10 say too, that you have the ability for surge, for
11 case managers to bring them on a different
12 states, because that was the other thing we
13 noticed in Iowa.

14 So, for case management, it's
15 important to have continuity. So, when you
16 bring them in, you're bringing them in for a
17 period of time. So, this is really new. This
18 is --

19 COL. FARIS: Yes, this is brand new,
20 because we just modified the contract too, and
21 we just hired, and so, the increases that all the
22 states have, and so, what we looked at, and I

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1 don't know off the top of my head, Iowa's
2 numbers, but I can get them to you, how many case
3 managers and care coordinators.

4 Usually, you have one, for every one
5 case manager, you have three care coordinators.
6 That is usually the model, as we were building
7 this.

8 And so, everybody, except for like
9 Guam and a few other small places, did not see
10 an increase. Some states saw a significant
11 increase.

12 So, we got those people hired. We
13 have the pool of people that we're hiring, that
14 are going to be used for surging, as we have large
15 formations that come back, that can come and
16 cover down in a mob station and help out.

17 One of the things that we're hopeful
18 for is that we can get the Army to the point that
19 when Faris comes back from deployment, Faris has
20 an option, if it's a low-risk/low-acuity, that
21 I could do RCMC right away.

22 If it's more complex, multiple

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1 modalities, behavioral health involved, then
2 I'm a candidate for the WTU, because they have
3 the right kind of resources. I don't have all
4 those resources available to take care of that
5 at home.

6 All that stuff could happen right
7 there, at the demob platform, because what is
8 happening right now is, Faris comes to the demob,
9 identify with a medical condition, SLAP tear.

10 Okay, I see a doctor there. Then I
11 go to the headquarters of Warrior transition
12 unit. I'm seen by another doctor. They make an
13 assessment. They do a care plan, then they say,
14 "Well, Faris, you meet the requirements to be
15 able to do remote care. Now, you're going to be
16 assessed into the community base Warrior
17 transition unit." Another assessment.

18 So, it takes about 100 days, as long
19 as there is space remaining in the CBWTU, for
20 Faris to get there.

21 If we could do it and move it all up
22 at the demob site, Faris has a

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1 low-risk/low-acuity thing, we do RCMC orders,
2 and as soon as they come off of active duty, they
3 go into a new set of Title 10 orders to get that
4 care taken done within 179 days.

5 So, we're getting there. I mean,
6 it's steps at a time. We're getting our foot in
7 the door to be able to do Title 10, and the way
8 that we're doing care, and probably a good person
9 to have come and talk to you would be General
10 Bishop from the Warrior Transition Command, as
11 they are looking at the new way of providing
12 remote care, and it's going to change.

13 MEMBER MALEBRANCHE: So, is this a
14 national contract or are you --

15 COL. FARIS: Yes, it's a contract
16 that is managed in my office, and yes.

17 MEMBER MALEBRANCHE: And the hiring
18 action is?

19 COL. FARIS: The hiring action is
20 done internally by each state. So, all the case
21 managers and care coordinators are supervised by
22 the full-time Deputy State Surgeon, and there

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1 are actually primary contractor and a
2 subcontractor that have the contract, and that
3 DSS works directly with whoever, Skyline or
4 whoever the contractor is, to hire the type.

5 Because the state may say, "You know
6 what? I really want to focus on behavioral
7 health. So, I want a social worker. I don't
8 want a nurse case manager," and they get to make
9 those decisions.

10 MEMBER MALEBRANCHE: Thank you.

11 COL. FARIS: Yes.

12 MS. DAILEY: Real quick, can I point
13 out something, I call it connecting the dots, and
14 you can correct me if I'm wrong, Colonel Faris.

15 But what we see so far is your
16 director of psychological health has a national
17 contract, in which she funds the director of
18 psychological health --

19 COL. FARIS: That is going to become
20 my contract.

21 MS. DAILEY: Which becomes yours,
22 but national contract. We just had Mr. Conner

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1 in here. He has got a national contract for
2 TAAs. We just had Colonel Faris and Mr.
3 HOLDEMAN talk to us. They have a national
4 contract out of the Army --

5 COL. FARIS: Case managers and care
6 coordinators.

7 MS. DAILEY: -- for case managers
8 and care coordinators.

9 So, you have -- this has been -- can
10 you philosophize a little bit on what these
11 contracts do for you or why --

12 COL. FARIS: It builds readiness.
13 It builds ready soldiers, resilient soldiers,
14 and the reason why we have to do national
15 contracts is because we have a cap on our force
16 structure.

17 So, not everyone can be in uniform.
18 Not everyone can be AGR. Not everyone can be a
19 technician, and so, the only way that we can
20 multiply the cap that Congress has given us is
21 to be able to augment with those resources that
22 we get, and I think that is a strength of the

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1 Guard.

2 The fact that we tell them this is
3 what we want. We want you to be 82 percent
4 ready, and then the states figure out how they're
5 going to do that, and we give them the resources
6 to do that.

7 MEMBER EVANS: Could you elaborate
8 on -- so, when you say national contract, so,
9 kind of help me walk through this.

10 COL. FARIS: So, it's a contract
11 that is managed through my office and the
12 Surgeon's Office. It's a contract that is led
13 by my contracting office at National Guard
14 Bureau.

15 We manage it. I have the COR that
16 manages the contract in my office, and then that
17 contract is then broken out in all the 54 states
18 in territories, get a piece of that contract.
19 We do the same thing for the directors of
20 psychological health contract, case management
21 contract and I'm sure, the TAA contract is the
22 same way.

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1 MR. HOLDEMAN: And just to take that
2 idea of philosophizing one step further, it
3 demonstrates how effective we've been in
4 communicating to the Director of the Army
5 National Guard and the Chief of the National
6 Guard Bureau, how important medical readiness
7 and access to care is for the health of this
8 force, their force, and they fully support it.

9 CO-CHAIR CROCKETT-JONES: Thank
10 you very much, Mr. Holdeman. Thank you, Colonel
11 Faris.

12 I think we have a brief break and
13 then we'll be back in about 15 minutes.

14 (Whereupon, the above-entitled
15 matter went off the record at 3:05 p.m. and
16 resumed at 3:15 p.m.)

17 MS. DAILEY: So, ladies and
18 gentlemen, I am going to turn this over to our
19 Task Force Director in a minute. Don't want
20 anyone tuning out. This is all kind of very
21 planned series of briefings. They're all
22 connected. They all are talking about the

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1 Reserve component and how their safety nets and
2 how their processes are working, and we have
3 Colonel Knowlton, you're all the way up here from
4 Tampa, Florida, right, Colonel Knowlton?

5 COL. KNOWLTON: Yes, I am.

6 MS. DAILEY: Yes, you can tell by
7 the tan. So, I had to get that in. I'm envious,
8 of course. I'm from Florida.

9 Ma'am, I'm going to turn it over to
10 you. Thank you.

11 CO-CHAIR CROCKETT-JONES: All
12 right, we're now receiving a briefing from
13 Colonel Knowlton, Keith Knowlton, the Deputy
14 Commander at Reserve Component Soldier Medical
15 Support Center in Florida.

16 The Medical Support Center was
17 established in January 2011 as a pilot program
18 to improve visibility of and accountability for
19 RC soldier medical evaluation board packets.

20 The center supports both Army
21 National Guard and Army Reserve personnel.
22 Colonel Knowlton's information can be found

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1 under Tab G in your briefing book.

2 COL. KNOWLTON: Thank you. I'm
3 torn between sitting and standing, because as an
4 Army Aviator by branch, I'm used to talking with
5 my hands, but now, that I've been hamstrung with
6 this microphone, I'm not quite sure if there is
7 a purpose in standing.

8 So, maybe if I sit here, I'll do less
9 damage to the things around me.

10 But first, thank you very much for
11 the invitation, the opportunity to speak to this
12 group, and for the work that you all do on behalf
13 of our recovering, wounded, ill and injured
14 Warriors. It's a pleasure to be here.

15 This particular briefing is going to
16 be somewhat centric to the Army, as a service,
17 and then the Guard and Reserve, as components.

18 So, I'll be mindful of the fact that
19 we have a diverse audience here of services, as
20 well as civilians and those who may or may not
21 be familiar with those service and component
22 specific acronyms, but please, feel free to ask

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1 questions throughout the presentation, if you
2 have any.

3 The structure of my presentation is
4 built around the questions that were submitted
5 to me, and I believe are under your Tab 9 of
6 those, where basically, you asked to know about
7 RC SMSC, and then its contributions to
8 recovering, wounded, ill and injured Warriors
9 and best practices associated with it, and then
10 challenges to those best practices.

11 So, the structure of my presentation
12 is going to begin with a quick overview of the
13 realignment under the Physical Disability
14 Agency, which is something that occurred
15 subsequent, I think to this invitation, and
16 speaking with the Board here, they said that that
17 would be of value to bring up, this recent
18 realignment.

19 Then we'll look at the RC SMSC
20 itself, in a little bit more detail, getting into
21 the meat of your questions, and then finally,
22 look at the way ahead, as we approach a slight

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1 realignment of the RC SMSC mission in the coming
2 month.

3 As the Chief of the Staff of the Army
4 took a look a medical readiness in our force,
5 specifically, the Reserve component, as well as
6 how to aid these recovering, wounded, ill and
7 injured Warriors, it became apparent that we
8 lacked a unity of command and a single
9 responsible agency for which to integrate the
10 active and reserve components into the
11 Disability Evaluation System.

12 So, the Chief directed along three
13 lines of effort, governance, process
14 improvement and reform, a series of initiative.
15 The one that's most relevant to my presentation
16 is the direction of a general officer to lead the
17 United States Army Physical Disability Agency,
18 and then the realignment of the Reserve
19 Component Soldier Medical Support Center,
20 underneath the Physical Disability Agency.

21 The idea here was to be able to
22 provide general officer level of visibility of

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1 the process, to manage metrics, implement
2 coordination and then to also act as a Department
3 of the Army advocate.

4 Previously, the RC SMSC, while under
5 a general officer, the Commander of USAR MEDCOM,
6 led to some challenges, because it wasn't
7 directly aligned vertically up through to the
8 Vice Chief, who has ultimate responsibility for
9 DES, as well in some ways, it didn't acknowledge
10 the contributions and needs of both the Army
11 Guard, as well as the Army Reserve.

12 So, as we see underneath this
13 proposed USAPDA organizational structure, we
14 now have a much clearer line from the center in
15 Pinellas Park, up through the Director of
16 USAPDA, who also has responsibilities for the
17 Physical Evaluation Boards, which ultimately,
18 we directly support, and then on up to the Vice
19 Chief of Staff.

20 The Director of the PDA is Brigadier
21 General Boone, who most recently served the
22 Department of the Army spokesperson in ISAF

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1 Afghanistan, with ISAF, rather, in Afghanistan,
2 and part of that, served as the Chief of Public
3 Affairs for the United States Army, and then I,
4 myself joined him on the first of October, while
5 he serves as Mission Commander from up here in
6 D.C., I serve as the Officer in Charge, down in
7 Pinellas Park, responsible for the day-to-day
8 operations.

9 I'm one of those operators that they
10 referred to earlier, as opposed to perhaps, my
11 administrative strengths are not quite as strong
12 as Colonel Faris or Mr. Holdeman.

13 My commands have been at the company
14 battalion and brigade level, so, it's somewhat
15 interesting that now, I find myself in an
16 administrative role.

17 But I think it's important to this
18 Task Force, that we have operators in the mix,
19 to kind of continue to get after this back-log
20 of packets.

21 So, as we take a quick look, just to
22 kind of establish some context, the background

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1 of the RC SMSC, we're looking now, at about --
2 coming up in January, on two years essentially,
3 of the concept being implemented. It was
4 established in January 2011, and as the
5 personnel started to gather together, resources
6 were made available, facilities identified.

7 Concurrent with that, the Executive
8 Order was issued, that was released on the -- in
9 April 2011, essentially standing up the RC SMSC.

10 Initially, the pilot consisted of
11 packets from SRMC, the Southern Regional Medical
12 Command, and over the Summer, and the center
13 worked through those packets and started
14 developing processes, the FRAGO to EXORD 1 came
15 out, then bringing online the 54 states and
16 territories, as well as the Reserve Component
17 Regional Support Commands, or RCS's, into the
18 purview of the center, as well.

19 What became very apparent though
20 there, as we came out of the Summer of last year,
21 is that the concept, while well intended, lacked
22 the business processes that are needed to

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1 implement the kind of program that we're looking
2 at here.

3 And so, in October of 2011, with the
4 assistance of an outside management consulting
5 team, an integrated process team was established
6 to develop a draft concept plan, as well as
7 business process management tools, and I draw
8 your attention to that internal tracking tool
9 that we developed called Appian, because that
10 tool is kind of the cornerstone of our operation.

11 What it does is, it provides a
12 mechanism for which we can process packets
13 through the center, handing off from section to
14 section, providing untold numbers of metrics, as
15 well as send out correspondence to our many
16 stakeholders, all through that same integrated
17 tool, and that is certainly among those best
18 practices, in terms of your request to identify
19 best practices, that certainly, at the top of the
20 list, is this business process software tool
21 that we developed.

22 The RC SMSC, following that initial

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1 concept plan and reached full operational
2 capability in January 2012, and so, we sit here
3 today with 11 months, really of operational data
4 behind us.

5 As we look at the mission purpose and
6 end state of this center, what I would ask you
7 to take away from this is that again, at a very
8 specific level within the Reserve components and
9 then only at the Army -- within the Army service
10 itself, the RC SMSC serves as a gateway for these
11 Reserve component soldiers to enter the IDES
12 system.

13 It provides a vital link between the
14 Reserve components and the Army medical system,
15 but ultimately, its purpose was -- is a surge
16 capability. It's specifically to get after
17 what has been projected initially at 40,000,
18 then 20,000, perhaps more realistically, 8,000
19 Reserve component cases that currently lie, we
20 believe currently lie in the states and RSCs
21 awaiting entry into the integrated disability
22 system.

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1 So, it's a surge mission, funded
2 with OCOA dollars, consisting of about 60
3 personnel, located in Pinellas Park, which is
4 across the bay from Tampa. So, you'll hear us
5 alternately referred to RC SMSC and/or Pinellas
6 Park, or as that group of tan people down there
7 in Florida, I guess.

8 But anyway, I can assure you, we're
9 not at the beach. I've only been there eight
10 weeks, I haven't seen the beach yet. But
11 anyway, it's fun to kid.

12 But this certainly is a surge
13 capability, although I will offer that the
14 benefit that is being quickly derived from this
15 is the opportunity to draw up plans for the
16 future, in both how the Reserve and Guard can
17 maintain this on a steady state, integration of
18 our wounded and ill and injured soldiers, into
19 the Disability Evaluation System.

20 We'll speak specifically to a plan
21 that the Reserve components are doing, I mean,
22 the Army Reserve, as well as the Army Guard.

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1 Because it serves as a cornerstone,
2 not only of our operation, but that of the
3 medical treatment facilities and then the
4 Medical Evaluation Boards, the MEB's and then
5 the Physical Evaluation Boards beyond that, the
6 PEB, this MED document checklist is very
7 important, and I would just draw your attention
8 to it. It's seemingly innocent enough, some
9 16/17 items that we need to travel with the
10 packet, as it goes through the system.

11 And this standardization is in fact,
12 relatively new. It's only within the last two
13 and a half years, that United States Army MEDCOM
14 produced the standardized checklist, based on
15 MEB and PEB requirements.

16 One of the challenges prior to that
17 was perhaps, disparity between the medical
18 treatment facilities in what documents they
19 needed, then a case would get part-way through
20 the system and stymied because a document wasn't
21 available.

22 So, this standardization lent a

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1 great bit, in terms of progress to the system.
2 It's also the cornerstone document that we use
3 with the RC SMSC, as we gather documents from the
4 states, then come to the RC SMSC for validation,
5 and then forwarding on to the medical treatment
6 facility, and I'll show you that more
7 specifically, in just a second.

8 But it certainly provided focus.
9 The challenge here that you'll hear, if you spend
10 any time in this small arena at all, is the first
11 three documents, those that deal with line of
12 duty investigation, the medical service
13 treatment record and then the profile, itself.

14 As you'll see a little bit later
15 here, those three documents account for the
16 biggest challenge in getting these cases out of
17 the states in the RSCs and into the Disability
18 Evaluation System. The remaining documents are
19 primarily administrative in nature, and are in
20 systems that we have ready access to, either
21 administrative or financial.

22 The biggest challenges with these

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1 first three, that don't necessarily reside in
2 systems that talk to each other and/or are
3 properly resourced.

4 As we take a look at where the RC SMSC
5 sits within the Reserve component disability
6 evaluation system process, we see that to your
7 left, we have -- starting from the left, the Army
8 National Guard states and the United States Army
9 Reserve Regional Support Commands are actually
10 the ones who have responsibility for building
11 the case files.

12 They certify then, that the profile
13 is valid, that there is a supporting line of duty
14 investigation, that under -- you know, that
15 validates that this injury or antagonation [sic]
16 of the situation occurred while they were on
17 active duty, and having certified that, they
18 send the packet forward to RC SMSC.

19 I'm going to blow up that square in
20 just second and show you in more detail, what it
21 is that we do there, because that gets to the meat
22 of your question about where we contribute to the

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Comment [SL1]: review

1 processing of these soldiers.

2 But from a big picture, you see that
3 it comes through this central gateway for
4 validation, prior to going onto MEDCOM, and
5 there is tremendous value in this process.

6 Not trying to make a case for it, but
7 I can see where as a career Guardsmen myself,
8 with 30 years of service in the Guard, I'm very
9 familiar with the disparity that exists between
10 states and any manner of processes, whether it's
11 in administration, in this case, medical issues,
12 even operational ones, as I go from state to
13 state, perhaps in my capacity as an aviation
14 officer and some other arena. It's just the
15 nature of the individual states and territories,
16 to have differences.

17 But unfortunately, to integrate
18 into an active component system, there is really
19 not a lot of room for too much variance, and so,
20 serving as a gateway, as it does, we enable these
21 packets to all kind of maintain a standardized
22 quality.

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1 In some cases, something as
2 distinctly different between states as
3 language, Puerto Rico is one of the states -- I'm
4 sorry, one of the territories that we service,
5 and so, it's not uncommon for us to receive
6 profiles and entire cases done in Spanish, and
7 it's fortunate we have a number of Spanish
8 language speakers on our staff and we're able to
9 accommodate that, which might not exist if these
10 packets went direct from a state or RSC to a
11 Military treatment facility.

12 We also maintain contacts at each of
13 these states, and you'll see that here in the
14 next slide as we drill down to what the RC SMSC
15 does, and this just gets to your question that
16 was presented, with regard to who do we
17 communicate with, perhaps how do we communicate
18 and how do we interact with other installations.

19 I want to pause for just a moment to
20 see if there is any questions up to this point.

21 Okay, so, you can see then that we
22 have a bidirectional communication with each of

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1 these enterprises, first off, of course, our
2 primary customer, the states and their Reserve
3 Component Regional Support Commands, who are
4 involved in the development of these cases, and
5 they're submitted to us by both electronic copy,
6 the majority of the documents and then also, the
7 hard copy of, for instance, things like the
8 service treatment record.

9 As much as we try to work around
10 that, hopefully, by getting service treatment
11 records into the appropriate electronic
12 databases, be it ALTA or HRR, that continues to
13 be a major challenge, not just for us, but I think
14 for our enterprises as a whole.

15 But the National Guard Bureau
16 Surgeons and the USAR Surgeons, as primary
17 stakeholders, deal with them on a regular basis,
18 as we deal either with frustrated cases or
19 develop and refine processes.

20 The Medical Evaluation Board
21 tracking office is the one who ultimately
22 assigns a MEDTO tracking number to our case, and

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1 then regulates it on to a medical treatment
2 facility for processing into the MEB system, and
3 then you see the Medical Evaluation Board
4 itself, comprised of those MTFs, and then also
5 the VA.

6 So, the value add, I think that RC
7 SMSC brings, which will be more apparent in a
8 moment, when we get specifically, to medical
9 evaluation, but it's this coordination and
10 tracking of packets.

11 One of the questions that was posed
12 was how long does it take for a packet to get from
13 essentially second signature, that is, the point
14 at which a condition is considered to be at the
15 medical readiness decision point, and we define
16 that as either a point at which a physician says
17 that that issue has stabilized and is not going
18 to progress any further and/or 12 months from the
19 date of initial diagnosis. Either one of those
20 constitutes the MRDP.

21 The MRDP results in a second
22 signature physician saying that it's reached

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1 MRDP, and at that point, the case is suppose to
2 enter into the disability evaluation system.

3 In the Reserve component though,
4 that means for those soldiers whom we address,
5 and we don't address all soldiers, we don't
6 address for instance, those that are on AGR or
7 other Title 10 statuses, we don't address cases
8 that are not line of duty cases.

9 We only address those cases that are
10 Title 32 Guard and Reserve that occurred in the
11 line of duty.

12 But again, the time that it takes
13 those cases to go from the states and the
14 Reserve, from second signature, is unknown to
15 us, and that is the subject of much speculation,
16 and depending on what you read, you hear anywhere
17 from 30 days to seven years, and yes, go ahead,
18 please.

19 MEMBER TURNER: Colonel Knowlton,
20 it says here that once the package hits the RC
21 SMSC, that you have -- that there is apparently
22 transparent communication with VA partners.

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1 What is that, exactly?

2 COL. KNOWLTON: Thank you for the
3 question. What we have there, with regards to
4 the transparent communication with VA partners,
5 this is one of the value-adds that came from this
6 concept, perhaps unbeknownst at the
7 origination, and that is, we have individuals
8 there at the center who work full-time in their
9 civilian capacity, with the Veteran's
10 Administration, in some cases, in senior
11 positions.

12 So, it became apparent early on,
13 that if we're going to do this integrated
14 disability evaluation system, that if we could
15 get this integration occurring at the earliest
16 possible point, it would be a value-add to the
17 system.

18 And so, several people there in the
19 Pinellas Park took the initiative to work with
20 VA, to get an authorization for the Veteran's
21 Administration pension and compensation exam,
22 to be given to the RC SMSC, right up front, right

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1 at the very beginning, as opposed to catching up
2 to the case when it got to the Medical Evaluation
3 Board, which is where it often occurs.

4 That way, we would have that as part
5 of the packet that went forward to the MEB, and
6 the case wouldn't be frustrated at that level,
7 for lack of that plan.

8 So, while perhaps, that is a very
9 broad generalization, when we say continuous
10 transparent communication, I will say that we do
11 have a relationship with VA, a relationship that
12 allows us to send a request for those records.
13 To date, our response rate has been in under 72
14 hours, they respond back with the complete comp
15 and pen exam.

16 Then as we need subject matter
17 experts, we have resources that we can go to, to
18 get them.

19 So, we're guilty of perhaps, a broad
20 statement there.

21 MEMBER TURNER: Am I to infer that
22 actually, the VA is hard-wired into your review

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1 process?

2 COL. KNOWLTON: Hard-wired into
3 our?

4 MEMBER TURNER: Review process?
5 You said that when you get the package, that you
6 -- you know, you talk to VA. Do you talk to the
7 VA on every package?

8 COL. KNOWLTON: No, no, no, and I
9 didn't want to give the impression that this is
10 a bidirectional communication.

11 It is us, requesting from them, the
12 pension and compensation packet -- or exams,
13 them sending them to us, and then when those
14 individuals on our staff, most of the healthcare
15 providers have questions, we have open lines of
16 communication back to the VA, again, because
17 many of them serve in leadership positions there
18 as healthcare providers.

19 But that would be the extent of that
20 relationship. There is not an official
21 relationship between the two.

22 MEMBER MALEBRANCHE: And Dr.

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1 Turner, as I understand, I'm from the VA, but as
2 I understand, Dr. Cross and our IDES process, we
3 have been working together, especially with
4 Pinellas Park when that first came up, so, that
5 sometimes, our docs are doing the exam for them,
6 and there's still even further -- yes, there is
7 even more collaboration occurring now with those
8 different IDES.

9 But Pinellas Park was a major issue
10 from when General -- the one that was up here,
11 General Officer that was up here working with us,
12 to set Pinellas Park up when we first discovered
13 it was going to occur and all those people were
14 coming in.

15 So, there is lot of communication
16 back and forth, but we're not wired, as far as
17 the electronic health record, if that's what you
18 were getting at.

19 COL. KNOWLTON: Okay, we'll
20 continue. This is the process through which --

21 MEMBER REHBEIN: Colonel?

22 COL. KNOWLTON: Yes.

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1 MEMBER REHBEIN: Let me just
2 clarify something in my own mind, for just a
3 minute.

4 COL. KNOWLTON: Yes.

5 MEMBER REHBEIN: The population of
6 people that you're dealing with, you said
7 something about Title 32 a minute ago.

8 The medical condition may have
9 occurred under Title 10, but they're under Title
10 32, now --

11 COL. KNOWLTON: Yes, that's
12 correct.

13 MEMBER REHBEIN: -- or the medical
14 condition occurred under Title 32?

15 COL. KNOWLTON: The former. It
16 could be either one of the two.

17 MEMBER REHBEIN: Okay.

18 COL. KNOWLTON: So, a soldier is in
19 a drill status IDT, Individual Duty Training,
20 and he incurs an injury or aggravates an existing
21 condition and/or as Colonel Faris illustrated
22 earlier, somebody comes off active duty and then

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1 perhaps, during the period of their PDHRA, 60 or
2 90 days into it, they develop -- the situation
3 gets aggravated, either one of those, as long as
4 the line of duty can substantiate that it was
5 service connected. Thank you for the question.

6 Here is the meat of what the RC SMSC
7 does, and there is a number of take-aways here
8 that address your questions, as they were
9 presented anyway, and I'll try to point those out
10 specifically, and some of those, you'll take
11 away on your own.

12 But as a packet comes to us, from the
13 Reserve component, the first thing we do is, we
14 triage that packet in our patient administration
15 department, and that is -- we literally have a
16 physical process that follows that of our
17 digital process.

18 Cases come into a room. They go
19 around a hallway, across a hallway, down other
20 rooms and then back to that originating room.
21 It actually is like a physical assembly line, as
22 well as digitally, our software allows for the

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1 passing of that case from section to section, and
2 during different points in that process, we're
3 able to do things like communicate with the
4 solider and/or the unit, in terms of requesting
5 additional information.

6 We're able to send out electronic,
7 as well as snail mail requests. But mostly,
8 we're able to pull tremendous metrics.

9 So, I can tell you to the case, how
10 long any case sits at any point in this process.
11 I can tell you how many cases a service provider
12 does, or a healthcare provider, how many cases
13 they handle, how long a case is here from start
14 to finish. We can slice the data 8,000
15 different ways.

16 But back to the process itself, the
17 initial triage is important because we currently
18 validate to see that all 17 items from the
19 checklist are present, and these are hard copy,
20 FedEx to us from the states or the RSCs.

21 So, we go through and just validate
22 that those are there. If they're not, then we

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1 immediately send them over to request for
2 information, another area we call RFI and VA
3 Hold, because it's in the physical area, and at
4 that point in the process, in which we make
5 requests for the remaining supporting documents
6 that might have been missing from that initial
7 checklist. We don't take a packet and just send
8 it back, if it comes incomplete.

9 So, it's our objective to try to get
10 that packet complete and get it on through the
11 system.

12 So, it's at that place as well, that
13 the packet awaits, and as I said, generally
14 speaking, 72 hours or less, a reply from VA with
15 the electronic documentation and support of the
16 P&C exam.

17 MEMBER TURNER: Sir?

18 COL. KNOWLTON: Yes?

19 MEMBER TURNER: This is all done
20 through Appian?

21 COL. KNOWLTON: Yes, and so, Appian
22 is the name of the business process management

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1 tool that we utilize, and that is the software.

2 Thank you for clarifying that.

3 That process of RFI Hold can take
4 anywhere -- can take the packet now, anywhere up
5 to the 20 to 30 day mark.

6 Generally speaking, what we find is
7 that when we send out the first request for
8 information, we give the customers, if you
9 would, states and RSCs, 20 days to reply, and
10 what we find is about 20 percent reply in those
11 20 days.

12 Then what we do is, we send out a
13 letter that says, "You have five days to reply
14 or the packet comes back to you," and it's
15 amazing, we have 80 percent compliance, at that
16 point.

17 So, anyway, we all work to the same
18 standard, I'm sure, of reacting to the nearest
19 50 meter target.

20 But we, general speaking, have
21 tremendous response from the states and the
22 RSCs, because they understand at that point,

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1 once the packet has come to us, we're doing
2 everything we can to get it on into the system,
3 and so, we work against ourselves, if for lack
4 of a piece of information, it gets, you know,
5 referred back to the states.

6 Once we have the packet or at this
7 point, most of the packet, we refer it over to
8 PEBLO Staging.

9 Now, PEBLO is a term, of course, the
10 Physical Evaluation Board Liaison Officer, and
11 the individuals within our organization are not
12 PEBLOs per se, although they receive most of the
13 same training, and we utilize them in a similar
14 capacity to the active component.

15 PEBLO, who works at the MEF and is
16 the person tasked with liaisoning back to the
17 individual soldier.

18 But in our case, the PEBLOs liaison
19 with the Deputy State Surgeons, and in some
20 cases, with the soldier, as well, to ensure that
21 the packet is valid and that the condition still
22 exists, et cetera, and you'll see more of that

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1 on the next slide.

2 From PEBLO Staging, the packet goes
3 to validation, and that is where it's actually
4 seen by a healthcare provider, either a
5 physician's assistant or a doctor, of which we
6 have eight on staff. Right now, we have eight,
7 and four physician's assistants and four
8 doctors, who then go through and look at the
9 profile to ensure that it meets the necessary
10 requirements for a disqualifying condition, to
11 ensure that there is an LOD that supports it, and
12 that there is a medical service treatment record
13 that supports that, as well, and if those three
14 conditions are present, then the case gets
15 forwarded on.

16 As you'll see here in just a moment,
17 in a number of cases, and this where the
18 value-add comes to the system, some of those
19 cases don't need to move forward, either they
20 never should have gotten there in the first
21 place, or the profile can be downgraded, because
22 either the physician who originally filled out

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1 the case and sent it forward, perhaps didn't fill
2 the form out correctly, maybe called something
3 a P3 that could have been a P2, or was unaware
4 of the intricacies of the rules regarding the
5 profiles.

6 Because what we find is that while
7 we have world-class physicians out there in our
8 Guard and Reserve components, they're not
9 necessarily world-class administrators of the
10 Army's administrative processes.

11 And so, just because we bring one
12 into the service, doesn't mean we can turn them
13 loose on this process, and expect them to
14 properly complete the paperwork.

15 After it goes through that
16 validation, it's returned to the physician -- I
17 mean, the patient administration department,
18 where it's uploaded into eMEDPRO, and then it
19 awaits a MEBTO number from the regulating
20 office, and at that point, that is when we are
21 told what medical treatment facility that case
22 is going to go to, and it's at that point

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1 currently, that the case enters into the VTA, the
2 Veteran's Administration -- thanks, give it to
3 me again, please.

4 MEMBER MALEBRANCHE: The Veteran's
5 Tracking Application.

6 COL. KNOWLTON: Tracking
7 application, I don't why I stumbled on that one,
8 but thank you. I did mention, I started 1
9 October, right? So, I'm getting the acronyms.

10 Anyway, so, it's at that point, and
11 on a serious note, it's at that point that the
12 case then gets visibility, if you would, at the
13 national level, or transparency to all the
14 stakeholders, because getting back to the
15 initial issue, and that is when a case resides
16 in the states and the RSCs, even though it's
17 second signature, it doesn't go into VTA at that
18 point, like it does in the active component.

19 It goes from there, through whatever
20 process it goes through in the states and RSCs,
21 before it ever comes to us, and even when it comes
22 to us, while it's entered into Appian, that is

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1 an internal process management tool. It has no
2 visibility, other than reports that we generate
3 and distribute, there is no visibility of that
4 system, by outside stakeholders.

5 So, it's not until that case gets
6 into VTA, that it now comes up on visible, if you
7 would, to all of the stakeholders.

8 This is the real meat of what the RC
9 SMSC does, in terms of adding value to the
10 process, and I think even to the individual
11 soldiers, themselves.

12 A lot of it has to do with the
13 orientation, the personal orientation of our
14 healthcare providers. Never having worked in
15 the medical arena, I certainly had plenty
16 physicians and other healthcare providers on my
17 staff, and I've always known them to be very
18 committed to their calling.

19 But it's been a joy these last two
20 months, to be able to sit and work hand-in-hand
21 with them, and see how that comes through in the
22 care that they give to each one of these cases,

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1 not just in terms of the hours that they work,
2 but the personal phone calls they make to the
3 soldiers, to find out what their condition is,
4 and in many cases, help them through challenges
5 that -- and the system that may not even have to
6 do with the specific medical case, but rather,
7 the administrative side, because many of these
8 healthcare providers served in the Deputy
9 Surgeon's Offices of their respective states or
10 RSCs.

11 But among those things that they do
12 is they contact the soldier, if there is a
13 question, and in some cases, these profiles come
14 through very straight forward. There is no
15 question. The packet is simply validated and
16 sent on to the MEB.

17 But more often than not, there may
18 be a question and the soldier is contacted to
19 review their current contact information, the
20 medical issues in the profile, because again,
21 from the time this case hits second signature in
22 the state, although we don't have that time

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1 frame, it's again, speculation as to how long
2 that might be.

3 Certainly, we have situations where
4 the soldiers either moved or change their phone
5 number or something else, and we're trying to get
6 that contact information correct, so that when
7 the packet enters the MEB stage, it's not stymied
8 for lack of contact information.

9 So, having verified those medical
10 issues and validated that the soldier's
11 condition doesn't meet the retention standards,
12 ensuring that those LODs are present, the docs
13 also identify additional diagnosis.

14 Now, you'll see as we change the
15 orientation slightly of the mission of RC SMSC
16 in the coming months, and that will be the last
17 slide that I'll present for you, we're going to
18 get away from identifying additional diagnosis,
19 and while there is an argument that that provides
20 value-add to the system, and certainly to the
21 MEBs and then ultimately, the PEBs, in some ways,
22 that duplicates the work of those professionals

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1 down-range, as well, and in order to get after
2 this back-log of cases that are in the states,
3 it may be better suited to allow the people
4 downstream to identify those additional
5 diagnosis and use the time of our physicians to
6 work more closely with the states in getting them
7 out of the shadows, if you would, and into the
8 system.

9 One of the other value-adds that the
10 physicians provide is this summarized in a
11 validation brief of the condition, and the
12 conversations that they've had with soldier,
13 which becomes part of the packet that is then
14 forwarded on to MEDCOM.

15 All right, here is a little eye chart
16 to wake up some of you. If it starts to spin,
17 all I can tell you is, you're hypoxiating and you
18 need to get some air, but those colors will deal
19 with you in a moment.

20 So, what we're looking at here is,
21 don't get too wrapped about the exact numbers,
22 if you would, please, we're looking at trends

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1 here, and that is, as we look at about the 4,000
2 packets that have been received at RC SMSC over
3 the two year period that we've been operational,
4 we see about 1,500 of those packets have been
5 returned back to the states.

6 Now, I know you heard me say earlier
7 that we try not to return any packets, that we
8 try to work them through to completion and send
9 them onto the MEB.

10 But here is why this is such an
11 important process, to have a centralized
12 gateway, if you would.

13 So, we see, for instance, starting
14 just at the top, and I won't go over each of
15 these, but AGRs and those soldiers who are
16 already discharged, they comprised eight
17 percent of the packets that were returned.

18 So, those are -- those are packets
19 that didn't now go down-range, get into the MEB
20 process, only to be found ineligible by a PEBLO
21 or somebody else in that downstream arena.

22 Now, in the current slide it says

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1 IRR. That is because at the time this slide was
2 developed, and I apologize for not having made
3 the correction, but we now, very recently, have
4 started doing the IRR cases, as well.

5 So, we now do both Army Reserve, IRR,
6 which is obviously, a sub-component of Army
7 Reserve, but we previously didn't handle those,
8 as well as Army National Guard.

9 Then we have cases, for instance,
10 that were just sent in error, or those that are
11 not at MRDP, and that accounts for three percent.

12 In other words, the case was
13 forwarded, but there is no finding of MRDP, maybe
14 there is an illness or injury that occurred, but
15 that person has not yet gone through any exams,
16 the condition has not stabilized, and really, it
17 needs to go back to the state or RSC to run its
18 course, to achieve MRDP.

19 The real money-maker though, is in
20 those cases that were downgraded, and we see that
21 eight percent, that means those are soldiers
22 that were returned to duty and ultimately, that

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1 gets at Army readiness, and then also, for the
2 soldier themselves, understanding what their
3 condition is, if there is one, and what their
4 future is, because if the case is down -- the
5 profile is downgraded and they're able to return
6 to duty, then that lets them get on with their
7 lives, as well.

8 But out of those, we still see that
9 51 percent -- I'm sorry, 56 percent, about half,
10 a little more than half are returned -- are
11 received, requiring additional information, and
12 so, as we expand on that particular piece of the
13 pie, and I've kept a copy of it down there in the
14 bottom left, for those of you that have been
15 mesmerized, we see that out of about the 850
16 packets, a very, very small percentage of them
17 are for those administrative items that I've
18 mentioned, which we refer to as items, basically
19 two and then nine through 16, if we were actually
20 to look at them enumerated on the checklist.
21 Those are the administrative documents,
22 everything from an LES, to copies of orders,

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1 promotion orders, discharged, DD-214's, et
2 cetera.

3 The lion's share of the challenges
4 that we experience are in those first three
5 documents, the medical documentation that
6 supports the finding, the Commander's statement
7 and the line of duty investigation.

8 We believe, as an enterprise, and by
9 that, I mean the leadership of the Army Reserve
10 and the Army Guard, we believe that that is the
11 piece that RC SMSC now has to go after, and that
12 is getting these three items together in way that
13 that case can come out of the states and into the
14 Disability Evaluation System.

15 A quick look here at the progress,
16 if you would, both in terms of the number of
17 packets validated, and you see that currently,
18 we're at over 3,000.

19 In the bottom right corner, I've
20 gone ahead and projected for you, first quarter
21 FY13 based on what I knew coming out here, that
22 we'll achieve a combination of about 702 packets

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1 for the Army Guard and Reserve in this quarter,
2 gradually increasing from that first quarter of
3 -- the second quarter of FY11, with a whopping
4 15.

5 Our challenge though is, this isn't
6 enough. We need to be doing on the order of 800
7 packets a month, in order to get after, although
8 admittedly an unknown number, but the number of
9 back-logged cases, as well as the steady state
10 ongoing ones that exist in the Guard and Reserve,
11 and I'll show you are plan for doing that.

12 So, while on the one hand, I'm proud
13 of the progress that the center has made, the
14 many stakeholders that support the center and
15 the agencies that work along side us, I think
16 that is a pretty good improvement,
17 unfortunately, we still have a lot of work to do.

18 MEMBER REHBEIN: You said 800 a
19 month?

20 COL. KNOWLTON: Is the target. One
21 of your questions was best practices at the
22 states and the RSCs, that they've done, and I

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1 just want to draw your attention to two cases,
2 or two situations, one from each, that have been
3 undertaken, that illustrate, I think where the
4 core issue is for getting these cases, and of
5 course, cases are not cases. Cases are people.
6 They are wounded, ill and injured soldiers that
7 we need to get into the process.

8 But these two exemplify some of the
9 best practices that we would like to see carried
10 out throughout the rest of the Reserve
11 component.

12 The first one was the United States
13 Army Reserve Command's medical management
14 activity, which did a review of essentially
15 7,800 packets, cases, rather, many of which had
16 been -- or profiles. Actually, it was just
17 specifically the profile, many of which had been
18 done under a contract, and of those 8,000
19 essentially that were done under this contract
20 over a period of a couple of years, what they
21 found was that far and away, the majority of the
22 cases were single issue psychological issues,

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1 that resulted in the profile rating that they
2 received.

3 Now, certainly, I would say that the
4 service components, everybody involved in this
5 process takes psychological issues very
6 seriously. I don't want my next statement to
7 reflect anything other than that. It's a
8 serious issue.

9 We have full-time on staff, one of
10 our physicians is a very well known doctor,
11 specializing in TBI and PTSD, for the VA, and we
12 have him for a year, working our cases.

13 But what we see is that when they
14 went through those profiles, they found that
15 more than half of those profiles were not
16 eligible -- were not eligible -- they didn't
17 require an MEB. Simply, the profile had been
18 too aggressively written, as we went back and --
19 as they went back and looked at those profiles,
20 they got the person either into the proper
21 category or back returned to duty.

22 But I was questioned once, if there

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1 was a correlation between that and the fact that
2 these were psychological issues, and I just
3 wanted to again, assure people that that is not
4 the case, although that's what most of the
5 profiles were written for, it's because there
6 was a lack of understanding, I believe to be the
7 case, on the part of the contractor at the time
8 who was writing those, but they were all screened
9 back again by physicians, who then made the
10 changes that were made.

11 But anyway, of the remaining
12 profiles, 43 percent required a Board.

13 So, that was an important process
14 that the Reserve component went through, and one
15 that kept, as you could see, a lot of cases out
16 of the system, returned soldiers to duty and gave
17 them a sense of a way forward, with regard to
18 their medical condition.

19 Now, one that was conducted here
20 more recently this Summer, and this is
21 illustrative of what we need to happen, I
22 believe, throughout our Reserve components, and

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1 that is the Texas Army National Guard, which by
2 force structure, is either the first or second
3 largest in the state, going back and forth with
4 California.

5 They completed an eight week Summer
6 annual training period here, where they went
7 through and took 1,170 P3/P4 profiles, and went
8 through and validated each of those for those
9 three conditions, a disabling qualification,
10 supporting line of duty investigation and then
11 supporting service treatment record for that
12 disqualifying condition.

13 And prior to even getting started,
14 with all the soldiers that they had aligned to
15 do this, the healthcare professionals and the
16 locations, they went ahead and screened these
17 and were able to eliminate 400 right off the top,
18 for a variety of administrative reasons.

19 Then after that, using those 30
20 personnel as you see here, they reviewed the
21 remaining 773 profiles and were able to get that
22 down to really on 260 of which were found as valid

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1 and requiring a MEB.

2 So, going from 1,170 down to 260, we
3 took those -- they took those cases, if you
4 would, out of the shadows, out of that unknown
5 status and the uncertain future of those
6 soldiers, and gave them clarification.

7 We see a correspondence between
8 those 22 percent within the Guard that were
9 appropriate for the MEB, and the 43 percent up
10 at the top there with the USARC, when we take into
11 account that USARC included those that were NDR
12 PEBs, as well as MR2, other Boards other than the
13 MEB, where the Guard will only address the MEB.

14 So, if we take out nine or ten
15 percent of the 43, we see a similar correlation,
16 and that is what we're trying to get after right
17 now, as a combined Guard Reserve, the leadership
18 of those organizations, what is the real number
19 that's out there, and what screening criteria
20 can we use to help us define which ones actually
21 need to enter the IDES process and which ones
22 have other administrative issues that need to be

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1 addressed.

2 MEMBER MALEBRANCHE: Excuse me, one
3 of the things on your request for information and
4 medical stuff, I'm just wondering, are you down
5 there for the Guard and Reserve, using ALTA, are
6 they using that for their records?

7 COL. KNOWLTON: Yes, it's -- in
8 fact, it's the primary source for records, in
9 addition to HRR and now, the acronym escapes me
10 for just a moment, health readiness records,
11 thanks, Jill, the health readiness records.

12 But ALTA -- if you talk to our
13 physicians, they'll say that that is the
14 document that they turn to first.

15 MEMBER MALEBRANCHE: So, the
16 missing information, what is that? Is it
17 because it's not in ALTA, or is that because it's
18 done by a TRICARE provider out in the network by
19 the state, or what is the -- for the missing
20 information, have you discovered what --

21 COL. KNOWLTON: Sure, you've hit on
22 the key, and then an example of why, and that is

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1 the key is that the information is not in ALTA.
2 Admit, not always in ALTA, and one of the reasons
3 why is, it's done by an outside healthcare
4 provider, the soldier doesn't bring the
5 treatment record into the unit, in order to have
6 it uploaded.

7 The systems don't always talk to
8 each other. What we think will transfer from one
9 to another, doesn't, and we'll look at that here,
10 in just a moment. I've got just a few slides
11 left, about four, and that one talks about the
12 challenges that we have in the Guard and Reserve,
13 and it's this interoperability of electronic
14 systems that is the key one.

15 So, the question was presented as
16 factors which prevent RC SMSC from meeting
17 needs, and I guess my response to that is that
18 we can look at a number of areas in which Reserve
19 component soldier cases have unique challenges,
20 and those of you in the Reserve component, these
21 will resonate with you quickly. Those of you
22 that have worked with any amount of time, can

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1 appreciate it, and that is that the four areas
2 really break down into command, process,
3 training/education and policy, and I'm just
4 going to touch on each of those four, for a
5 moment.

6 So, at the command, you know, we find
7 that Reserve component soldiers are often
8 dislocated or remote from commands and medical
9 treatment facilities.

10 So, but they still have the same
11 needs for support, whether it's one soldier on
12 the far western side of a state, you know, that
13 is wider than it is tall, and that the state
14 headquarters, the treatment facility is on the
15 far eastern side, several hours drive away.
16 Those are some of the challenges that we have
17 that are geographically induced.

18 It's the limited duty time, the one
19 weekend a month. You know, I still chuckle
20 sometimes, when I'm told, well, you know, we give
21 the active component only four days to do that,
22 and the Reserve gets 30 days. So, we're already

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1 giving you 26 more days than the active
2 component, and my response to that is, reservist
3 is always, you're given the active component
4 four days, you're giving me 30, you've really
5 given me two duty days, so, you've given me half
6 the time that you've given the active component.

7 But anyway, that is one of the
8 challenges we have, is the limited duty and then
9 all the requirements that still have to be done
10 during that period of time, and particularly for
11 those soldiers who may not actually even be
12 drilling because of their medical condition.

13 What we find here, as other studies
14 have shown, is that command emphasis is what
15 makes the difference.

16 In those states where we've seen
17 significant command emphasis, and not just at
18 the senior leader level -- senior most leader
19 level, in terms of the Adjutants General, but
20 with those Deputy Surgeons and in many cases,
21 their Assistant State Surgeons, where they've
22 taken initiative and leaned forward into getting

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1 after these cases, either coming down to
2 Pinellas Park, having us come out to their
3 organizations, in conducting screenings like
4 you saw from Texas, or just establishing steady
5 communications vis-à-vis our Town Hall
6 meetings, tele-conferences, et cetera, these
7 are the states where we see a very, very high
8 percentage of cases that -- that we show as very
9 high levels of P3/P4 profiles --

10 (Microphone disconnected)

11 COL. KNOWLTON: Okay, we're back
12 on, I guess. We see a very high correlation
13 between the number of profiles they have, the
14 number of cases submitted, those that we are then
15 able to move on to the MEB, because we look at
16 each one of those. It's not just enough to see
17 how many cases are out there, and how many
18 they've submitted to us, but then of those, how
19 many get forwarded on, and somebody mentioned a
20 recent visit to Iowa, was that correct, and that
21 is a state where we have a very, very high success
22 rate in moving packets forward, and the very fact

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1 that you've been out there to see them, tells me
2 that that is probably because they're one of
3 those states that kind of leans into this task
4 of getting these cases out of the shadows and
5 into the system.

6 So, as we look at process, just as
7 I showed you with the large blue pie chart that
8 showed proper case identification, I mean, that
9 is one of the challenges that we have, and that
10 really ties into training, and that is getting
11 the healthcare providers to understand which
12 cases should be going forward to a MEB, and which
13 cases shouldn't.

14 The quality of the supporting
15 documents, I think that speaks to your question
16 about ALTA, in a round-about way.

17 It's both the quality of the
18 document and then the system that it goes
19 through.

20 I've done this myself, just to see
21 how the system works, sat down and tried to build
22 a case myself, through HRR and ALTA, to see what

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1 it is that our administrative personnel, our 42
2 alphas and our PEBLOs, our 68-Whiskey medics, to
3 see kind of -- to share in their pain, and it's
4 not uncommon to open a file that has got the case
5 to the one that I recently did, 74 to 76 records,
6 and those records, while they were filed under
7 a folder that said x-rays, because I was looking
8 for a separated shoulder, that is what this
9 particular disqualifying condition was. I was
10 going through there as a layperson, looking for
11 this, you know, every file was simply labeled
12 with the date, that was it. So, I had to open
13 all 77 files in order to identify which of these
14 was a separated shoulder, and while our
15 68-Whiskies, our medics would have caught this,
16 I don't know that it's -- it's why we have to have
17 them as well, because a 42 alpha, an admin
18 specialist alone, might not have even identified
19 which one of those photos was, in fact, of a
20 separated shoulder, particularly if it had the
21 medical terminology associated with that
22 instead, which was many, many syllables, and I'm

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1 an aviator, not a physician, and there is a
2 reason.

3 So, in some cases, those images were
4 just repeats, and you've all seen this, if you've
5 ever gone into your personnel records, perhaps,
6 and you've seen multiple copies of the same
7 document.

8 Those are some of the challenges
9 that we struggle with in the medical records
10 system, and I'm sure none of those are new to you,
11 but that is what we mean by the quality of the
12 supporting documents.

13 So, as we continue looking at those
14 unique challenges of the Reserve component, and
15 that one may not be unique to the Reserve
16 component, it's just that it's aggravated by it,
17 by time and distance. We look at training, and
18 that is the one I referred to, with regards to
19 our physicians.

20 You know, we have world-class
21 healthcare providers out there, but they're not
22 necessarily all able to get the training from the

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1 time they hit the ground, on the Army -- on all
2 of the Army systems that they need, in order to
3 assign -- to do these profiles.

4 It's also command familiarization.
5 Prior to coming here, I served at ISAF and then
6 I had -- I commanded a brigade for three years,
7 and I have to tell you, even in all that time,
8 I was not as familiar with the IDES process, as
9 I recognize now, that I needed to be, as a
10 Commander, both in terms of situational
11 awareness and then, actual hard regulatory
12 awareness.

13 This travels all the way down to
14 soldier education. I mean, soldiers need to
15 understand what their own requirements are for
16 going through this system, and that includes
17 bringing in those records from private care
18 providers.

19 That is a novel idea to those who
20 haven't served on active duty, that even though
21 they go to a private care physician, they have
22 to bring those records in and post them to their

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1 service treatment record.

2 So, as we look at the fourth of those
3 areas, and that is policies, you know, the one
4 that essentially separates the active component
5 from the Reserve is this idea of a line of duty
6 investigation.

7 You know, if you're on active duty,
8 you have an injury, an illness, you're presumed
9 that it occurred in the line of duty, where in
10 the Reserve component, it works the other way,
11 it was presumed not to have occurred in the line
12 of duty, unless you have supporting
13 documentation that it was, and that is all the
14 difference in the world, because it's the
15 production of that line of duty investigation
16 that is one of those three items, that stymies
17 these cases there at the states and the RSCs.

18 Then the last thing is variation in
19 the MEB processes at the MTFs.

20 So, here, we have the packets, even
21 though they may be as well put together as we can
22 get them and validated and with the supporting

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1 documentation, and even if we were able to train
2 every healthcare provider in a standardized way
3 of doing it, we still have to look at the
4 downstream piece, which is the medical treatment
5 facilities, and they're used to working
6 primarily with active component cases.

7 And so, they need to understand the
8 uniqueness of -- and be trained in the uniqueness
9 of the Reserve component ones, and there is a lot
10 of work going on in that area, and we find that
11 the cases are primarily regulated to one of eight
12 or nine MTFs for that very reason, so that they
13 wind up working over and over, with Reserve
14 component cases, and not having to reinvent the
15 wheel every time a case goes forward.

16 Go ahead, please.

17 MEMBER EVANS: Are you using AWICTs
18 to track these patients, or as you using -- what
19 system do you have in place to ensure you capture
20 -- that you don't lose anyone?

21 COL. KNOWLTON: I'm sorry, I'm not
22 familiar with the system you identified, but to

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1 your question of, what system are we using to be
2 sure we don't lose someone, at what point? Lose
3 them where?

4 MEMBER EVANS: At any point. So, I
5 mean, this is a Reserve -- I can speak to the
6 Navy.

7 COL. KNOWLTON: Yes, sure.

8 MEMBER EVANS: So, we have, you
9 know, we have a problem with tracking our Reserve
10 component.

11 So, I'm just trying to make sure, do
12 you have a system that you could place any
13 Reservist that returns from theater with an
14 injury, you have a tracking system for everyone?

15 COL. KNOWLTON: Yes, I mean --

16 MEMBER EVANS: And we were --

17 COL. KNOWLTON: And again, I'm
18 trying to get to the question there.

19 So, yes, we have systems that track
20 as they come back. We have the -- that was
21 briefed in the last session, the physical
22 disability health reassessment period, in which

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1 we have required follow ups by the soldiers, in
2 the 90 days up to one year, following the time
3 they return, to be sure that they're -- that they
4 don't have a follow on condition.

5 So, we're aware of who those
6 soldiers are. The piece that we don't -- are
7 unable to track at this time, is when a soldier
8 does -- is issued a P3 or P4 profile, while we
9 have that in a database, and I have a copy of it
10 here, frankly, I can show you all the P4 profiles
11 for the country, we -- while we're able to see
12 that, we're not able to document really, how long
13 it then takes for that soldier to go out of that
14 -- in the cases that we have back-logged right
15 now, we don't have documented how long it took
16 them to go from that point up until the point that
17 they came to our organization.

18 Now, once they're in our
19 organization, Appian, our business process
20 management tool, will track them. In fact, even
21 when we return a case to the state, for instance,
22 maybe the condition wasn't disqualifying, and

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1 then later on, it does become a disqualifying
2 one, and that case comes back to us a second time.

3 We actually are aware -- we actually
4 identify that case when it comes in, as a
5 returned case, and then it's tracked as a return
6 case.

7 So, one of the many metrics we have
8 is, what number of cases we get that have come
9 through for a second time, or even a third time.

10 So, yes, there is tremendous
11 tracking and then of course, once it hits the
12 medical treatment facility and is assigned into
13 VTA, then there is visibility throughout the
14 entire system.

15 But so, there is the challenge, and
16 I think what speaks to your question is, there
17 are different tracking systems. They aren't
18 inter-related. Some are proprietary and in
19 some cases, there is a void, and one doesn't
20 exist, but not at the big picture level of, who
21 has deployed, who hasn't, but rather, how long
22 it takes to get them through.

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1 MS. DAILEY: Yes, this is all before
2 it ever gets seen at a medical division board,
3 sort of like at Walter Reed, and Lieutenant
4 Kelly, who came to see us. This is all happening
5 before that.

6 So, this doesn't count against the
7 295 days that we see in the DES system, the IDES
8 system, and then the 30 days they add for a
9 Reserve component system. The clock has not
10 started on that piece, is that correct, Colonel
11 Knowlton?

12 COL. KNOWLTON: That is correct.
13 That has been the case up until now, and so, with
14 my final slide, I want to speak to that point
15 specifically, and the way ahead.

16 My apologies, I actually don't have
17 that slide. I'll be happy to provide it to you,
18 either electronically or this copy, when I'm
19 done, but there is just a couple of -- two major
20 areas, and then some subordinate points
21 underneath it, as we look at what has been
22 directed as a re-missioning of the RC SMSC, and

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1 I prefer to describe it as an expansion of the
2 aperture, if you would, of what is it that we're
3 doing, because I don't see it as a re-missioning.

4 Under the purpose of -- under the
5 mission statement purpose and end-state that I
6 showed you in the beginning, you know, those are
7 still perfectly suitable for what it is that --
8 the direction that we're going in, and the
9 direction that we're going in is simply, rather
10 than being focused primarily on validation of a
11 case that comes to us, that it has all 17 items,
12 and that we've identified the additional
13 diagnoses and that we have the supporting
14 medical treatment record for that, et cetera,
15 before it goes to the MEB, our focus is now going
16 to shift to working in partnership with the
17 states and the subordinate commands, the
18 Regional Support Commands rather, in the Reserve
19 component, to pull those cases out.

20 In other words, the thought now is
21 instead of it being pushed to us, and us
22 validating, we'll go in and pull them, and help

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1 do case development instead of case validation.

2 We have the resources to be able to
3 do that, both in terms of personnel and more
4 importantly, in terms of process.

5 Systems like our business
6 management tool, Appian, that allows us to go in,
7 identify a soldier, their case, make notations,
8 correspond with that soldier, both through email
9 and then through the regular postal service, to
10 be able to maintain contacts at each of the
11 states and the RSCs, which is a full-time job.
12 Every one of our people in our organization, just
13 about, I mean, every day, I'll get an email,
14 because they go out to everybody in our
15 organization, identifying a change in a point of
16 contact in one of the 54 states or territories,
17 and because that is a real-time dynamic update
18 in our system, and so, it automatically lets us
19 know that there is a change, so that we don't --
20 if we're in the middle of a case, you know, we
21 go and use the new contact information.

22 But anyway, those tools, the belief

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1 is that we can leverage those to go out into the
2 states and the RSCs and help pull these packets
3 forward, and the way we're going to do that is
4 by the dissemination of a fragmentary order, a
5 FRAGO that will come out after the first of the
6 year.

7 That FRAGO is going to be the one I
8 referred to in the first couple of slides, that
9 talked about directing General Officer, General
10 Boone over at the PDA and our realignment, that
11 will be part of that fragmentary order to the
12 initial Executive Order, and it will also
13 redirect our mission to doing this case
14 development.

15 It will direct the Reserve and
16 Guard, Army Reserve and the Army Guard to then
17 go through their states and validate all the
18 packets for those three conditions, a
19 disqualifying condition, a legitimate profile,
20 the service treatment record and then a line of
21 duty investigation, and they'll take those and
22 they'll move them into a folder within the

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1 electronic information system, MEDPROS, that
2 will allow our soldiers then to go in, access
3 that file, pull those forward, begin validation
4 on those three items, and then start going in
5 through adjacent electronic systems and build
6 out that case.

7 Then at the end of 30 days, we're
8 going to forward that case to the MTF, whether
9 it's complete or not, as long as it has those
10 three underlying documents, the three required
11 documents that support entry into IDES. As long
12 as it has those three, we're going to forward it
13 to the MTF.

14 One of the things we're trying to do,
15 and this speaks to the question of
16 accountability and visibility, is we're trying
17 to identify a way in which we can assign the VTA
18 at the time that we get the case, because that
19 will begin the clock ticking, if you would,
20 against the requirements that you noted a moment
21 ago, the several hundred days for the active
22 component and the slight increase for the

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1 Reserve.

2 We'll be able to get that case then
3 into -- visible to all of the stakeholders and
4 customers, you know, once it goes into VTA, but
5 doing that at the time that we get the case.

6 Of course, the onus on us then will
7 be to have that case on to the MTF within 30 days,
8 and if you'll remember, the slide earlier, I
9 showed you currently, it takes us 45, and we're
10 allotted -- we use 45 days to process that case.

11 So, that will all get compressed,
12 but we think there is a lot of value in doing that
13 as a way of getting these cases out of the -- as
14 I like to say, out of the shadows, you know, and
15 into the light.

16 The key to that, and this is the
17 second point on the slide that you don't have is,
18 is the command emphasis has to take center stage.
19 It's going to require the Guard and the Reserve
20 to really lean forward into validating these
21 processes, whether it's a state that decides to
22 do like Texas did, and commit the resources it

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1 did, to go through and screen its packets, or if
2 it's just an active participation in building a
3 relationship with RC SMSC, and then educating
4 their own commands and their own surgeons, about
5 what needs to be done, in order to get valid
6 profiles coming forward.

7 Then we, like everybody, fight the
8 electronic systems monster. You know, we
9 recognize we have to get permissions and access
10 into those systems, and then somebody at much
11 higher pay grades is working how to tie all those
12 together, but I'm not waiting for that to get
13 done.

14 I'm here to tell you that I'm leaning
15 forward into this. The folks down at RC SMSC are
16 leaning forward into it. As you've seen, just
17 in this quarter so far, we expect to continue to
18 increase the number of cases that we're
19 processing, because we recognize, both from a
20 Military readiness point of view, these are
21 vacant positions out there in units, and I've had
22 those vacant positions, and I want to fill those

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1 vacant positions for the Commanders that are out
2 there today, and I also understand that these are
3 soldiers, and soldiers' families, and we want to
4 get those cases through the system, so that those
5 soldiers can have some sort of clarity, as to
6 what their future is.

7 And so, I can assure you that you
8 have the commitment of myself and everybody on
9 the staff down there at RC SMSC, to support you
10 in the work that you're doing, and then getting
11 those cases forward.

12 So, do I have any questions,
13 otherwise, that concludes my portion.

14 MEMBER REHBEIN: I'm going to be
15 blunt here for a moment.

16 Those two examples you presented
17 represent something of a 60 percent error rate,
18 cases that should never have been submitted. Do
19 you anticipate that kind of rate going forward,
20 as you get the rest of that backlog out of there
21 and now, this isn't -- really isn't a fair
22 question to ask you, but how does -- how does that

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1 error rate get minimized? How does that get
2 corrected?

3 There is a lot of time and effort
4 spent here, first in the people making the error
5 and then in the people finding it.

6 COL. KNOWLTON: Absolutely, thanks
7 for the question. I'll address both of those.

8 We expect that that error rate is
9 going to go down significantly. The Guard has
10 already initiated a screen, an administrative
11 screen, of the cases that they have, sorting out
12 people that might be in a Title 10 status, AGR
13 or are, in fact, even separated from service, or
14 whose condition is -- no longer warrants a
15 profile.

16 They've done a -- they've already
17 undertaken that with the separate 54 states and
18 territories. Of course, you can understand how
19 challenging that is. You're not directing just
20 one organization to do it, but rather 54.

21 The Reserve component, which has a
22 smaller number of personnel in the batch, have

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1 been doing that, as well, and they believe that
2 they've screened out already, about 2,000 people
3 out of that 8,000, just on administrative
4 processes alone.

5 I can tell you anecdotally, from
6 where we sit at RC SMSC, during the last month
7 that concluded here for business days, for my
8 purposes of a business day on Friday, we only
9 returned 16 packets to the state for the month.
10 Of those 16 packets in the month of November that
11 were returned, eight were returned because the
12 soldier was returned to duty. We literally, in
13 conjunction with the state, were able to reduce
14 the profile and get that soldier back in the
15 ranks, and doing what they wanted to do, which
16 is soldier on. Of the other eight, three were
17 an administrative issue and then I can't
18 remember what the other five were.

19 But what I'm saying is, where you saw
20 an earlier slide that showed 40 and 50 packets
21 a month being returned, many of which were
22 because they weren't properly vetted, we now see

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1 that number going down into the single digits as
2 we move forward.

3 So, yes, I see those numbers going
4 down. I believe the states and the Reserve are
5 working diligently to try to screen those out,
6 and I think those administrative issues won't be
7 a factor going forward.

8 MEMBER DeJONG: Some of that, I can
9 help validate a little bit, is the knowledge of
10 the -- since the expiration of the contract docs
11 that were there, I know the State of Indiana had
12 a bad problem with some of the contract doctors
13 and physicians that came in automatically making
14 certain conditions P3 and carrying that forward.

15 So, have you seen a difference? Can
16 you see where those contracts have expired, is
17 that still a problem that exists, sir?

18 COL. KNOWLTON: I'm familiar with
19 the situation, and thanks for bringing that up.

20 Unable, at this point though, to say
21 that we can see a difference, because we process
22 cases as they come in, if you would, as they come

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1 in, and so, if those cases aren't coming to us,
2 then I don't have a way of seeing that, and it's
3 one of the reasons why, and this is literally,
4 this morning's conversation at great length with
5 many of our stake -- with a number of our senior
6 leaders, is getting this list validated, what
7 are the -- who are the 8,000 or 5,000 or 6,000,
8 so that we have something by name and social
9 security number, that we can start working
10 against, and we expect to have that out within
11 the next week or two, that we'll then be able --
12 and maybe I shouldn't have tried to put a time
13 on that. But my expectation is in the near
14 future, we'll have this list that then we'll be
15 able to go and work against, because even right
16 now, for myself, the cases that are coming in,
17 I don't know if the cases that are coming in are
18 part of that backlog or if they're part of the
19 steady state, because I think it's fair to say,
20 we'll always have several hundred packets a
21 month coming through, and that is why we need to
22 develop an enduring process, because this is, in

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1 fact, a surge mission.

2 I promised at the beginning, that I
3 would tell you what those were, and I'm sorry
4 that I forget momentarily, but the Army Reserve
5 is setting up a program, they're actually in the
6 same building as us. They've set up a program
7 of about 30 soldiers, nurses and contractors,
8 who are working right from the very beginning
9 with new cases in partnership with the Reserve
10 component regional support commands, from the
11 time a temporary profile is issued.

12 They work with that profile to -- if
13 it's going to become a permanent profile, to use
14 that time in between, that 12 month period,
15 generally speaking, to get all of those
16 supporting documents, so that at the time it does
17 reach MRDP, the Medical Readiness Decision
18 Point, and is ready for second signature and then
19 to go into VTA, all those documents are already
20 gathered.

21 Now, survey of one, personally, I
22 think that is a great model, and I can see where

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1 the Guard would look seriously at that, as well,
2 and perhaps even transition Pinellas Park into
3 that moving forward, where we partner with the
4 states to develop the -- to manage those profiles
5 right from the very beginning, because the
6 biggest challenge is training and education.
7 It's the turnover in the states.

8 It's the reassignments. I mean,
9 you're in this duty position this month, next
10 year, you're in a different duty position, the
11 training went with you, and there is not always
12 time to do a hand-off.

13 So, if we don't have a centralized
14 gateway, we're going to have 54 states and
15 territories trying to feed into an active
16 component system with a divergent standard, and
17 I think that takes us back to where we were.

18 MEMBER MALEBRANCHE: Question.
19 For the Reserve component and the Guard, are only
20 physicians allowed to write profiles, or verify
21 profiles, the medical profile?

22 COL. KNOWLTON: I believe that is

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1 correct, but unfortunately, Jill has stepped
2 out. I would like to ask her to verify that, but
3 my understanding is that physicians must write
4 and/or change the profile, that a physician's
5 assistant can't do that.

6 I believe our process is that the
7 physician -- certainly, our process is the
8 physician's assistant sends it to a physician,
9 for signature.

10 MEMBER MALEBRANCHE: Okay, I guess
11 one of the questions -- the reason I'm asking
12 that is because when you look at the supporting
13 paperwork, which it sounds like it's at issue
14 when they come to the VA, the backlog issue,
15 oftentimes, is for that very same reason,
16 because we have to have the supporting
17 documentation, and the profiles, usually when
18 they're done, you would have a medical support
19 document and that's why I was wondering, I wasn't
20 sure.

21 But when this first set up down in
22 Pinellas Park, it was General Cheek, I think that

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1 went down there and started some of this, I just
2 recall that they said that they didn't always
3 have, and I didn't know if that has changed or
4 not.

5 COL. KNOWLTON: Well, again, it was
6 a very narrow subject, in terms of the Reserve
7 component, and then more narrow under that, just
8 the Army Guard and Reserve, but when you look at
9 the percentage of the population that that
10 represents, you see that this single gateway is,
11 you know, quite a large percentage of the
12 soldiers that are affected by IDES, you know, go
13 through this gateway, and that is why I think
14 it's worthy of your attention and again, I
15 appreciate your inviting us out today, to
16 discuss it with you.

17 MEMBER MALEBRANCHE: One last
18 question.

19 COL. KNOWLTON: I'm sorry.

20 MEMBER MALEBRANCHE: I'm sorry, I
21 forgot this, too. But the number that you have
22 there, and the numbers anticipated, are you --

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1 how are you doing that? I mean, are there more
2 numbers out there waiting, because at one time,
3 there was this huge surge group, thousands that
4 were supposed to be coming through Pinellas
5 Park.

6 Is there a lot in the backlog or in
7 the wait from the states, or what kind of numbers
8 are you anticipating?

9 COL. KNOWLTON: Yes, actually,
10 thanks for the question. I'm a little
11 horn-tooting here, on behalf of the center.

12 We actually have a zero backlog
13 right now. Last month, we received 238 packets
14 and we processed 340. We actually process more
15 packets, in terms of getting down that -- and
16 because we've been doing that, we've now
17 whittled that backlog down.

18 In-house, I have less than 300 cases
19 in-house, and it takes about 300, just to keep
20 the process going, because again, like any
21 assembly line, you can't take every can off the
22 assembly line, otherwise, you know, you have to

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1 start up the assembly line again and wait for all
2 of those systems to load back up again, in
3 manufacturing, as an analogy, and it's the same
4 with us.

5 I mean, we have to have -- we,
6 generally speaking, a healthy number for us
7 validated both by practice, as well as by the
8 consultants that came in and wrote the draft
9 plan, is to have about 300 cases in our facility
10 at one time.

11 Now, the objective is to have the
12 case out in 30 days, and we've been doing very
13 good about doing that, but that is because we
14 have identified about a steady state of 300
15 coming in, but at this point, while there was in
16 January 2012, 12 months ago, 11 months ago, there
17 were almost 1,000, 970 cases in backlog in the
18 facility, and we now have narrowed that down
19 essentially to none.

20 But in the states and the Reserve,
21 that is where the cases are that I need to get
22 after. Those are the ones I want now.

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1 MEMBER TURNER: Sir?

2 COL. KNOWLTON: Yes?

3 MEMBER TURNER: While you've
4 covered, you know, an excellent process and the
5 tracking tool that you use, do you, Army aviator,
6 feel that any of those processes or tools are
7 exportable to other branches or areas?

8 COL. KNOWLTON: Yes, I think they
9 are, and that is certainly one of our
10 responsibilities, is to share our best practices
11 with others, and we try to do that through our
12 various communications channels, and that
13 includes working closely with the medical
14 treatment facilities, as well as the National
15 Guard Bureau Surgeon and the USARC Surgeon and
16 the MTFs.

17 So, in fact, Eisenhower, at Fort
18 Gordon, has come out, looked at our Appian
19 system, and we are currently in a program in
20 which they're going to build essentially a
21 railroad track from our system into theirs, is
22 the proposal, I should say that.

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1 It's a pilot right now. We believe
2 it will be successful and they'll want to adopt
3 it, but their IT team is in the process of taking
4 and building a pathway from our internal
5 software to their software, so that they can get
6 visibility on these because most of our cases go
7 there.

8 So, they can get visibility on these
9 cases as we first develop them, and then they
10 were suitably impressed enough with the physical
11 process itself, and they've been there several
12 times now, to observe the process, that they're
13 going to -- they're implementing a similar
14 process there, and so, they're taking our
15 existing process software, and adapting it for
16 use inside their medical treatment facility.

17 Then they will also, the good news
18 for us about that is, right now, Appian is
19 provided to us under a private contract, if you
20 would, private service provider. You know, we
21 paid for the license, we paid for that software,
22 but their developers will now take that and put

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1 it behind AKO, so they can now make modifications
2 to the system, something that we're somewhat
3 hampered in doing without additional funding,
4 which is there.

5 I mean, we've been resourced very
6 well, but I'm just saying, it's one more thing
7 you have to do, go get money, where if Eisenhower
8 takes this on, their G6 guys, their intel -- I'm
9 sorry, information systems guys will be the
10 owners of it, and able to provide tweaks as we
11 go.

12 So, yes, we do export our best
13 practices, both in terms of concept and then hard
14 product.

15 CO-CHAIR CROCKETT-JONES: Thank
16 you very much, Colonel Knowlton.

17 COL. KNOWLTON: Thank you.

18 CO-CHAIR CROCKETT-JONES: I think
19 we've got a lot to digest on this, and I'm -- we
20 might have some more questions for you later, by
21 you know, communicated to you through the
22 office, because this was a lot, and thank you

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1 very much for that.

2 COL. KNOWLTON: Yes, please, we
3 welcome not only your questions by email, it's
4 Keith.Knowlton at either us.army or at
5 usar.army. You'll find me global, pretty
6 easily, and we welcome you to come down and visit
7 it, at any time, either individually or as a
8 group, and my recommendation is, February or
9 March is a great time. Thanks again, for your
10 time.

11 CO-CHAIR CROCKETT-JONES: Okay,
12 are we finished for the day and reconvening again
13 in the morning at 8:30 a.m.?

14 MS. DAILEY: Yes, ma'am, 8:30 a.m.
15 tomorrow morning, ladies and gentlemen. We
16 will start with our public forum tomorrow
17 morning at 8:30 a.m.

18 Thank you very much. Thank you,
19 Colonel Knowlton. Thank you, audience.

20 (Whereupon, the above-entitled
21 matter went off the record at 4:31 p.m.)

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