

U.S. 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

+ + + + +

BUSINESS MEETING

+ + + + +

TUESDAY
FEBRUARY 26, 2013

+ + + + +

The Task Force met in the Washington Room of the DoubleTree by Hilton Hotel Washington DC-Crystal City, 300 Army Navy Drive, Arlington, Virginia, at 8:00 a.m., VADM Matthew L. Nathan, DoD Co-Chair, and Suzanne Crockett-Jones, Non-DoD Co-Chair, presiding.

PRESENT

VADM MATTHEW L. NATHAN, M.D., USN, DoD Co-Chair

SUZANNE CROCKETT-JONES, Non-DoD Co-Chair

JUSTIN CONSTANTINE, J.D., Member

CSM STEVEN D. DEJONG, ARNG, Member

RONALD DRACH, Member

TSGT ALEX T. EUDY, USAF & SOCOM, Member

CAPT CONSTANCE J. EVANS, USN, Member

LTCOL SEAN P.K. KEANE, USMC, Member

KAREN T. MALEBRANCHE, RN, MSN, CNS, Member

MG RICHARD P. MUSTION, USA, Member

STEVEN J. PHILLIPS, M.D., Member

DAVID REHBEIN, M.S., Member

MG RICHARD A. STONE, M.D., USAR, Member

RUSSELL A. TURNER, M.D., Member

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ALSO PRESENT

DENISE F. DAILEY, PMP, Executive Director,
Designated Federal Officer
ANNE E. SOBOTA, Alternate Designated Federal
Officer
BG DAVID BISHOP, USA
LTC EDWARD BRUSHER, USA
REGINALD COFFEY
COL JEAN JONES, USA
LTC JON BAKER, USA
MARY COLLEEN TUDDENHAM
LTC DANIEL DUDEK, USA
NANCY ADAMS
MELISSA GLINER
COL PRISCILLA BERRY, USA
HORACE LARRY
COL NICHOLAS DEMARCO, USAF
COL TODD POINDEXTER, USAF
COL GARY WALKER, USAF
CARRA SIMS
LTCOL MICHAEL C. WYATT, USAF
TIM TOWNES
TAMARA NEWTON
LTCOL ANTHONY LANUZO, USAF
EDMUNDO A. GONZALES

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

2 (8:03 a.m.)

3 CO-CHAIR NATHAN: Okay, well, good
4 morning, everybody. It looks like we have a
5 quorum. For those of you who are new to the
6 meeting or who weren't here last time, I'm Vice
7 Admiral Nathan, Matt Nathan. Pleasure to be
8 here.

9 I've been informed that we're not
10 having a group photo this morning, which is a
11 shame because I spent a lot of time on my hair
12 today and all for naught, so we'll do that
13 tomorrow.

14 Before we get into the battle rhythm
15 here and sort of kick things off, I just thought
16 I'd make a few comments and, Suzanne, welcome
17 your comments as well, on what can't be ignored
18 these days, the 500-pound gorilla in the room,
19 which is sequestration and, you know, how we look
20 at that in the services right now.

21 After copious amounts of testimony
22 on our service chiefs, the surgeons general,

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1 both to staffers and to Congress on the effects
2 and what has been first and foremost on many
3 Congressional members and Pentagon leaders, not
4 all but many, is effect on wounded warrior care
5 and recovering warrior care.

6 I won't speak for the other
7 services. I think I have pretty good
8 situational awareness of where they are, having
9 talked at great length with my counterparts.

10 But the bottom line is each service
11 has a fairly robust representation of civilian
12 personnel who work for it in the medical
13 departments, the Army probably having the
14 highest percentage and then the Air Force and the
15 Navy. So there is an impact.

16 The question that we're always asked
17 is do you think that this is going to have a
18 direct effect on wounded warrior care, both
19 medical care and non-medical care?

20 And the answer, in theory, is it
21 should not. We have been told that wounded
22 warrior programs will continue to be funded.

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1 There is no hiring freeze on requirements
2 specifically ordained for wounded warrior care.

3 That said, what I've told Congress,
4 and Rich and others please chime in on this from
5 the other services, but what I've told Congress,
6 I don't have two doors in my big hospitals, one
7 door that says wounded warrior care and the other
8 door that says all others.

9 Eventually the wounded warrior
10 recovering care, rehabilitative care, be it
11 emotional, physical, is interlaced with the care
12 I provide in all my components. They share
13 cardiologists, rheumatologists, orthopedists,
14 dermatologists, psychiatrists.

15 And so, outside of those
16 practitioners and support personnel who are
17 completely demarcated just for wounded warrior
18 care, e.g., a family medicine physician or a
19 sports medicine physician or an orthopedic PA
20 who is put into a wounded warrior clinic and does
21 nothing but see recovering warriors, the
22 majority of our care sees everybody and so there

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1 has to be an effect at some point if this goes
2 for any degree of time.

3 What we'll do, of course, is we'll
4 shift resources to the active duty and the
5 recovering warrior care. We'll take all
6 remaining resources that we have and we'll shift
7 in that direction. That'll just simply erode
8 care to some of the non-warrior, non-active duty
9 beneficiaries.

10 It'll probably push care out to the
11 network, to the private sector. Again, most
12 likely not warrior care, most likely not active
13 duty care, but it would eventually push some care
14 out to the network.

15 You can do that for a short period
16 of time and there's no problem at all. If you
17 do that for a prolonged period of time in the
18 services, you end up losing some of your patient
19 base, you end up losing some of the diversity of
20 the kind of care and pathology that you see that
21 keeps your skills current, and so that's the
22 concern.

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1 So I just thought I would share with
2 the Committee what we in our service are telling
3 them, which is we see no dramatic short-term
4 impact or threat to wounded warrior recovering
5 care.

6 In the long run if we were to have
7 a prolonged sequestration, maintain a prolonged
8 continuing resolution with the toll on civilian
9 availability, with the toll on purchasing
10 materials, eventually something has to give and
11 it's pretty hard to just make it give strictly
12 in the non-wounded warrior care arenas where we
13 get the care.

14 So I think this is something we need
15 to keep an eye on if sequestration does occur.
16 And I was coming into the radio today in the car
17 and on one channel it's going to occur; on
18 another channel it's not. But if it does occur
19 and Congress takes no mitigating actions on
20 military-specific issues for staffing and/or
21 medical support, I think it's something the
22 Committee will need to look at in the future and

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1 we'll need to ask the services to tell us, you
2 know, where they see this going.

3 So the good news is I think Congress
4 and the leaders of the Pentagon are very
5 concerned about what they should be. What will
6 this do to recovering warriors, what will this
7 do to the men and women who have gone to battle,
8 their families, family support activities,
9 family service centers, wounded warrior
10 workshops, all those things which take care of
11 and help lift up a family that's in the throes
12 of recovering from either visible or invisible
13 wounds of war.

14 So I think our leaders are
15 interested in that. I just don't want them to
16 become complacent, thinking that it's very easy
17 for us to partition everything we do for wounded
18 warriors and protect that. We can't.
19 Eventually it's going to erode into the other
20 care systems.

21 Other comments or questions on that
22 before we get started?

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1 MEMBER STONE: Sir, appreciate your
2 comments. From an Army standpoint we're
3 exactly where you are with exactly the same
4 concerns.

5 There are a couple of things that
6 we're quite pleased. Number one, we've
7 continued to hire against our IDES staffing and
8 that has been exempted from the freezes. In
9 addition, we have a commitment from senior Army
10 leadership to continue to authorize the funding
11 and the billets for our WTC.

12 About half of our Warrior Transition
13 Command is reserve component and we have a
14 commitment to really actually make it a little
15 bit easier to use the reserve component by
16 allowing 730-day orders rather than the 365-day
17 orders.

18 The subtleness of where we're
19 concerned is as we look at those service members
20 that may need escorts in transport. Some of the
21 regional commands are making decisions that they
22 can't afford the escort, and this last week we

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1 worked through some concerns in the
2 authorization of those type of positions.

3 We believe that most of the initial
4 effect will be out of just clarifying business
5 processes during this time, although in the
6 long-term this could be very dangerous to our
7 ability to sustain a system.

8 And we share the same concern that
9 when people begin to leave our direct care system
10 to go to the purchased care system it will be hard
11 to get them to come back as they gain confidence
12 in other providers. We feel that we, therefore,
13 may not keep the faith with them long term, but
14 you cannot draw a line between recovering
15 warrior care and all the rest of our care system.

16 So we do believe we're safe but we're
17 watching it closely as we develop the business
18 processes that'll allow us to transition through
19 this. But I appreciate your comments, sir.

20 CO-CHAIR CROCKETT-JONES: Can I
21 just add in that some of our most severely
22 injured folks have family members who are

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1 dislocated from their homes. They don't have
2 contact with their own primary care. They have
3 to find new primary care. They are long-term
4 caregivers and non-medical attendees, and they
5 are not in the same track system as the wounded
6 warriors themselves and so they're going to
7 probably feel potential impact more quickly than
8 the wounded warriors.

9 For those who are most severely
10 injured, they do have a serious impact on
11 care-giving, and if they are not able to get good
12 medical assistance, then the services are going
13 to have to provide more of that non-medical
14 attendant and care-giving assistance.

15 So this is just a little, small
16 population but they're already pretty much at
17 their limit so we need to keep an eye in this on
18 their care.

19 MEMBER PHILLIPS: I can't speak
20 officially for the Department of Health and
21 Human Services, obviously, but the impact is
22 affecting us tremendously as well.

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1 The National Library of Medicine, we
2 deal with information and communication. NIH
3 in general, a lot of research grants. The
4 budget cuts, which we have been furiously trying
5 to figure out how to manage the last week or so,
6 is impacting and will impact if this goes on for
7 more than a few months.

8 The research efforts related to
9 post-traumatic stress, traumatic brain injury,
10 the whole spectrum that affect indirectly and
11 then directly will be impacted.

12 The ability to provide information
13 and databases for researchers or just the
14 general public to find that information about X,
15 Y and Z will be impacted.

16 Again, I think if it goes on for more
17 than a few months, it will affect us so there's
18 really no good long-term outlook if this
19 continues, I think, in general.

20 CO-CHAIR NATHAN: Okay, well,
21 again, I think the good news is we work for
22 organizations that are fairly agile and

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1 adaptable and will flex where needed.

2 But I think it's important since the
3 raison d'etre of this Task Force is to monitor
4 and look for opportunities to improve and align
5 best resources with best capability for
6 recovering warriors and their families.

7 And, Suzanne, thank you. You point
8 out what this Task Force, I'm sure, is learning
9 every time more and more, is that there's these
10 second and third order effects, kinetic effects,
11 that reach the people that we hadn't even thought
12 of.

13 And so I think that's where the
14 collective talent and experience from this group
15 comes from. It brings us situational awareness
16 of some of those things.

17 So I just bring this up this morning
18 because I think it's important to get on the
19 record that simply making a statement on a
20 PowerPoint slide somewhere on the Hill with
21 regard to sequestration with an asterisk that
22 says, "don't worry about wounded warrior care,

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1 we fenced that," or "wounded warrior issues, we
2 fenced that."

3 We can't just simply say, oh, good,
4 that's not a problem during sequestration. I
5 think it's incumbent on us to look during our
6 business meetings and in between at anything we
7 think needs to be surface forward where
8 sequestration will have an effect.

9 Again, as everybody has said here,
10 we're not going to fall off the abyss March 1st.
11 People will kind of wake up on March 1st and go,
12 what? You know, the walls are still standing.

13 It's going to be a gentle erosion and
14 a gentle reconfiguration of resources over the
15 next several months, if this continues, that
16 could take a toll on some of these things.

17 And Rich brings up a great point,
18 which is the travel restrictions and everything
19 else are making it hard for attendant travel, so
20 this is what happens when you have sort of this
21 general one-size-fits-all budget cuts. So
22 we'll see what happens.

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1 MEMBER STONE: Sir, if I may, I'd
2 like to make one other comment, and it's based
3 on Steve's. We have very substantial concern
4 that we will be able to get through the initial
5 number of months of this. We operate under the
6 concept that we will be given authority to move
7 buckets of money around and lines of money
8 around.

9 But I think that places research at
10 really very substantial risk and I think the
11 long-term effects of this will be a compromise
12 in the trust that civilian educational and
13 academic institutions have in us if we start to
14 move money around of things that are in the
15 second or third or fourth year of various
16 research studies.

17 In order to assure the access to
18 care, to assure the payment of claims, we may
19 need to move some money around if this goes on
20 for a period of time.

21 And, therefore, one of the things I
22 would ask this Committee to watch is our ability

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1 to sustain long-term research. I think it's at
2 very, very substantial risk if this goes on for
3 any period of time uncorrected. Over.

4 CO-CHAIR NATHAN: Okay, great
5 points. No further comments on that, we'll go
6 ahead and kick off.

7 So, as you know, since our
8 beginning, our FY '13 activities in November of
9 '12, we have completed two business meetings and
10 we've had seven installation visits.

11 During the first two business
12 meetings, we discussed such topics as the Army
13 National Guard and Reserve transition and the
14 IDES support, the SCAADL PDBR, the various
15 Centers of Excellence, the IPOs, the VA, VR&E and
16 recovery support programs as well as TBI and PTSD
17 research efforts.

18 Over these next two days we're going
19 to having the opportunity to hear from all the
20 services regarding their responses and status to
21 the FY 2012 recommendations that were made by
22 this Task Force.

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1 We'll also hear about methodology
2 and progress of their respective survey
3 programs. We'll be covering a lot of
4 information and in a short amount of time so,
5 again, hopefully we'll have time to hear from the
6 services and where they and what they're doing
7 in response to each of our recommendations as
8 well as discussing the roundups from the site
9 visits that have occurred.

10 And I look forward to everybody's
11 collective discussion and thoughts. Thank you.

12 CO-CHAIR CROCKETT-JONES: As we
13 move forward from this business meeting, we have
14 three more business meetings and seven more
15 installation visits to round out the fiscal
16 year.

17 The next business meeting in April
18 will be our last before we begin work on
19 recommendations, so it's our last chance to do
20 some discussion of what we've gathered at the
21 installation visits.

22 During the June business meeting,

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1 we'll meet to create recommendations. In July,
2 we need to conduct final votes on the
3 recommendations for the annual report.

4 Before we go any further, I'm going
5 to ask that we go around the table and introduce
6 ourselves and I'm going to ask you to start, Mr.
7 Rehbein.

8 MEMBER REHBEIN: Dave Rehbein.
9 I've been a member of the Task Force. Come out
10 here from Iowa. Spent my life as a research
11 scientist and a year as National Commander of the
12 American Legion. Very glad to have served on
13 this and very glad to see the progress that this
14 group is making.

15 MEMBER PHILLIPS: Steve Phillips,
16 physician, Associate Director National Library
17 of Medicine, NIH, Vietnam veteran, Reservist for
18 25 years.

19 MEMBER DEJONG: Command Sergeant
20 Major Steve DeJong. I represent the National
21 Guard Bureau for the Task Force.

22 MEMBER STONE: Rich Stone, Army

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1 Deputy Surgeon General.

2 CO-CHAIR NATHAN: Matt Nathan, Navy
3 Surgeon General, and Co-Chair of the Recovering
4 Warrior Task Force.

5 CO-CHAIR CROCKETT-JONES: I'm
6 Suzanne Crockett-Jones. I am the civilian
7 Co-Chair and I am the spouse of a recovering
8 warrior.

9 MEMBER MUSTION: Rick Mustion.
10 I'm the Commanding General of the Army's Human
11 Resources Command at Fort Knox.

12 MEMBER EVANS: Good morning.
13 Captain Constance Evans, Nurse Corps -- they
14 finally got it right on the sign -- Navy
15 Medicine, BUMED Case Management.

16 MEMBER MUSTION: So I could just
17 write "Go Army, Beat Navy," on your name tag
18 there?

19 MEMBER EVANS: Yes.

20 (Laughter.)

21 MEMBER KEANE: Lieutenant Colonel
22 Keane, Marine Corps Liaison for the VA.

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1 MEMBER EUDY: Technical Sergeant
2 Alex Eudy. I'm representing both the Air Force
3 and Special Operations Command.

4 MEMBER TURNER: Russ Turner,
5 civilian physician, Operational Medical
6 Solutions.

7 MEMBER DRACH: Ron Drach, non-DoD
8 member, semi-retired, worked in Veterans
9 Affairs for the last 45 years.

10 CO-CHAIR NATHAN: Okay. So let's
11 spend the remainder of this morning's session
12 reviewing some of our past site visits.

13 Since the January business meeting,
14 we've conducted visits to the Captain James A.
15 Lovell Federal Health Care Center in Illinois.
16 I'll go off-script for a second just as we talk
17 about that one so the point's not lost. That's
18 a pretty pivotal place. That represents the
19 test kitchen, if you will, for the VA/DoD
20 integration of health care in one facility.
21 There's nothing like it anywhere else.

22 We've got basically military health

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1 care and VA health care under one roof, being
2 shared by the same staff, working in the same
3 ICU, the same wards, the same clinics trying to
4 figure out how to put the same electronic medical
5 record together.

6 There's room on Mount Rushmore for
7 one more face, as I understand it. They'll
8 carve it of whoever can figure out how to combine
9 the VA and DoD electronic medical records
10 cheaply and efficiently.

11 As well as -- there's North Chicago,
12 which is the Lovell Health Care Center. There's
13 Fort Bragg, North Carolina, the Community-Based
14 Warrior Transition Unit in Arkansas and the
15 Joint Base San Antonio in Texas.

16 The focus groups were only conducted
17 at the Fort Bragg and CBWTU Arkansas visits. If
18 you'll turn to Tab B in our binders, you'll find
19 a list of these sites with the respective
20 attendees.

21 And we'll begin our discussion with
22 the James Lovell Federal Health Care Center

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1 visit in North Chicago.

2 CO-CHAIR CROCKETT-JONES: Well,
3 yes, I was on that visit but I'd like to start
4 with Captain Evans.

5 MEMBER EVANS: So good morning. So
6 that was an outstanding visit. We definitely
7 was able to see the integration between DoD and
8 VA. The staff, able to work together in one
9 unit. Definitely you can tell they had that
10 integration with me just coming from Walter
11 Reed. They definitely had the integration
12 stare in their face, so recognize that look.

13 The one challenge, the medical
14 record system. We didn't do any focus group but
15 we were able to sit down with the case managers.
16 And the concerning part's that you have a
17 recovering service member come into the primary
18 care setting. If they're DoD, they'll have to
19 go on one side of the clinic to be seen because
20 of documentation, because of the medical record
21 system.

22 And then once they transition to the

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1 VA side, they would have to go on the other side
2 of the clinic to be seen and we walked away
3 wondering why. That shouldn't be. It's one
4 primary care setting. It should be one clinic,
5 so we did leave that with the leadership.

6 In addition to that, the case
7 managers kept calling themselves DoD and then we
8 had the case managers on the VA. And so we asked
9 the leadership about staffing, you know, was it
10 DoD, VA? And clearly they said it was one staff,
11 FHCC, and so that's how they should have been
12 identifying themselves.

13 So, I mean, that was out of the
14 visit. Outstanding, I mean, they've made so
15 much progress from over I think a year or two,
16 unbelievable progress. In the ER we were able
17 to see at the bedside how they were able to pull
18 up the documentation. One single sign-on, so
19 the provider can sign on at his desk and pull up
20 all four systems.

21 Not the best methodology but it
22 works for the provider, right, and so they

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1 compensated for not having the iEHR available.
2 They really spoke highly of the iEHR but it's a
3 read-only. It's not interactive and not able to
4 put in orders in order system. So I think
5 they've done well, you know, to bring two health
6 care systems together.

7 A lot of challenges, so I think the
8 Advisory Board we found to be very successful
9 there. They have oversight of implementation
10 and actually one of our members sit on the
11 Advisory Board. Karen is a member of the
12 Advisory Board. So, for mine, I think those
13 were the key.

14 CO-CHAIR CROCKETT-JONES: Yes, I
15 think the two impressions that I came away with
16 most strongly were, first, that it was more joint
17 than any other joint forces space we've seen.

18 Leadership had an attitude of parity
19 between the two organizations in a way that I'm
20 not sure that I've seen anyplace else. They
21 were comfortable with shared responsibility
22 rather than just shared space. I was impressed

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1 by that.

2 And the other thing that really
3 struck me was as we talked to folks about their
4 interactions with the record system, the folks
5 who were newer to the organization were actually
6 most comfortable utilizing, for getting
7 information, the emerging independent
8 electronic health record.

9 The people who had been using one
10 system or the other for any period of time were
11 more comfortable with it. But some of their
12 sort of newest members, some of the youngest,
13 newest folks into the system were the most high
14 praise of getting their information from the
15 integrated electronic health record which I
16 thought spoke well of its future utility.

17 Anything else, Mr. Rehbein? Did I
18 forget anything?

19 MEMBER PHILLIPS: I wasn't there.
20 I just have a question. Can we take away some
21 very strong bullet points from them to pass on
22 in our report as to how things can be jointly

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1 integrated?

2 The record, I know, is a technical
3 issue. Technical issues can be solved if the
4 will is there to solve it. But at least
5 functionally how they proceeded and how they
6 interacted, it might be very helpful. I wasn't
7 there so I don't know the details, but.

8 MEMBER EVANS: I would think, just
9 in my opinion, that the Advisory Board, to how
10 they outside grouped to assist or make
11 recommendations probably helped with the
12 integration process.

13 Another key point was, as far as the
14 technical, it was interesting, while we were
15 there, BUMED staff, their IT staff, and I asked
16 the question, I said how often do you come down?

17 They are there at the drop of a dime
18 to assist any issues they have as far as the DoD
19 side of IT, so that was a powerful statement as
20 far as the DoD side. If you're needing
21 assistance, we're here on-site to assist. So I
22 think that, too, provided a comfort level for the

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1 staff.

2 I'm not sure how that leader -- it's
3 amazing how he brought that staff together.
4 When I was at Great Lakes, I saw the pediatrician
5 and the claimant that was at Great Lakes. He's
6 now VA and very comfortable as working as a VA.
7 And first time they've had pediatric care in the
8 VA facility, so they're doing a great job on
9 integration.

10 CO-CHAIR NATHAN: Yes, it wasn't
11 always that way. There was a lot of
12 polarization at first, two different systems,
13 two different pay scales, the VA which tends to
14 have people stay in one place for a long time and
15 the DoD which tends to rotate a lot of folks, and
16 not dissimilar to when I was at Walter
17 Reed-Bethesda and we were putting it together.

18 And if you let the clinicians and the
19 nurses and the corpsmen and the LPNs and the VA
20 administrative people get together, they'll
21 find their way in spite of leadership.

22 And I was asked one time by the

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1 Secretary of Defense when he was out visiting
2 warriors at Walter Reed-Bethesda, how's the
3 integration going? I said it's a lot like a
4 Little League game where the staff are like the
5 kids on the field throwing the ball, hitting,
6 laughing, you know, hitting fly balls, throwing
7 people out at first, and you look over in the
8 stands and the parents are strangling each
9 other.

10 But I think now we've got good
11 leadership there on both sides. People are
12 following it. The significance of this place to
13 us, I think, on the Task Force is they don't have
14 a very large footprint of recovering warriors
15 there. They do in the North Chicago area as they
16 amass a VA population that comes back.

17 But the significance of it is that
18 this place is under a microscope from the
19 national imperatives from the White House for an
20 integrated electronic health record, for a
21 virtual lifetime electronic health record.

22 The Secretary of the Defense and

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1 Secretary of VA meet on this particular issue and
2 it's generated a lot of heat and a lot of light,
3 hopefully more light than heat as it rolls out.

4 But that's what we, I think, need to
5 watch, is how well can we bring the two systems
6 together?

7 Again, you know, while we're talking
8 about DoD, VA, my experience when I talk to
9 wounded warriors, and most of the ones that I
10 come in contact with are the ones that are
11 acutely rehabilitating and are getting ready to
12 migrate to the VA system.

13 And I ask them what their number one
14 complaint is in that part of their transition
15 phase. This is when they're over their acute
16 injury and they're going to the VA.

17 Their number one complaint is when
18 they get to the VA, the care is good, the
19 compassion is good, the people are helpful, they
20 don't have their medical record. They get very
21 frustrated. The VA staff gets frustrated and
22 the patient gets frustrated, the warrior gets

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1 frustrated, because they don't know what's
2 happened to them.

3 And my wife who retired about two
4 years ago from the military was going down to the
5 VA for some sort of disability thing. She had
6 a backpack on her back and I've never seen my wife
7 with a backpack.

8 And I said what's in the backpack,
9 you know, lunch, you think you're going to get
10 lost on the Metro or, you know -- and she said,
11 no, it's my medical record.

12 And she had her volumes of her
13 medical record that she was asked to bring down
14 there where somebody was going to go through and
15 flip through the pages because the VA couldn't
16 see what was going on.

17 So, again, there's a tremendous
18 amount of energy and money and emotion being
19 spent on trying to marry these two systems.

20 We work with AHLTA in the DoD system,
21 and the VA works with VistA. And there's been
22 great debate on whether to try to merge these two

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1 with some sort of gap using the JANUS system,
2 using what's called a GUI system, provider GUI
3 system to put them together.

4 There's another camp equally
5 divided that says let's just go back to ground
6 one and rebuild both systems from a third-party,
7 off-the-shelf system.

8 And so there hasn't really been
9 consensus reached and everybody's cordial and
10 civil. But the two camps, in my opinion, still
11 tend to retreat to each other's corner and will
12 continue to come out and answer the bell I think
13 because this is something that the President has
14 said is an imperative, to figure out how to
15 create these two systems.

16 If we're going to get to a personal
17 electronic health record for everybody in the
18 country, we have to at least be able to start by
19 getting the Department of Defense and the
20 Department of VA to be able to speak to each
21 other, so I think that's where the imperative
22 comes.

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1 MEMBER STONE: Let me ask the
2 Committee, and I appreciate this discussion, but
3 let me ask the Committee to think about this in
4 a little bit different manner.

5 If, in fact, the result of this visit
6 is commentary on the need for a technical
7 solution to electronic health records, the
8 Department will look and say, yes, we got it and
9 we got a lot of money put against it and both
10 Secretaries are actively involved.

11 But I think the broader discussion
12 that I would ask you to think about in the next
13 few months is what is the role of integration of
14 these two systems? How should we view ten years
15 from now the integration of these systems?

16 We are beginning to struggle as we
17 approach the end of this war with the same issues
18 that have been present in every war before this,
19 and that is what is the end point of DoD health
20 care and what is the beginning of VA health care?

21 And I would ask that this Committee
22 could help us a lot by thinking through a

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1 recommendation on future integration platforms.
2 The fact that we take our most complex wounded,
3 go through the acute process and then reach some
4 point in which we hand off to remote, complex
5 rehabilitation care platforms in Tampa or
6 Richmond or the other places in the country, Palo
7 Alto, that the VA operates. You have to
8 question whether that's the right platform for
9 the future for complex rehabilitation and
10 complex battle wound care.

11 It would challenge both systems but
12 would be a unique opening to really some broad
13 discussion of what the future ought to look like.
14 And I would ask you to think about this visit in
15 that broader context of what the delivery system
16 should be 10 or 20 years from now.

17 MEMBER REHBEIN: There's been, from
18 the other side, from the other side of the fence,
19 really, I guess, there has been a great deal of
20 interest out there in the veterans community
21 over the last 15, 20 years as what's the best
22 delivery method for veterans health care? Is it

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1 the VA health care system or is it a private
2 provider?

3 I personally see this as the future
4 of a very good way to deliver veterans health
5 care because this helps ensure the health of the
6 VA system itself, because not only does it
7 provide that seamless care but it's drawing
8 those two populations together.

9 And so one day when that young man
10 or woman comes out of the military and takes the
11 uniform off they're still seeing the same
12 doctor. They're not having to navigate an
13 entirely different system.

14 And I just want to make a comment
15 about the Lovell Care Center. There's two
16 potential attitudes that you could see when you
17 walk into a place like that, one of them being,
18 on one side of the coin, we want to see if this
19 will work. That's not the one we saw.

20 The one I think we saw is we're going
21 to make this work. And between the Navy and the
22 VA, every office we were exposed to either had

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1 a VA director and a Navy deputy or vice versa.

2 And they were addressing that
3 continuity problem that way and I think
4 addressing it very well and those two people
5 would all seem to sit next to each other at the
6 table and interact very well.

7 The tension wasn't there, so it was
8 really an attitude of we're going to make this
9 work. We see the value and it needs to work and
10 we're going to make it work.

11 MEMBER EVANS: My final comment, I
12 think the Lovell system of care has already
13 demonstrated that we can do this. They take
14 care of our very young coming in, so those are
15 our recruits, and so we have DoD coming in to a
16 VA system.

17 And, again, I think that as she said,
18 clearly they had at the beginning lots of
19 challenges, I mean, unbelievable. I was there
20 at the beginning, not in their system but, you
21 know, just over at Great Lakes.

22 And so but they're taking care of the

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1 recruits. They're not missing a beat. It's
2 DoD. It's VA. So I think we already have the
3 answer as to the recommendation of future health
4 care.

5 We know that we need to probably
6 integrate into one building DoD and VA, and we
7 made that recommendation last year, how to look
8 at that joint process or integration, and so I
9 think we need to probably carry that
10 recommendation again. But it works.

11 And so we didn't have the
12 opportunity to hear from the patients on the
13 actual ground and that's the disadvantage. I
14 wish we could have heard from the enlisted,
15 officers, VA patients, as to their opinions but
16 we didn't have that opportunity.

17 But I think it's already there and
18 I think we probably at the end of the year should
19 look at -- or when we make our recommendations,
20 that we already have a system out there and it's
21 working.

22 MEMBER PHILLIPS: But perhaps to

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1 just take it one step further, we know roughly
2 20 percent of the veterans do not seek VA care.
3 They're in the civilian sector. We all know
4 what has to be done, and to quote Suzanne
5 Crockett-Jones, we have one monetary system for
6 the U.S., we should have one IT system for the
7 U.S.

8 I think we would go a long way to
9 solve the issues, as we all have said, if we had
10 one IT system. Then everything else should fall
11 into place. Again, I just ask the Committee is
12 this something that we want to emphasize again
13 in our recommendations? Whether that will
14 happen is up to Congress, but I think that is an
15 initial start.

16 And if we're going to do it, we
17 should include the civilian sector because as we
18 stand down more and more people, whether they're
19 remote or in urban areas, will be using the
20 civilian sector, especially with the
21 sequestration that will have to go out. We want
22 to maintain the quality of care in the DoD and

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1 VA system as much as we can. I agree with that.
2 But we also have to look at the movement over to
3 the civilian side.

4 And that, again, goes along with the
5 concept of if you're eligible for VA, if you're
6 eligible for TRICARE, perhaps, you should very
7 easily be eligible for Medicare depending on
8 your location.

9 CO-CHAIR NATHAN: Okay, great
10 comments, and I think this serves as the nidus
11 of discussion for large tectonic issues that we
12 would consider at the Task Force, one being do
13 we stay in the rehabilitative business when
14 there are marquee organizations in the civilian
15 sector, academic world that can also do these
16 things?

17 We fall back to they don't provide
18 the family support and the total warrior support
19 that we do within our own lifeline to the VA and
20 the DoD but that could be rectified, so that's
21 a discussion that happens.

22 As we move to the next site visit,

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1 I do want to point out, though, that I'm
2 encouraged and I think the glass is half full.
3 We tend to knock, and I did it myself, our
4 electronic medical record system
5 interoperability, but at least we have them, at
6 least we have them.

7 You know, the majority of patients
8 in this country don't have or don't see someone
9 with an electronic medical record. You know, 80
10 percent of the patients in this country when they
11 go to their doctor there's a paper record that's
12 stuffed in a room somewhere.

13 So the DoD and the VA have very
14 robust electronic medical records so that you
15 could go to anywhere in the country -- in the DoD,
16 in the world -- and see what's happened to you
17 from someplace else. So I'm encouraged by that.
18 But if we're going to get to a place where we can
19 easily see each other's systems, there's more
20 work to be done.

21 And Chicago is helping us find out
22 some of the questions we didn't even know about

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1 to find the answers and I applaud the good work
2 they're doing there.

3 Okay, we can talk about Fort Bragg
4 visit.

5 MEMBER EUDY: I'll go ahead and
6 begin. Some of these comments will go both
7 between Fort Bragg and mirror into the CBWTU.

8 But as we noted at Fort Carson, we're
9 starting to see the large increase of PTSD, TBI
10 and long-term ortho injuries from these large
11 divisions coming off of deployments, let alone
12 the big drawdown coming up, so that's starting
13 to flood into our systems across all the
14 services, having an increased population.

15 Key issues that we saw at Fort Bragg
16 or things that were brought up. Something
17 specific was the separation between the junior
18 and senior NCOs and officers within the WTU
19 structure that they had done there. I know we
20 had addressed that. That was something
21 different that we had seen separate of the other
22 focus groups we had conducted, and a very high

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1 regard for the legal folks in the IDES process
2 there.

3 I believe, and correct me if I'm
4 wrong, Ms. Dailey, that we'll be looking into
5 some of the processes that legal had provided
6 there, just to communities of practice, best
7 practice amongst all the legal avenues.

8 Two of the key things, though, that
9 were identified between both of those visits.
10 Regarding our Title 10 and Title 32 soldiers,
11 sailors and the Marines and falling off of orders
12 coming close to the MEB or the IDES process, if
13 a civilian provider or active-duty provider is
14 putting together a care plan, we know that that's
15 going to be a long-term care plan requiring a
16 long period of care. So there's no reason that
17 orders should be dropping or coming to the 11th
18 hour on a Friday afternoon to get things done.

19 So I would like to see something come
20 down from the services specifically regarding
21 those service members, some type of policy that
22 would state, you know, if a service member is

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1 placed into a long-term care plan that they would
2 have to meet orders requirements by certain
3 dates so we don't have to risk falling off during
4 the IDES process.

5 CO-CHAIR CROCKETT-JONES: I just
6 want to point out this was reiterated. The same
7 issue has come up at multiple sites with
8 variations in where the frustration on getting
9 orders -- we've seen a variety of wrinkles of the
10 same problem. It was discussed at San Antonio
11 as well. We heard that from case managers.

12 So this is not just a perception or
13 problem felt by service members. This is also
14 their cadre, their case management are also
15 frustrated in keeping people in a transition
16 plan, moving forward when they have this
17 administrative issue.

18 MEMBER EUDY: And follow-up to that
19 comment and something you had mentioned,
20 Admiral, at the last meeting of, you know, what's
21 the one-stop shop resource? Where do we connect
22 families in?

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1 And, Ms. Crockett-Jones, you always
2 mention this. Where do we align families to
3 bring up that education piece? And regarding
4 the services movement towards a medical home
5 health care type model regardless of what each
6 service calls it, when we have our members going
7 out and receiving care at those VAs or civilian
8 facilities, it is key to involve those family
9 members in that in-processing phase at those
10 locations.

11 From all these focus groups I've had
12 the benefit to go to every single site visit and
13 to hear again the same things of education
14 regarding whether it's respite care you know,
15 TBI, PTSD, family member travel if I'm taking my
16 service member to and from those MEB/IDES
17 appointments, or what have you.

18 Building that knowledge base at the
19 beginning of the in-process, because we're
20 getting great response from, you know, when I'm
21 at the large Warrior Transition Unit regardless
22 of what facility, regardless of what service.

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1 But once I go off to the mom and pop, my support
2 activity, we find that leaning on those, you
3 know, if you go to a community-based or a home
4 health care model, you're going to lean on those
5 people heavily.

6 You know, we got such high rapport
7 from those NCOs and amongst the cadre members
8 saying, wow, you know, I really appreciate this
9 person just the same as we do for non-medical
10 case managers and an overwhelming support
11 because that's where the services are provided.
12 That's what they need at that time. Obviously
13 that person will be held in high regard.

14 But because they're leaning so
15 heavily on that, getting them engaged in that
16 early in-processing phase, whether that's so
17 they know what's going on in the CTP or CRP, and
18 then they can play that active role. Obviously
19 it's going to depend specifically on our, you
20 know, service members and families to take the
21 initiative at some level.

22 But I think a push towards family

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1 member processing or in-processing to know what
2 service is available before they go to the home
3 health care model is key. That's the end of my
4 comments on that.

5 CO-CHAIR CROCKETT-JONES: I want to
6 reiterate that this was the only place we've seen
7 the model of separating senior NCOs and officers
8 into a particular platoon within the Warrior
9 Transition Unit. And we've asked them to give
10 us some measurable outcome and evidence
11 regarding the success of this model.

12 I can say that in our focus group and
13 even just in my own cadre this was not
14 necessarily a comfortable model for anyone
15 involved, but it needed time. It was fairly
16 new. I will be interested to see any measurable
17 outcomes and the impression that this model
18 stands.

19 It made the senior NCOs feel fairly
20 cut off from their comfortable lane of
21 leadership by having no association with junior
22 NCOs to mentor and it did eliminate that sort of

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1 mentorship role when they are in among others,
2 among their junior NCOs.

3 So we will see and I hope we do follow
4 up on that and it gives us some good information.

5 MEMBER PHILLIPS: My comment's
6 related to Fort Bragg, just a few bullet points.

7 "Where am I in my process?" We've
8 heard that repeatedly. I don't know how to
9 answer that but that was focus group, family and
10 recovering warrior.

11 Again, we've heard repeatedly the
12 low enlisted don't have advocates or they don't
13 advocate for themselves, both family and
14 recovering warriors.

15 From the command, I think this was
16 at Fort Bragg, what I took away was, I won't
17 mention names, but the command said we would
18 really like to have a short, concise guidance
19 document with standard terminology.

20 I mean, there are long guidance
21 documents but just something short and concise,
22 which is obviously always helpful, that the

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1 resources are out there but we need better ways
2 to connect the dots, connect the recovering
3 warriors to those resources.

4 And the other thing which I hear
5 again, and we all know, is that many things get
6 done via social networks, not via the standard
7 policies and procedures.

8 CO-CHAIR NATHAN: Thank you.
9 First of all, a couple points. One is, Suzanne,
10 thank you. It is interesting to see the good and
11 the bad that we can take away from
12 compartmentalizing the NCOs and the officers
13 and, again, it fosters and also can impede esprit
14 de corps advocacy.

15 Again, your points about sort of the
16 warrior care non-medical support 101, you know,
17 giving somebody a pamphlet with cartoon figures
18 in it that just shows where you start and where
19 you end.

20 As far as "where am I in the
21 process," I know we've heard a lot of folks come
22 in and brief us on IDES and the various service

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1 things. One of the things we've done in the Navy
2 and, again, I always preface this by saying that
3 our footprint in the Navy is much less than the
4 Marine Corps and in the Army so it's easier for
5 us to get our arms around the numbers.

6 But what we have in many of our
7 centers are PEBLOs. We have partitioned one
8 PEBLO who is a senior enlisted whose job is to
9 do nothing but interact with the system and tell
10 the individual where they are in the system.

11 So what that means is you have one
12 PEBLO who's guiding you, who's filling out your
13 paperwork, who's helping you navigate the system
14 and getting your medical narrative summary
15 together, getting your PEB together, getting all
16 that together.

17 You have another PEBLO whose job is
18 to do nothing but get on the phone and call D.C.
19 and talk to where your case is, because what
20 happens is you've got a PEBLO who's in the middle
21 of doing somebody who's new to the system.

22 And then there's a knock on the door

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1 and it's somebody who says, hey, I know you're
2 busy with him or her but can you tell me where
3 my case is right now? So they have to stop what
4 they're doing and they have to get on hold for
5 20 minutes and call around.

6 So we've partitioned in our more
7 robust places one PEBLO whose job is to do
8 nothing but simply track cases and help the
9 individual figure out where they are in the
10 system. It seems to have helped. We're
11 hitting our numbers now. We're both at the MEB
12 and PEB milestones and I think that's one reason
13 for it.

14 So, again, I think this reemphasizes
15 the need for all this passion, these shoots of
16 passion that come up everywhere, from the VA,
17 from the federal health coordinators, from the
18 recovering warrior coordinators, from the case
19 managers, from the various support agencies, be
20 it Safe Harbor or Special Ops, an integrated
21 thread that gives people sort of situational
22 awareness on one screen they can look at.

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1 Any other comments in regard to
2 Bragg? Okay, how about Arkansas? Anything
3 else to add?

4 MEMBER REHBEIN: Not necessarily.
5 Just sort of a follow on from what you just said
6 about Bragg, because that's one of the things we
7 heard in the focus groups in Arkansas, people
8 trying to get in contact with their PEBLOs to
9 find out what's going on and not getting phone
10 calls returned, whether it's because the PEBLO
11 doesn't have anything new to say or whether it's
12 because the PEBLO's overworked.

13 But it was a definite source of
14 frustration down there too. I think in at least
15 two of the focus groups that we worked, and maybe
16 in all three of them, we heard that as one of the
17 predominant problems.

18 One thing I do want to say about
19 Arkansas, but not necessarily the CBWTU. We
20 heard several instances, when you asked a
21 question about support from your line unit, we
22 heard several people come back with, yes, we talk

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1 regularly. That's supposed to be the rule.
2 It's not. It's the exception. But it's nice to
3 see the exception actually come into being in
4 places. I think the one young man said he talked
5 with his sergeant major about once a month and
6 that's good to hear.

7 MEMBER EVANS: So another great
8 visit. A couple of takeaway, this was the first
9 visit where we heard "I know what CTP stands
10 for." Every focus group, even the family
11 members, they said, "Yes, we've heard the term.
12 Oh yes, that's what my soldier, he gets on to the
13 system and he completes his CTP."

14 The problem we had with that is that
15 the families didn't have input into it. The
16 families were very separated from that plan. It
17 was a good thumbs up but the families didn't have
18 any input or didn't have any communication with
19 the plan.

20 Another part is that the families
21 were definitely separated from the process of
22 transitioning out of the military, so they felt

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1 that they were hands off. Their responsibility
2 was to get the member to the appointment and
3 that's it. They didn't realize they could get
4 reimbursed for those drives down from Arkansas
5 to Fort Gordon. I believe that's where they
6 were going.

7 And so that was a disconnect and so
8 we left that as probably they needed to have a
9 family -- what's the position? One person that
10 worked with the families there at the CBWTU.

11 What we found also is that I believe
12 the soldier or the reservists spend a lot of time
13 at the WTB. So I'm Navy, so make sure I get this
14 right, WTB, and then they transition into the
15 WTU. When they get to the WTU, they still --
16 CBWTU. Once they get to the CBWTU, the social
17 workers and the case manager were still having
18 to find long-term medical care such as for PTSD,
19 TBI.

20 So they were still going back to the
21 NICOE at Walter Reed. They were still going
22 back to Laurel Ridge in San Antonio.

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1 That we found interesting. If
2 you're spending several months in the WTU, they
3 shouldn't have to have those type appointments
4 once they get to the CBWTU.

5 The social workers were concerned
6 with the ratio because they were having to send
7 the patients out for so many appointments. The
8 ratio was 1 to 83, which I went back and did my
9 own research, what's the standard? And I think
10 it's 1 to 100 for a CBWTU. But they felt that
11 that was overwhelming because of the type of
12 patients that they were receiving.

13 CO-CHAIR NATHAN: Social worker
14 ratio?

15 MEMBER EVANS: Yes, sir.

16 CO-CHAIR NATHAN: One to 100?

17 MEMBER EVANS: One to 100.

18 CO-CHAIR NATHAN: Is the standard?

19 MEMBER EVANS: For CBWTU.

20 CO-CHAIR NATHAN: Okay.

21 MEMBER EVANS: Yes. I think across
22 a standard practice, I believe it may be 1 to 50.

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1 I'm not sure.

2 MEMBER STONE: I want to make sure
3 I heard you correctly. Are you saying that
4 individuals that need ongoing TBI care should
5 not come into the CBWTU?

6 MEMBER EVANS: No. What I'm saying
7 is that they found they had several -- that when
8 they got to the CBWTU the care that probably
9 should have taken place at the WTU didn't happen
10 and so they picked up on a lot of the gaps in the
11 CBWTU. So not that it shouldn't take place.

12 MEMBER STONE: So should, in fact,
13 those individuals needing that type of care be
14 in a place that that care is co-located or
15 someplace close to them so they don't have to TDY
16 to get that care?

17 MEMBER EVANS: I would say yes to
18 that one.

19 MEMBER STONE: So that calls into
20 question whether the skew of diagnoses within
21 the CBWTU is correct. CBWTU is to have the
22 service member recover closer to their home of

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1 record.

2 MEMBER EVANS: Right.

3 MEMBER STONE: That should not
4 supersede the decisions on care. Care should
5 take precedence and, therefore, it may not have
6 been an appropriate referral.

7 MEMBER EVANS: Correct. And that
8 was the feeling of the staff in the CBWTU,
9 exactly.

10 MEMBER DEJONG: And some of those
11 issues are actually disqualifications from
12 getting into the CBWTU. Generally TBI, severe
13 TBI and/or severe PTSD is a disqualification for
14 anyone to go into the CBWTU.

15 So need to look a little bit deeper
16 into: was everything disclosed or somebody just
17 wanted to get closer to home and then things
18 progressed and got worse?

19 CO-CHAIR CROCKETT-JONES: Yes, and
20 also, if these are folks coming from a single MTF
21 or a WTU that is perhaps not going to the standard
22 exactly, you know, if they've misinterpreted.

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1 MEMBER DEJONG: And ladies and
2 gentleman, it is 9 o'clock and I do have a cast
3 of thousands back here for the Army's
4 presentation at 9:00.

5 We have an hour tomorrow. I would
6 like to follow up on the discussion we've just
7 had but I'd also like to do justice to our visit
8 out to San Antonio, so we have an hour tomorrow
9 morning where we can continue this discussion.
10 Is everyone okay with that?

11 Okay. I'm going to bring the Army
12 up. It's going to take a minute to get them all
13 settled and get into place. Please take a quick
14 break, and we will be back and start at five after
15 nine. Thank you.

16 (Whereupon, the above-entitled
17 matter went off the record at 9:01 a.m. and
18 resumed at 9:08 a.m.)

19 CO-CHAIR CROCKETT-JONES: Just to
20 let the Task Force members know that our
21 comprehensive copy of last year's
22 recommendations can be found at Tab N, so as we

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1 receive briefings from services on their
2 responses we have a reference.

3 We are beginning with the Army
4 Warrior Transition Brigade. We welcome
5 Brigadier General David Bishop. Am I correct?

6 BG BISHOP: That's correct, ma'am.

7 CO-CHAIR CROCKETT-JONES: The
8 Commander of the Warrior Transition Command and
9 his supporting staff will begin their session
10 briefing the Task Force on their response and
11 status to the specific recommendations that
12 directly apply to the Army.

13 Their biographies are found under
14 Tab C of our binders, and I'll turn it over to
15 you to introduce your staff and brief us.

16 BG BISHOP: Okay, ma'am, thank you.
17 Vice Admiral Nathan, Mrs. Crockett-Jones,
18 distinguished members of the Task Force, good
19 morning.

20 I am Dave Bishop, Commanding General
21 of Warrior Transition Command. I'm also
22 dual-hatted as the Assistant Surgeon General for

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1 Warrior Care and Transition, so I have two hats.

2 My staff and I work for the Surgeon
3 General of the Army, Lieutenant General Horoho,
4 and we serve as the Army's proponent for Warrior
5 Care and Transition.

6 I'd like to thank the Recovering
7 Warrior Task Force for the opportunity to come
8 talk to you today and share with you some of the
9 work we've done over the last year.

10 As the Army continues to face new and
11 changing global demands, one constant remains,
12 and that's the care for our wounded, ill, and
13 injured soldiers and their families and our
14 veterans.

15 We have a sacred and enduring
16 obligation to do this and this program and this
17 group of people dedicate everything they do
18 every day to ensuring that the obligation is met.

19 Just as a refresher, I know many of
20 you are very familiar with what we do, but just
21 as a refresher, the Warrior Transition Command
22 mission is to provide centralized oversight,

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1 guidance and advocacy, empowering wounded, ill
2 and injured soldiers, veterans and their
3 families through a Comprehensive Transition
4 Plan for successful reintegration back into the
5 force or into the community with dignity,
6 respect and self-determination.

7 And today across the Army we have 29
8 Warrior Transition Units on installations and 9
9 community-based Warrior Transition Units away
10 from Army installations providing remote care.

11 They support over 9,600 soldiers
12 currently and they do that with about 4,400
13 dedicated, committed staff and cadre.

14 As you know, our program is based on
15 a triad of care concept which includes a squad
16 leader, a nurse case manager, and a primary care
17 manager. This concept has been in existence for
18 about five years and has proven to be very
19 successful.

20 Success of each WTU is ensured
21 through what we call a triad of leadership which
22 consists of the MTF commander, the senior

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1 mission commander, and the WTU commander on each
2 and every installation.

3 Now, Warrior Transition Command
4 remains diligent as the proponent for the
5 Warrior Care and Transition Program and our
6 commitment to improve clinical and non-clinical
7 care is what keeps us busy every day.

8 We do not have mission command over
9 the WTUs. We are the proponent and we provide
10 the systemic oversight of the program throughout
11 the Army.

12 We also run the Army Wounded Warrior
13 Program or AW2 as you've probably known it, a
14 population of over 15,000 of our most seriously
15 wounded, ill, and injured soldiers and veterans
16 and we do this through the use of about 200
17 advocates who are spread around the country.

18 Our goal at WTC is to ensure we are
19 value added in the eyes of our stakeholders.
20 That's our soldiers and families, our cadre
21 members, the regional medical commands, the
22 Office of the Surgeon General, DoD, VA, and of

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1 course the American public.

2 And we do this by providing enhanced
3 operational oversight. We oversee the force
4 structure of the program and we assist Army
5 leadership in making good, sound decisions about
6 warrior care and we ensure that the program is
7 adequately resourced and structured.

8 We publish and improve policies that
9 relate to warrior care and transition and WTUs
10 and we do this so that the results are successful
11 for each soldier that goes through the program.

12 We focus on cadre selection,
13 training, and support as they're the front line
14 of this effort to take care of our people.

15 And we also provide personalized
16 support for every wounded, ill, and injured
17 soldier that goes through this program through
18 a Comprehensive Transition Plan which is
19 continuously updated.

20 Now, over the past eight months some
21 of our focus areas have been a well-trained,
22 resilient and resourced cadre. I've seen

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1 firsthand the demands of that job and I'm sure
2 many of you as well.

3 To support this we've secured
4 Reserve Component CO-ADOS staffing at the WTUs
5 through 2014 to provide stability and
6 predictability for the staffing model.

7 We've obtained 730-day orders for
8 these RC cadre to support the wounded, ill and
9 injured in our WTUs. We hope that this will
10 enable the most highly qualified Reserve
11 Component cadre to volunteer and come and serve
12 in this very demanding and rewarding position.

13 We've enhanced cadre training by
14 launching a five-day Cadre Resilience Course
15 which draws from Comprehensive Soldier and
16 Family Fitness and Master Resilience Training.

17 And we've added this five-day course
18 since October and we've received significant
19 positive feedback from everybody that's gone
20 through it.

21 And I've asked commanders in the
22 field if they've seen a measurable outcome in the

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1 daily performance of the cadre and commanders
2 are at this point anecdotally reporting that
3 they've seen positive outcomes.

4 We've also taken action to transfer
5 demobilizing Reserve Component soldiers closer
6 to home as soon as possible but when and where
7 the capacity and medical capability is present.

8 And we're hoping that we can get
9 Reserve Component soldiers in the right place to
10 heal, to get the right care and also be with their
11 families more.

12 We've also decentralized in
13 conjunction with DAX or FRAGO 4 the approval
14 authority for Reserve Component senior soldiers
15 to be entered into the program and we think that
16 we could reduce some of the processing time
17 between 8 and 15 days by doing that.

18 We've additionally built systems
19 here in Warrior Transition Command to help
20 resolve soldier issues quickly while also
21 identifying systemic issues and trends in order
22 to basically improve policies and guidance that

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1 we're putting out to the units.

2 These accomplishments are just a few
3 examples and serve as a testament to the Army's
4 commitment to improve and refine the Warrior
5 Care and Transition Program and to ensure that
6 we continue to meet and exceed the expectations
7 and needs of our wounded, ill, and injured
8 soldiers and their families.

9 Now, what I'd like to do is introduce
10 our august panel members here. Our first panel
11 member is Mrs. Nancy Adams. She's the Branch
12 Chief for the Career and Education Readiness
13 Branch at Warrior Transition Command.

14 Prior to working at WTC, Nancy
15 worked as the Branch Chief for military training
16 for the Defense Contract Management Agency.

17 She served as an Army Education
18 Services Specialist at Fort Belvoir and at
19 Patton Barracks in Heidelberg, Germany, and she
20 managed the Army Career and Alumni Program
21 offices in Heidelberg and Mannheim, Germany,
22 from 2000 to 2001.

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1 She also holds a B.A. in European
2 history from UVA and a master's in vocational
3 rehab counseling from San Diego State.

4 Our second panel member, Lieutenant
5 Colonel Jon Baker, is the Deputy Director for the
6 MEDCOM IDES Task Force. Colonel Baker has more
7 than 17 years of active duty service.

8 He served as a brigade operations
9 officer at Fort Hood as well as an S3 and deputy
10 surgeon and medical operations officer for the
11 1st Special Forces Group at Fort Lewis.

12 Our third panel member, Mr. Reginald
13 Coffey. He is our Army Wounded Warrior Program
14 Advocate Branch Chief for Warrior Transition
15 Command.

16 Mr. Coffey has served in this
17 position since 2009 and he has over 24 years of
18 service as both a soldier and an officer and over
19 20 years as a patient advocate serving as a
20 patient administrative officer.

21 Our fourth panel member is
22 Lieutenant Colonel Danny Dudek. He is our Chief

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1 of Plans, Policy and Programs for WTC and Danny
2 is a former successful WTU commander.

3 And he has 19 years of service in the
4 active Army and three years as a Reserve soldier.
5 A wounded warrior himself, Colonel Dudek is a
6 member of the COAD program still.

7 Our fifth member today is Dr.
8 Melissa Gliner and she is a senior health policy
9 analyst with MEDCOM.

10 Dr. Gliner holds a master's degree
11 in statistics and experimental psychology as
12 well as a Ph.D. in statistics, research
13 methodology and women in leadership roles from
14 University of California, Santa Cruz.

15 In 2001 Dr. Gliner began work with
16 her current position where she assists senior
17 AMEDD leaders by conducting research and
18 statistical analysis.

19 And she currently serves on a
20 variety of Department of the Army and DoD
21 initiatives and has focused her efforts on
22 MEDCOM survey programs focusing on MEB and WTU

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1 satisfaction.

2 And our sixth panel member is
3 Colonel Jean Jones. She is our Chief of
4 Clinical Support Division for Warrior
5 Transition Command.

6 Jean holds a master's in nursing
7 from the University of Washington specializing
8 in acute care, is both a clinical nurse
9 specialist and a nurse practitioner.

10 Prior to her current position, Jean
11 was the Chief Nurse for the Warrior Transition
12 Command and before that she was the Deputy WTB
13 Commander of the National Capital Region and she
14 also served as a WTU Battalion Commander at Fort
15 Belvoir.

16 Our seventh panel member is Mrs.
17 Colleen Tuddenham and she is from Soldier and
18 Family Outreach for ACSIM, Assistant Chief of
19 Staff for Installation Management.

20 Colleen has served five years as an
21 Army finance officer with assignments at Fort
22 Hood and Burtonwood, England.

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1 And she holds a Master of Arts degree
2 in psychology, counseling, and guidance from the
3 University of Northern Colorado and a
4 post-graduate certificate in organizational
5 development from Georgetown University.

6 Prior to her current position,
7 Colleen worked at Family and Morale,
8 Welfare/Recreation Command where she assumed
9 oversight for the Employment Readiness,
10 Survivor Outreach, Financial Readiness, and
11 Exceptional Family Member Programs.

12 And finally our eighth and last
13 panel member that I'll introduce is Lieutenant
14 Colonel Edward Brusher. Ed is the Chief of
15 Operations Branch for Behavioral Health
16 Division, Health Policy and Services Director at
17 Office of the Surgeon General for the Army.

18 Colonel Brusher is deployed to
19 Bosnia and Herzegovina to provide peacekeeping
20 in support of S46, and he holds a bachelor's of
21 psychology and a master of social work degree
22 from the Florida State University.

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1 And, in fact, we're going to start
2 off with Colonel Brusher this morning. Thank
3 you.

4 LTC BRUSHER: Thank you, sir. If I
5 could have you advance the slide to
6 Recommendation Number 8.

7 Again, I'm Colonel Brusher with the
8 Office of the Surgeon General, the Behavioral
9 Health Division, and I will be providing a
10 response to both Recommendation Number 8 as well
11 as Recommendation Number 9.

12 Recommendation Number 8 has to deal
13 with the recommendation to train 100 percent of
14 our behavioral health provider inventory in
15 evidence-based treatments as well as educate our
16 primary care providers in the ability to screen
17 and identify PTSD.

18 Based on a data call that the Task
19 Force requested, we queried the MEDCOM inventory
20 and were able to identify that about 18 percent
21 of our respondents are not currently trained in
22 evidence-based treatment.

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1 But I would caveat that the
2 categories of providers that were included in
3 that data call included our behavioral health
4 technicians and our behavioral health nurses.

5 So if you excluded those and only
6 included psychiatry, social work, psychology,
7 nurse practitioners, then the total percentage
8 of untrained providers drops to about 9 percent
9 which equates to about 316 providers of an
10 inventory of just over 3,200.

11 This is consistent with current
12 workforce turnover in the Army which is roughly
13 about 20 percent and well within the current
14 capacity of existing evidence-based treatment
15 training programs within the Army that can
16 certify roughly 25 percent of our entire
17 inventory annually.

18 It's about an 800 annual training
19 requirement that we currently have within the
20 Army so easily could train the 300 or so
21 providers that exist that reported not being
22 trained in evidence-based treatment.

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1 The Army has already validated that
2 evidence-based practice is being utilized in 90
3 percent of existing episodes of care.

4 There are many reasons in which
5 alternative approaches may be utilized to
6 include unresponsive reaction, basically lack
7 of improvement based on what was presented with
8 manualized approaches or other A-Level
9 treatments.

10 And an A-Level treatment is a
11 trauma-focused treatment protocol that's
12 considered a strong recommendation with
13 benefits substantially outweighing harm based
14 on randomized control studies.

15 In April of 2012 MEDCOM policy
16 guidance on the assessment and treatment of PTSD
17 established revised treatment standards in the
18 use of screening, assessment, and treatment of
19 PTSD with special emphasis in the use of
20 evidence-based treatment.

21 MEDCOM directed clinicians to use
22 the 2010 VA/DoD CPG, which are Clinical Practice

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1 Guidelines, for the management of PTSD,
2 endorsing the use of A-Level psychotherapy as
3 the preferred treatment as the first option
4 which include manualized packages such as
5 prolonged exposure therapy, cognitive
6 processing therapy or eye movement
7 desensitization and reprocessing, all of which
8 are on the curriculum that is provided by the
9 AMEDS training program currently.

10 When considering our primary care
11 providers, our current effort is known as
12 RESPECT-Mil. RESPECT-Mil is transitioning as
13 we convert to patient-centered medical home.

14 So once the existing primary care
15 treatment clinics are recognized by the National
16 Center of Quality Assurance, then R-Mil will be
17 rebranded to what's going to be termed the
18 Patient-Centered Medical Home, Behavioral
19 Health.

20 Under PCMH-BH all adult
21 beneficiaries in primary care clinics and
22 medical homes will be screened at every

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1 encounter by a primary care provider using
2 approved screening tools that specifically
3 address depression, PTSD, anxiety and alcohol
4 use.

5 Positive screens will complete
6 additional diagnostic aids to include
7 functional impairment and suicidal ideation.

8 Training will be provided by
9 certified site champions who will educate all
10 required personnel at their location on how to
11 score and interpret these instruments.

12 And one of the unique changes as we
13 move into PCMH-BH is the higher-end integration
14 of behavioral health providers that will be
15 organic to the primary care clinic itself.

16 The R-Mil program uses consultation
17 currently so that's a shift where we're putting
18 actual providers in the clinic structures.

19 CO-CHAIR NATHAN: Colonel Brusher.

20 LTC BRUSHER: Yes, sir.

21 CO-CHAIR NATHAN: Quick question.

22 What's the penetration of patients that are in

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1 medical home clinics where you have your WTUs?

2 LTC BRUSHER: The percentage where
3 the wounded warriors are seen by primary care?

4 CO-CHAIR NATHAN: Yes.

5 LTC BRUSHER: I don't have that
6 data, sir.

7 CO-CHAIR NATHAN: Okay, I mean,
8 you're talking about, and I buy it, medical home
9 with organic primary care people juxtaposed to
10 emotional health providers who can get people in
11 at the front door very quickly and also maintain
12 continuity of care.

13 So I'm a huge PCMH fan. All you have
14 to do is read AMSUS journal this month and I've
15 got the editorial in there touting the benefits
16 of medical home.

17 My concern is, though, when we talk
18 about it I'm not sure how much effort, my service
19 included, is putting behind actually getting it
20 stood up, fleshed out, and the gears turning at
21 the various either WWRs or WTUs.

22 So you don't have a good idea of

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1 about how many of your wounded warriors who are
2 seen through MTFs have exposure to a medical
3 home?

4 LTC BRUSHER: I do not, sir.

5 CO-CHAIR NATHAN: Okay.

6 MEMBER PHILLIPS: Colonel, just a
7 quick question. The screening tools, are they
8 in standard use? Are they standard tools or are
9 we still testing them and trying to determine
10 which are the better ones?

11 LTC BRUSHER: All of our screening
12 tools are based on civilian metrics or tools.
13 The one specifically used in R-Mil that will be
14 converted to the PCMH-BH is PCL, specific to
15 PTSD.

16 But that's a validated measure
17 that's recognized both in the civilian community
18 as well as the DoD.

19 MEMBER REHBEIN: If I can stay on
20 that subject for a minute, Colonel, in some of
21 our focus groups we've met people in CBWTUs that
22 it appears their PTSD has severely gotten worse,

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1 in fact, some folks in CBWTUs that have gone back
2 to NICOE for help.

3 And I wonder about the screening
4 tools. As a soldier leaves a WTU and goes to a
5 CBWTU, their living environment changes quite
6 drastically.

7 Are the screening tools able to
8 project how a soldier is going to react, how
9 their PTSD will react, once that living
10 environment changes?

11 You know, when you're surrounded by
12 fellow soldiers, that's a support system. When
13 you go home, that part of the support system goes
14 away. There's another support system with
15 family, but it's a different support system.

16 LTC BRUSHER: I agree social
17 support systems, especially as you transition
18 into a more civilian setting, are absolutely
19 critical in the total care and expected
20 improvements that a soldier or wounded warrior
21 would experience.

22 The tools themselves are only going

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1 to be able to grade the level of PTSD that a
2 soldier or wounded warrior is currently
3 presenting.

4 So it doesn't have the predictive
5 ability to incorporate what social systems or
6 support systems or peer support groups would be
7 able to -- that would, if effective, would reduce
8 the overall score as an outcome measure and then
9 you would see the total score go down preferably,
10 and that's obviously what we seek to see in any
11 soldier that we treat.

12 MEMBER STONE: Ed, I'm not going to
13 throw you a softball, so let me pause at this
14 moment. Give you a moment to get ready for this
15 one.

16 LTC BRUSHER: Yes, sir.

17 MEMBER STONE: One of the
18 frustrations in the evolution of the concept of
19 post-traumatic reactions is: where's the
20 evidence?

21 We still go places and some people
22 are getting group therapy, some people,

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1 individual therapy.

2 When we talk to people about the
3 difference, some people say that, well,
4 everybody knows that group therapy makes people
5 worse.

6 Is there effort on the part of the
7 services or the behavioral health community at
8 large to reach consensus on how to approach these
9 conditions?

10 LTC BRUSHER: Sir, the evidence
11 actually does exist related to the manualized
12 treatment protocols that I just mentioned, eye
13 movement desensitization, cognitive processing
14 therapy. A lot of that is group.

15 We also endorse what I referred to
16 earlier as the A-Level and it's any combination
17 of exposure therapy, psychoeducation.

18 And those are randomized trials that
19 have validated that those particular techniques
20 if applied -- and, again, it's difficult within
21 our community to always stick to the entire
22 manualized treatment protocols but if you use

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1 those techniques, then you tend to have better
2 outcomes.

3 If you're looking at both civilian
4 and military populations, it's only around the
5 40 percent where we see some clinical
6 improvement.

7 But then we're targeting the length
8 of sessions also. Anywhere from 8 to 12 is
9 optimal, where we expect to see improvements.

10 But we do have good evidence that
11 shows that when applied and if you're able to
12 complete a full course of treatment, that you can
13 expect some improvement.

14 Again, it's a subjective science and
15 there are other impacts that a soldier or a
16 wounded warrior may experience as they progress
17 forward, movement into a different environment
18 where they lose some support systems that may
19 impact their current functioning status that
20 then would need to be incorporated in the
21 treatment plan.

22 So it's not a simple answer, sir,

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1 because the treatment care plan changes over
2 time because of the nature of the work that we
3 do.

4 CO-CHAIR NATHAN: Let me tag onto
5 that. Yes, agree, very difficult to stay
6 current, find best practice, collaborate.
7 Where do you integrate with DCoE in this, or do
8 you?

9 I'll say this to the folks who
10 weren't here last business meeting. One of my
11 concerns is the Centers of Excellence which do
12 good work, sometimes these are some of the
13 better-kept secrets in the government.

14 We don't share that or we don't
15 collaborate that across the dynamic. Do you
16 have an interaction with the Center of
17 Excellence for TBI and/or PTS?

18 LTC BRUSHER: We do, sir, and we
19 have paid close attention to the efforts as they
20 have evolved over time.

21 We also have one of our most recent
22 staff members who has come into our team, Major

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1 Jocik, who is coming from DCoE.

2 And our intent is to try and use him
3 to reach back into DCoE to strengthen our
4 partnership with them as we evolve our efforts
5 under the Army known as the Behavioral Health
6 Service Line and the Behavioral Health System of
7 Care.

8 CO-CHAIR NATHAN: So I'll just cut
9 to the chase. Given that this recommendation
10 was that behavioral health and primary care
11 people receive the best training available which
12 is logistically difficult, to tag onto General
13 Stone's question, do you feel that DCoE is value
14 added and makes a material difference in your
15 ability to find best standards, best
16 evidence-based training and be able to provide
17 that across the dynamic?

18 LTC BRUSHER: Sir, DCoE hasn't
19 influenced that to the degree that the DoD/VA
20 CPGs have and the CPGs establishes the current
21 best practice which drove the AMEDD Center and
22 School's curriculum.

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1 So the CPGs recognize specifically
2 the manualized treatments that I identified
3 earlier, EMDR, cognitive processing therapy and
4 prolonged exposure.

5 And so those are the current
6 evidence-based practices that are recognized by
7 both the DoD and the VA and published in the CPGs.

8 And that is the reason why they are
9 specifically being trained to the providers in
10 the courses that we've put together through the
11 AMEDD Center and School. The DCoE recognizes
12 the same CPGs.

13 MEMBER STONE: So let me be fairly
14 provocative. During Vietnam, about 17 percent
15 of service members emerged from Vietnam with
16 post-traumatic stress disorders. Nine percent
17 of those have been persistent, meaning about a
18 40 percent response rate to therapy.

19 Are you saying to us that 40 years
20 later there's been no improvement if your
21 response rate is about 40 percent?

22 LTC BRUSHER: I would point out to

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1 you, sir, that in Vietnam PTSD didn't exist as
2 a diagnosis.

3 And the state of the science has
4 increased over time so that we have a better
5 understanding of the reactions that a human
6 being has when exposed to traumas specifically
7 associated with combat environments or any
8 civilian experience that you may have.

9 So I would say that our ability to
10 address that from a clinical perspective has
11 significantly improved.

12 And we do have science that will
13 inform us on certain techniques to utilize that
14 we believe will lead to improvements.

15 MEMBER STONE: And we are going to
16 hear from your sister services and my sister
17 services after this over these next two days.
18 When we ask this same question about response
19 rates, is it all going to be about 40 percent?

20 LTC BRUSHER: I believe so, sir,
21 because that's also similar with what you would
22 see in the civilian setting.

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1 MEMBER STONE: And the Veterans
2 Administration is delivering about the same 40
3 percent response rate?

4 LTC BRUSHER: I don't know their
5 specific response rate but, again, that's
6 consistent with what you find in the civilian
7 setting.

8 MEMBER STONE: How should this
9 Committee view the role of DCoE as Admiral Nathan
10 has discussed? How should DCoE influence this
11 process and what should their role be in the
12 future from your standpoint as a provider?

13 LTC BRUSHER: I think that one of
14 the intents of what DCoE has to offer is the
15 ability to look at the changing best practice.

16 So as evidence provides more data
17 elements that then redefines what we're calling
18 evidence-based practices, because that changes
19 over time as the science improves, DCoE is the
20 engine that can help field to all of the services
21 which protocols seem to be showing the best
22 response, if you will, the best improvements in

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1 expected outcomes, so that we can incorporate
2 those modalities into the services that we offer
3 at the service level.

4 CO-CHAIR NATHAN: Do you have a
5 mechanism to obtain that from DCoE? And we need
6 to move on because you're the canary in the
7 mineshaft right now and you're suffering -- and
8 I get it and I preface this by saying this is hard
9 stuff and the DCoE is comprised of hard-working,
10 passionate people. It's not a criticism to
11 them.

12 My concern is: you've just said,
13 hey, in theory the DCoE is charged with finding
14 best practices, seeing what works better,
15 looking at the research, figuring out there's a
16 better mousetrap somewhere and then letting us
17 know about it.

18 But your answer to me previously
19 was, well, no. The CPGs and everything come
20 from somebody else. DCoE sort of does their own
21 thing.

22 So where is the linkage? And if

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1 DCoE went away tomorrow, would it materially
2 change the way you're doing business right now?

3 LTC BRUSHER: The answer is no.
4 But I can tell you that we have specifically
5 designed a position because of his past
6 experience and where he's coming from so that we
7 can reach back out to DCoE and try to reframe our
8 partnership with them so that we can bring more
9 value --

10 CO-CHAIR NATHAN: I hear you. No,
11 I hear you. What you're saying is, because
12 you're fortuitous enough to have a former member
13 of DCoE join your staff you think you're going
14 to have a better uplink to them, right?

15 LTC BRUSHER: Yes, sir.

16 CO-CHAIR NATHAN: Okay. That's
17 great and we'll settle for that, but that's not
18 the ideal system, right?

19 We're looking at a way to better
20 integrate these Centers of Excellence into the
21 tactical efforts of the services to materially
22 change the way they do business.

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1 Good people spinning their wheels,
2 but we've got the left wheel spinning one way,
3 the right wheel spinning another and we're
4 wasting a lot of energy, so that's our concern.

5 And I apologize, Madam Chairman, for
6 monopolizing this. Go ahead.

7 CO-CHAIR CROCKETT-JONES: I just
8 don't want to lose the opportunity to ask: when
9 you talk about evidence-based treatment
10 successes, 40 percent success, you're talking
11 about a measurable outcome of increased
12 functionality, I assume, as the measure.

13 How far past end of treatment are
14 those outcomes measured at this point? When I
15 hear 40 percent, my impression is that at the end
16 of treatment 40 percent show an increased
17 functionality. I'm wondering how long that
18 lasts.

19 LTC BRUSHER: Well, specific to
20 PTSD you have to understand that there are other
21 things that may happen post-treatment that
22 triggers flashbacks, that re-exposes an

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1 individual that might end up bringing back what
2 was once maintained.

3 It may be that a soldier didn't
4 return back to pre-exposure functioning and,
5 thus we're trying to maintain a different status
6 of life for that individual as they move forward
7 and incorporate their experiences.

8 In the past, most of the treatment
9 gains were measured through subjective
10 disclosure on the part of the soldier, the
11 wounded warrior.

12 I will tell you that we have moved
13 forward and you'll find that in the civilian
14 setting most of the changes are recorded by
15 subjective interpretation disclosures.

16 There's not good systems out there
17 that can track outcomes but within the Army we
18 actually do have what we call, and I actually
19 will give a little more information in the next
20 recommendation, the Behavioral Data Portal
21 which is going to enterprise the collection of
22 real outcomes data so that we can see, and PCL

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1 is one of the measures that we're using specific
2 to PTSD, we can see clinical changes and outcomes
3 not just measured in how long an individual
4 attended treatment sessions.

5 So what we want to see is: did your
6 recorded number go up or down in terms of the
7 symptoms that you're presenting that met the
8 criteria for PTSD?

9 And that is a clinical tool that we
10 used both at the enterprise level so we can
11 recognize programs that really are showing
12 outcome changes and at the clinical level for the
13 individual soldier and wounded warrior so that
14 we can see and show that your reported scores are
15 going down as well as your subjective statements
16 and disclosure that hopefully are also parallel
17 in stating improved functioning and performance
18 and that they are able to re-engage in other
19 facets of life as they move forward with their
20 own post-exposure.

21 MEMBER STONE: The VA has recently
22 published some very interesting data on World

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1 War II veterans and post a major event such as
2 loss of a spouse has had re-emergence of various
3 post-trauma exposure problems, whatever we call
4 it today. Your thoughts on lifetime care needs
5 for the veterans of today's wars.

6 LTC BRUSHER: I think it's going to
7 vary by the individual, sir, and the type of
8 trauma that they were exposed to and the support
9 systems that they return to, because what's
10 critical in long-term improvement is a good
11 social network that you can build around you that
12 can help to support you, whether it be use of the
13 VA or purchased care services, but also your
14 spouse, your friends, the community that can
15 support you as you basically transition through
16 the rest of your life cycle with an experience
17 that was tough to get through.

18 So I think the more we educate on
19 PTSD, the more we build community networks that
20 support not just soldiers but anybody exposed to
21 something significantly traumatic for them, the
22 more likelihood we'll have improved performance

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1 and outcomes in continued life functioning.

2 MEMBER PHILLIPS: You mentioned
3 that the individual will be a determinant. Is
4 there any effort related to pre-screening
5 recruits in order to perhaps sub-select out
6 those that might be more affected by these
7 experiences?

8 LTC BRUSHER: Well, I would first
9 point out that PTSD is not the only behavioral
10 health diagnosis that the Army supports, whether
11 you're assessing soldiers or maintaining the
12 inventory or looking to transition soldiers
13 because of injuries and a mental health
14 condition being one of the recognized conditions
15 that are being addressed.

16 There are screening attempts within
17 the assessed inventory of potential soldiers
18 that more look at behavioral kind of constructs
19 to see whether or not you would be a good soldier.

20 Existing diagnoses from the
21 civilian setting that are reported are certainly
22 factored in to make a determination.

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1 If I repeat exposure to more
2 high-stress environments and you've already had
3 an incident that generated a PTSD diagnosis or
4 anxiety disorder or depression or maybe even
5 suicide attempts that were recorded in the
6 medical record, will that somehow exasperate
7 your condition and then cause you not to be a
8 soldier who is able to perform the way we desire
9 you to perform?

10 We have got annual screenings that
11 we do now for the entire Army inventory so if
12 you're Guard, Reserve or active component, you
13 now have enhanced behavioral health screening
14 beyond the deployment cycle screening.

15 And that's something that the Army
16 self-imposed. It went beyond Congressional
17 mandates.

18 And that's going to give us the
19 ability to look at what are our rates over time
20 in a healthy force because you'll have baseline
21 rates of disease, PTSD, anxiety, depression.
22 We're looking at those kind of things.

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1 Family, relationships, again, a
2 mark of the social systems that you have in place
3 that are going to affect your ability to
4 transition through high-stress exposure.

5 The majority of soldiers with PTSD
6 are still serving in the inventory, and I think
7 the last number I saw was some 88,000 diagnosed
8 cases of PTSD.

9 But the actual data is that you're
10 more likely to have family issues, anxiety
11 issues, depression, substance abuse than a PTSD
12 diagnosis itself. It's mental health
13 conditions that we support across the board
14 regardless of origin.

15 But we do a lot of screening now in
16 an attempt to understand what our historical
17 baseline is, where you're at in the deployment
18 cycle so that we can track and see if there's an
19 increase post-return from a deployment or
20 military operation and screen at a session, not
21 just looking for PTSD but are there behavioral
22 conditions that need to be considered as we

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1 entertain bringing you in as a soldier or any
2 other service member?

3 But I can't speak for other services
4 on their attempts to try and screen prior to
5 enlistment or commissioning.

6 Barring any further questions, we
7 can move to Recommendation Number 9.
8 Recommendation Number 9 is a request to audit
9 military treatment records, specifically with
10 the diagnosis of PTSD, to assess completion
11 rates so our soldiers, wounded warriors, who
12 have a diagnosis of PTSD staying in an episode
13 of care and completing that.

14 As noted in my earlier comments, the
15 Army has already conducted a record review and
16 determined that of PTSD treatment techniques
17 provided by behavioral health providers, when
18 we're providing PTSD, over 90 percent of
19 soldiers in treatment were receiving, in fact,
20 evidence-based care.

21 So we've already conducted a record
22 review and I believe we surveyed about 28 percent

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1 of our provider force and were able to determine
2 that over 90 percent of the time we are already,
3 in fact, using evidence-based care.

4 Additionally, the Army has
5 established a Behavioral Health Service Line
6 known as the BHSL to implement its behavioral
7 health system of care.

8 The BHSL will standardize and
9 optimize the vast array of behavioral health
10 policies and procedures across the medical
11 command to ensure seamless continuity of care to
12 better identify, prevent, treat and track
13 behavioral health issues that affect soldiers
14 and families, the BHSL's enterprising 31
15 complementary BH programs under the umbrella of
16 the Behavioral Health System of care and the
17 primary care effort that I mentioned earlier is,
18 in fact, one of those 31 programs.

19 Part of this effort is to establish
20 a measure of effectiveness and measures of
21 performance that will drive further evolution of
22 programs and resource allocations.

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1 Specific to behavioral health, the
2 Army has established multiple measures of
3 effectiveness through a web-based portal known
4 as Behavioral Health 360, BH360.

5 The BH360 provides a one-stop,
6 360-degree view of all BH metrics and reports,
7 integrates multiple data sources and entities
8 which generate reports and data and leverages
9 existing products and IT infrastructure.

10 BH360 tracks all behavioral health
11 services so it's not just limited to PTSD but it
12 has, in fact, identified PTSD as a separate
13 data-collecting measure of effectiveness and
14 specifically tracks PTSD treatment and PTSD new
15 diagnoses.

16 Specific to the recommendation,
17 which is session completion rates, the Army
18 currently tracks frequency of treatments over a
19 12-month period of time by number of treatments
20 within a year grouped into three groups: one to
21 three visits, four to seven visits and eight or
22 more visits.

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1 RAND published their criteria that
2 it's optimal to have 8 to 12 treatments. This
3 is a new metric for us. In general, eight or
4 more treatments are desired.

5 If an MTF percent, meaning the
6 desired treatment, is significantly different
7 than its peers, so it's graded against peers
8 right now, a root cause analysis is recommended.

9 The data shows no significant
10 changes or trends at this time but the BH360 is
11 something that was just packaged recently and
12 incorporated at an enterprise level.

13 In addition to the BH360, which has
14 a lot of process, workload, efficiency measures,
15 the Army is developing a technical solution to
16 track BH outcomes.

17 And as I mentioned earlier, outcomes
18 really is the measure that we're trying to look
19 at over time. We want to see do the clinical
20 scales go down, not did you complete an episode
21 of care.

22 What's important to us is because

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1 you completed an episode of care, did that result
2 in a better outcome in terms of your overall
3 functioning, and can we quantify that in a
4 recorded measure?

5 There are about ten outcome measures
6 that are currently in the Behavioral Health Data
7 Portal and in there of those ten PTSD is
8 specifically being tracked.

9 The Behavioral Data Portal is a
10 web-based application module in the Medical
11 Operational Data System, MODS.

12 The Behavioral Health Data Portal
13 will track patient outcomes, patient
14 satisfaction, and risk factors enabling
15 improved assessment of program and treatment
16 efficiency.

17 BHDP has been fielded to all active
18 installation medical treatment facilities in
19 their behavioral health clinics and we did that
20 last year, late last year.

21 So it's a new system. It doesn't
22 really have a counterpart on the civilian side.

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1 I'm not aware of a large enterprise effort to try
2 and incorporate this type of a system.

3 There are a range of metrics
4 available to determine both efficiencies and
5 outcome related to behavioral health efforts
6 currently supported by the Army.

7 In general, Army relies on
8 civilian-based validated outcomes metrics as
9 behavioral health services follows civilian
10 standards in diagnosing and treatment
11 behavioral health conditions.

12 And that's important because the way
13 we diagnose mental health conditions, we follow
14 the civilian guidelines published in the DSM and
15 the ICD.

16 There are no military-specific
17 guidelines in determining what type of mental
18 health condition you may have. It all is tied
19 to civilian practice standards.

20 CO-CHAIR CROCKETT-JONES: Can I
21 just ask you a question? I've heard you now say
22 clinical outcomes versus subjective. Can you

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1 give me an example of a clinical outcome versus
2 a subjective? What are one of those things that
3 is called a clinical?

4 LTC BRUSHER: Well, you could say
5 both of those are used in clinical measures but
6 a subjective finding is just that.

7 I ask you how are you feeling today?
8 You may say I feel good, you may say I feel not
9 so good or it's the worst day of my life.

10 It's a subjective determination on
11 your part and it has to do with the way you're
12 perceiving things happening at that moment in
13 time or what maybe happened just prior to me
14 asking that question.

15 So a lot of things that would
16 generate that response. There's no way for me
17 to quantify that, if you will, in a measure that
18 I could then record.

19 I would write in a note that the
20 patient reported good functioning that day or
21 good use of their network of support systems.

22 Tomorrow you may come in and say that

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1 you were in a fight with your husband or a friend
2 and, thus, your support systems are failing you,
3 again, a subjective finding on your part.

4 When I'm talking about outcome
5 measures, we are trying to employ standardized
6 tools that will give me an actual score. So if
7 I give you the PCL, what's your score going to
8 be?

9 And that's been validated as a good
10 measure in determining whatever the condition,
11 depression scale, PTSD scale, anxiety scale.

12 So if you're on a one to ten and you,
13 by the responses that you provided, graded to be
14 an eight, that would be a quantifiable clinical
15 measure that I can use.

16 And it has a clinical cutoff, say of
17 five, where I'm looking to get you to a five or
18 less because that would be in the range of what
19 you would expect somebody else to report.

20 If you're an eight, you're at a
21 clinical threshold that indicates the existence
22 of that particular mental health condition.

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1 CO-CHAIR CROCKETT-JONES: I'm
2 trying to understand what specific things. If
3 I'm filling out this PCL, what am I answering?
4 Basically I'm trying to see the difference
5 between someone asking me how I'm feeling and
6 filling out a form basically to respond to my
7 situation.

8 I'm trying to understand where the
9 difference is, so what is an example of something
10 that would be on the PCL that would be measured,
11 that I would be asked to measure?

12 LTC BRUSHER: I don't actually have
13 a copy of it but it would be: were you exposed
14 to an event that caused you to have nightmares?
15 And it's the same question regardless of who
16 takes it, and there's a series of questions.

17 Again, the value in using an
18 objective measure is that it's been
19 statistically validated to give a good indicator
20 of the existence of that particular mental
21 health/behavioral health condition. I'm not
22 answering your question. I don't have a copy of

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1 it.

2 CO-CHAIR CROCKETT-JONES: Okay.
3 I'm just trying to find out how objective it
4 really is if I'm still the source of the
5 response. I'm trying to understand these
6 things, so I guess at some point I would like to
7 see what the PCL is.

8 LTC BRUSHER: Sure.

9 CO-CHAIR CROCKETT-JONES: Thank
10 you.

11 LTC BRUSHER: Again, it's not an
12 Army- or DoD-specific measure. It's recognized
13 as a validated metric for behavioral health
14 practice across the world.

15 MEMBER STONE: So in service
16 members that are in community-based recovery
17 modules, how do you implement what you just
18 described?

19 LTC BRUSHER: Well, with the BHDP
20 because that's through MODS, it's a web-based
21 platform that potentially, and I'm not sure that
22 it's in the CBWTUs, but you would be able to

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1 access that.

2 We've just fielded it to all of our
3 MTFs in the behavioral health clinics where we
4 are integrating the screens that primary care
5 uses.

6 MEMBER STONE: So my question
7 really relates to the fact that the majority of
8 this care is out in the civilian community. How
9 would they even have access to this?

10 LTC BRUSHER: It, again, is a
11 web-based platform that the social workers would
12 be able to pull up.

13 MEMBER STONE: So they'd have to
14 pull it back in based on information obtained
15 from the civilian community that was then sent
16 in?

17 This follows Captain Evans'
18 question earlier of the Arkansas-based
19 discussion of having to go TDY someplace to get
20 care.

21 Is there a different standard of
22 care in the CBWTU population for these

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1 conditions versus the WTU population or the rest
2 of the Army community?

3 LTC BRUSHER: I don't think the
4 standard of care changes, sir. I don't think
5 that the level of care can be provided in a WTU
6 specific to long-term PTSD treatment that in a
7 community would be a purchased care requirement.

8 The civilian providers all follow
9 the same treatment protocols that the military
10 uses because the CPGs are universally
11 recognized.

12 MEMBER STONE: So do you track
13 outcome measures between the two populations?

14 LTC BRUSHER: We do not have access
15 to the records that the civilian-based providers
16 have, so, no, sir, we wouldn't have that
17 available to us.

18 MEMBER STONE: So if the records are
19 not available, then we can't tell?

20 LTC BRUSHER: Correct.

21 MEMBER STONE: So therefore would
22 the safe thing to do to not move patients with

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1 these diagnoses to the CBWTU?

2 LTC BRUSHER: I think that that's an
3 independent consideration and it has to do with
4 the level of functioning that that particular
5 soldier --

6 MEMBER STONE: You want to phone a
7 friend?

8 LTC BRUSHER: I'm sorry, sir?

9 MEMBER STONE: You want to phone a
10 friend on this one?

11 LTC BRUSHER: Yes, sir.

12 BG BISHOP: Colonel Jones, why
13 don't you take a stab at that?

14 COL JONES: So, hi. I'm Colonel
15 Jones. One of the things that the nurse case
16 managers in our CBWTUs are charged with is
17 actually getting the records from the civilian
18 facilities.

19 Now, sometimes it is a lengthy
20 period of time. The soldier has to sign a
21 release form. The release form's accepted by
22 the provider. The provider then sends those

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1 records.

2 And at times it does take up to a
3 month, but those records all get scanned into
4 their AHLTA notes. It's not a system that's
5 going to be done in two to three weeks but it is
6 something that is a tool that we use for those
7 providers to see what's going on.

8 MEMBER STONE: I think one of the
9 concerns we have is we are very respectful of the
10 need to reintegrate into civilian communities,
11 into garrison communities.

12 But it seems to me that our COMPO 2
13 and COMPO 3 service members are at an inherent
14 disadvantage for the treatment of these
15 conditions.

16 And unless you can produce evidence
17 that says that they're all responding at about
18 the same rate, then we have to assume what is
19 intuitive, and that is if I don't have access to
20 records for a month, I have a problem.

21 MEMBER EVANS: And, sir, I will have
22 to concur with you on that. That was the message

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1 from CBWTU Arkansas, is that they did not have
2 the records.

3 They didn't have any evidence that
4 treatment was provided at the MTF or out in the
5 community so that's one of the reasons they had
6 to refer this member back for treatment into one
7 of the long-term inpatient facilities.

8 MEMBER STONE: We could suppose,
9 though, that if I reestablish the connections of
10 the service member to their family and their
11 civilian support structure and their friends
12 that they may do better.

13 The problem is we've got no access
14 to records to really judge that and, you know,
15 a one-month delay in getting that versus the
16 active component or those service members that
17 are part of the WTU process at an MTF, it's much
18 easier to understand their response and really
19 study the response, and certainly our entire
20 population deserves the same standard of care.

21 MEMBER PHILLIPS: Often when you go
22 to a civilian office to get records, they'll

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1 charge you for those records. I don't know if
2 that's the case with your folks.

3 COL JONES: Sir, they're not. It's
4 under the TRICARE management system that anybody
5 who takes TRICARE, it's a contractual
6 relationship, so they do not.

7 But, General Stone, we'll take that
8 back as something that we need to work on and
9 incorporate into our system.

10 CO-CHAIR NATHAN: So you understand
11 the spirit of these two recommendations?

12 Recommendation Number 8 was
13 basically, DoD, do your providers receive
14 evidence-based training who see these patients?
15 And we talked about that previously.

16 And then the follow-up to that is
17 this recommendation which is: okay, how many of
18 your patients are getting evidence-based
19 treatment?

20 You make a pretty bold statement.
21 You know, Army has determined that EBTs,
22 evidence-based treatments, are utilized roughly

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1 90 percent of the time. So that means that you
2 have good visibility then on these civilian
3 records?

4 As General Stone's pointed out, you
5 have a large cadre of patients with PTSD who are
6 also being followed in the private sector via
7 managed care and/or VA, so you're able to see 90
8 percent of those records as well.

9 I'm assuming from the statement that
10 your nine out of ten people in the Army, and I've
11 asked the same questions of each service, but
12 nine out of ten people in the Army who have a
13 diagnosis of PTSD, which is an ICD-9 or slash
14 ICD-10 diagnosis, are getting evidence-based
15 treatment based on record audits.

16 Then you go on to say that the good
17 news is we're doing a web portal system so that
18 we can also follow along those patients who are
19 being seen in your system, not necessarily in the
20 civilian system but in your system by Army
21 providers or DoD providers.

22 We can follow along where they are

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1 in their treatment plan and how they're doing.
2 That's another thing that'll give us visibility.

3 So that's the spirit of all this, is
4 the Task Force just wants to know is there
5 evidence-based treatment out there? Yes, there
6 is.

7 You're relying on the Clinical
8 Practice Guidelines that the VA and the DoD
9 adopts to mainly engine those. You've already
10 said to us the DCoE does good stuff but doesn't
11 necessarily change the game for you.

12 And then are those evidence-based
13 treatments being applied to the patients that
14 come to see us? And the answer is you believe
15 yes.

16 LTC BRUSHER: Specifically the
17 survey was just the inventory within our MTF
18 structure. That did not include network
19 purchased care providers, so just to clarify
20 that, sir. But, yes, within our direct care
21 system the answer is yes.

22 CO-CHAIR NATHAN: Okay, so that's a

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1 big distinction and that's a problem not just in
2 mental health but it's a problem in physical
3 health as well.

4 In other words, when we send
5 patients out with diabetes or asthma to the
6 private sector that we can't see in our own MTFs
7 we don't have a good way to do the QA on those
8 patients that are being followed in the private
9 sector.

10 We rely on the managed care
11 contractor, Health Net, Humana, United, whoever
12 it is these days, to police that for us.

13 So do you know about what percent in
14 your service of patients with PTSD are not being
15 followed by an MTF or a DoD or a federal health
16 care provider?

17 LTC BRUSHER: If they are still on
18 the active inventory rolls, all of them are being
19 case managed. If they're moved to purchased
20 care and obviously if they're in the direct
21 system, we have good visibility on them as you've
22 just articulated, sir.

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1 CO-CHAIR NATHAN: And those that
2 are managed in the purchased care sector,
3 Colonel Jones, you're getting the visibility of
4 the records to audit those records?

5 COL JONES: Sir, the CBWTUs
6 themselves do not audit the records. We know
7 our providers will ensure that, you know, the
8 treatment that they have referred the person to
9 is being done and getting those results back.

10 But we don't audit those records for
11 quality type stuff. We do talk to the soldiers
12 and say, you know, do you feel your care is
13 appropriate? Are you seeing any progression?

14 And look at the notes that are
15 provided to us from the physicians and our
16 physicians do make an assessment of whether or
17 not that physician is doing the right treatment
18 for those soldiers.

19 CO-CHAIR NATHAN: So let me ask it
20 a different way then. Do you feel that either
21 the number of patients, recovering warriors,
22 with PTSD that are seen in the private sector are

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1 either so small, those numbers are so small, or
2 if they're not do you feel comfortable that we
3 have visibility on how they're being treated?

4 COL JONES: I do, sir. We do have
5 visibility, and just let me back up a little bit.
6 About 25 percent of our population is diagnosed
7 with PTSD so we do know that we have --

8 CO-CHAIR NATHAN: Twenty-five
9 percent of your recovering warrior population?

10 COL JONES: Of our recovering
11 warrior population.

12 CO-CHAIR NATHAN: Right.

13 COL JONES: And of those, you know,
14 I don't have the exact number that's in a CBWTU
15 but they all start at a WTU. Most of our WTUs
16 are obviously located right beside an MTF.

17 Of those soldiers, prior to them
18 going to a CBWTU, they have to get clearance and
19 the clearance comes from not only our team but
20 also the medical professionals in the MTF that
21 are treating them.

22 So if somebody is diagnosed with

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1 PTSD, a behavioral health provider at the MTF has
2 to give us clearance prior to them moving over
3 to a CBWTU.

4 So they have to reach some steady
5 state of treatment. So we do know that those
6 soldiers that transition over to a CBWTU have
7 received care and their behavioral health
8 providers have signed off on them to go into a
9 CBWTU. We also know through the discussions that
10 as soldiers get into different environments,
11 their reactions to different things may cause a
12 relapse in their PTSD.

13 We have PCMs at the CBWTUs and social
14 workers that are designed to help ask the same
15 questions that would be asked at an MTF to elicit
16 the responses to see if a soldier in a CBWTU needs
17 to be transferred back to a WTU because their
18 care is exceeding what they can provide or the
19 risk level is exceeding what they can provide in
20 a CBWTU.

21 So we do have some checks and
22 balances to allow us to ensure that the quality

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1 is being given.

2 CO-CHAIR NATHAN: Thank you.

3 LTC BRUSHER: Okay, subject to any
4 further questions, I'm going to be followed by
5 Mr. Coffey to respond to Recommendation Number
6 13.

7 MR. COFFEY: Good morning. I'm
8 Reginald Coffey. I'm the Army Wounded Warrior
9 Advocate Branch Chief for the WTC and I will be
10 responding to Recommendation Number 13.
11 Recommendation 13 deals with ensuring that all
12 recovering warrior squad leaders, platoon
13 sergeants, and advocates attend the joint DoD
14 Recovery Care Coordinator training course.

15 All advocates obtain a one-week RCC
16 training in accordance with the Office of the
17 Secretary of Defense guidance. Advocates
18 provide the same services and support as an RCC
19 for those warrior transition soldiers that are
20 AW2 eligible. Advocates provide direct RCC-type
21 coverage to approximately 1,500 of the
22 approximately 9,000 warriors in transition

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1 assigned to either a WTU or a CBWTU.

2 The WTC working with OSD has
3 identified training topics that can be developed
4 and trained in a virtual environment.

5 These topics can then be embedded into the WTU
6 cadre course. The identified training modules
7 will provide WTU cadre with exposure to RCC-type
8 training and functions.

9 Based on this training, squad
10 leaders and platoon sergeants, along with the
11 enhanced triad which can consist of such members
12 as the PCM nurse case manager, squad leaders,
13 platoon sergeants, advocates, OT/PT, et cetera,
14 will ensure that the services and support
15 provided by RCCs are functional within the WTU
16 from an enhanced triad team's perspective.

17 The Army has determined that sending
18 all authorized squad leaders and platoon
19 sergeants, which is approximately 1,500, to a
20 one-week RCC course held here in the National
21 Capital Regions is not currently feasible. If
22 there are no questions, I'll be followed by

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1 Colonel Jones.

2 CO-CHAIR CROCKETT-JONES: No, I
3 have a question for you, so --

4 (Laughter)

5 CO-CHAIR CROCKETT-JONES: Yes, not
6 going to happen. AW2 advocates, the
7 eligibility to get one is based on the rating.
8 So what is the average length of time an eligible
9 warrior in transition unit service member is in
10 the unit before they get an AW2?

11 MR. COFFEY: Well, actually that
12 varies a little bit because although it is based
13 on a 30 percent rating, there are many cases up
14 front which you can identify based on the
15 clinician's input that they will be eligible for
16 our program. And, therefore, the advocates are
17 very proactive and start treating and taking
18 care of and servicing those individuals.

19 However, on average, I would say
20 about six to eight months into the program is
21 when we can clearly identify that these
22 individuals will be AW2 eligible.

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1 CO-CHAIR CROCKETT-JONES: So for
2 the six to eight months before they normally get
3 assigned an AW2 they're in the transition unit.
4 Who would be at that point providing that RCC
5 component of care for them in an Army transition
6 unit?

7 MR. COFFEY: Until the time as they
8 are determined to be AW2 eligible, that service
9 and support is provided by the triad which can
10 include the squad leaders, nurse case manager,
11 PCM.

12 And the AW2 advocate's a member of
13 that triad and can provide advice, services and
14 support to the other members of the team to
15 assist that soldier and that family.

16 CO-CHAIR CROCKETT-JONES: Okay,
17 I'm just thinking of some examples that we have
18 seen across the board, different places, where
19 people wind up being in the Transition Unit for
20 extended periods of time, sometimes two years.

21 Their IDES can take another year or
22 can be a year of that and they can be in a WT Unit

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1 for well over a year without an actual
2 RCC-trained person providing those services
3 before they get an AW2 advocate. And the other
4 services have the advantage of folks having the
5 RCC-trained care provided as soon as they really
6 arrive at the WT Unit.

7 And I'm wondering if perhaps some of
8 this is why when we do our focus groups we have
9 issues with folks who feel they have been for
10 quite a time in a Transition Unit but have not
11 yet gotten a grip on access to non-medical case
12 management. I'm just throwing it out and I
13 wanted, you know, a recognition of those
14 timelines. This is an area where the Army is not
15 using the same model as the other services.

16 MEMBER EVANS: Before you answer,
17 Reggie, so I think let's take it a step farther.
18 When we talk to the family members and the
19 recovering service members, I mean, look at what
20 we're saying. Platoon sergeant, fleet liaison,
21 Navy Safe Harbor, non-medical case manager, AW2.
22 We haven't even thrown in the FRC clinical case

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1 manager.

2 Do they clearly understand the roles
3 and functions, the lanes, that all these folks
4 play? And if they don't, you know, do we? And
5 so the question at a training, what we're saying,
6 you know, with all these folks in the same room
7 clearly outline the roles and the responsibility
8 for all the folks we have touching our service
9 members and the family.

10 So this is where this recommendation
11 because if we can't get it then, you know, what
12 are we doing to our recovering service members
13 and their families? And if we can't get everyone
14 in the room to say this is your role, this is your
15 responsibility, then, you know, again, we need
16 to go back and wonder why do we have so many
17 involved in the care and transition process of
18 our families and recovering service members?

19 CO-CHAIR NATHAN: And so then to
20 once again address Ms. Crockett-Jones' question
21 about service disparity.

22 LTC DUDEK: Just real quick, we

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1 passed out that Comprehensive Transition Plan
2 Leaders' Guide. It's a small little handbook
3 that you have there.

4 The model of the interdisciplinary
5 team which you guys are very familiar with is the
6 model that has very clear roles and
7 responsibilities for each individual member of
8 the interdisciplinary team and triad of care and
9 that's how we delineate them. And the training
10 that's required to do that is very robust and
11 very close to what RCC actually is requiring as
12 well and I think Reggie can talk more to that.

13 MR. COFFEY: Right. What I was
14 going to say is recently we just met with OSD and
15 we did a crosswalk between our current training
16 curriculum and the RCC training curriculum and,
17 lo and behold, we had about a 70 percent match.

18 So what we've done is we've
19 identified those other nine training modules
20 that we need to develop and that's what we're
21 working on closely with OSD. And once we develop
22 those, we intend on launching those in a virtual

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1 environment to make sure that our nurses, our
2 squad leaders, the advocates and so on are well
3 exposed to all the functionalities that are
4 performed by an RCC.

5 CO-CHAIR CROCKETT-JONES: Okay,
6 then let me ask a question and I'm not singling
7 -- I'm just saying squad leaders and platoon
8 sergeants are providing RCC services.

9 But it's not feasible to train them
10 on those services but it is feasible to increase
11 the training through some other venue to the
12 nurse case managers, that is, it's more feasible
13 to have a secondary kind of training brought up
14 to this. That's for nurse case managers. But
15 you're still not exposing squad leaders or
16 platoon sergeants to be trained to the services
17 that we are telling them that they are to
18 provide.

19 I mean, the designation from the
20 Department of Defense for who is in charge of the
21 transition plan, the CRP or the CTP, was RCC. And
22 if someone sits eight months in a WTU with no RCC,

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1 no specific RCC, no one trained to do that job,
2 that's eight months of transition plan time for
3 which there is no one who is responsible, even
4 though the DoD has said an RCC is responsible.

5 I just want to be clear that the DoD
6 says we have an RCC as being responsible and I
7 can guarantee you, I can tell you from personal
8 experience and from our focus groups, that
9 soldiers in that unit feel that lack of
10 understanding who is responsible for that plan
11 with them, guiding them through that plan.

12 BG BISHOP: Ma'am, if I may, I think
13 what we've been saying here is that we believe
14 that the role of the RCC is currently resident
15 within the triad of care. We recognize that there
16 may be a training gap between the RCC training
17 and that training which we're providing to our
18 cadre and our AW2 advocates.

19 So what I would recommend is that I
20 take this on as an operational planning team
21 analysis to determine if our current triad of
22 care does have any sort of gap relative to the

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1 requirement of the RCC and determine a feasible
2 approach to resolving that gap and I think we can
3 have that done in a reasonable period of time.

4 CO-CHAIR CROCKETT-JONES: Thank
5 you.

6 MEMBER EUDY: One thing, sir, I
7 wanted to add in regards to follow-up on the
8 cadre squad leader, platoon leader training
9 program. As we heard from our focus groups, the
10 knowledge of the CBWTU and the course curriculum
11 was addressed by several members for both their
12 active duty counterparts to hear more about the
13 CBWTU, increasing that portion of training at
14 the cadre training course so that way they knew
15 more of what they were going to be facing,
16 whether that was, you know, you're going to have
17 a lot of cases now especially as we move towards
18 the home health care model of active duty
19 soldiers taking care of their Guard and Reserve
20 brothers and sisters, even in the local areas of
21 the larger MTFs as we start moving out to some
22 of those Guard and Reserve units.

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1 So I would look, sir, into expanding
2 that CBWTU-specific component in the cadre
3 training program.

4 MR. COFFEY: Okay, what's the
5 question, sir?

6 MEMBER EUDY: Oh, I didn't ask my
7 question. That was it. It wasn't much of a --

8 MR. COFFEY: Just a statement.

9 MEMBER EUDY: -- question. Just a
10 statement of look into following up with more
11 CBWTU-specific training to facilitate that need
12 as the CBWTUs are going to continue to expand and
13 address --

14 MR. COFFEY: Right. As we re-enhance
15 and redevelop our cadre training, the CBWTU
16 training will fall in line with that as well.

17 MEMBER EUDY: Okay, thank you.

18 MR. COFFEY: If there's no further
19 questions, I'll be followed by Colonel Jones.

20 CO-CHAIR NATHAN: Just one
21 follow-up. What you're hearing basically is we
22 recognize the triad of care between the nurse

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1 care manager, the squad leader and the PCM.

2 As you've said, General, there needs
3 to be some resident semblance of RCC knowledge
4 within that triad because the patients or the
5 recovering warriors are kind of cast adrift with
6 those folks and if they haven't had the training
7 -- you have a lot of good ideas up there.

8 The only thing I would take issue
9 with -- and it's not directed at you, it's
10 directed at DoD -- is a joint RCC course for all
11 squad leaders or platoon sergeants is not
12 currently feasible.

13 I think we're charged with trying to
14 drive that kind of feasibility. This Task Force
15 is charged with trying to drive out variation and
16 drive in a more joint approach so that the
17 soldier or the sailor or the airman or the Marine
18 who lands at any facility, there'll be more
19 interoperability among the RCC process.

20 I recognize there are significant
21 service differences, cultural differences, in
22 how we approach the Army triad of care. The Navy

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1 has a different command and control structure
2 for its Marines and for its sailors. I get all
3 that.

4 But, again, you know, just as we're
5 sort of peppering you, you should be standing on
6 the desk looking at us saying use whatever
7 collective energy and connections you have, Task
8 Force, to try to drive in more interoperability
9 in our system, because we really don't want to
10 see the Navy building its best plan, the Army
11 building its best plan.

12 We don't think that's going to be
13 survivable given the influx of veterans and
14 recovering warriors that'll be coming back over
15 the next several years. We've got to increase
16 our interoperability. And so, you know, you
17 should be pushing on us and you should be pushing
18 on the services to try to figure out a more joint
19 solution to recovering care training,
20 coordination training from us.

21 Editorial comment, and then we'll
22 move on there. I think we have time to talk

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1 about the next recommendation and then maybe
2 we'll take a small break after that.

3 MR. COFFEY: Yes, sir. I think one
4 thing that's going to facilitate that, and it's
5 being driven by both DoD and the VA, is a lead
6 coordinator initiative. I know Captain Evans
7 is deeply involved with leading us up to that and
8 --

9 CO-CHAIR NATHAN: You'll get a
10 quick Amen from Captain Evans on --

11 MR. COFFEY: Yes. So that may give
12 us that single facilitator that everyone is
13 looking for.

14 CO-CHAIR NATHAN: Right, good
15 point. Thank you.

16 COL JONES: And, sir, I'd just like
17 to add the IC3 group that's working on really
18 gaining consistency across the services in how
19 we manage our recovering warriors will also do
20 some of that as well and we're an active part in
21 that group as well.

22 All right, I'm Colonel Jones and

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1 I'll be taking the next two recommendations.
2 Recommendation 14 talks about, "The services
3 should provide support to family members and
4 caregivers without requiring the recovering
5 warrior permission."

6 The Army understands that
7 recovering warriors' health and healing improve
8 with their families' active involvement in their
9 care. We also understand that for families to
10 have a solid impact, families need to feel
11 supported, educated, and informed.

12 However, the Army, along with the
13 other services, must obey the HIPAA law. The
14 HIPAA law requires that we must maintain written
15 authorization from an individual to use or
16 disclose their protected health information so,
17 because of that, the recovering warrior has to
18 be involved in their care plan.

19 However, I will tell you we have
20 numerous services that we provide to our
21 families without necessarily involving the
22 warrior. These come from both our structure and

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1 our CTP. Our structure has multiple components
2 to it. Of that, our families have daily contact
3 with our social workers, our social service
4 assistants, our nurse case managers, and our
5 PCMs.

6 These health care professionals
7 assess and advocate for our families. They
8 provide referrals to appropriate counseling
9 services for families in crisis, to individual
10 therapies and provide specific referrals for
11 children. One example of behavioral health
12 service designed specifically to help children
13 with the wounds of war is Operation Brave
14 Families that's currently at Walter Reed.

15 This provides parents with
16 techniques to talk to their children about the
17 wounds of war and it also provides an environment
18 in which children can speak freely about those
19 wounds of war and how it affects them. Our
20 providers establish referrals to such programs
21 so that our families get into the right care that
22 they need.

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1 Our structure also includes a thing
2 called the Soldier and Family Assistance
3 Centers. These centers are specifically
4 designed to assist families. They offer
5 numerous services such as financial counseling,
6 life skill development, child care and legal
7 services.

8 In addition, they offer education
9 assistance and vocational assessments to help
10 families develop the skill sets to support their
11 future. Entitlement and benefit coordinators
12 who are counselors provide families with
13 in-depth reviews of their entitlements and
14 benefits, not only at the federal level but at
15 the state and local levels as well.

16 Within the SFACs we also have our VA
17 counselors that provide counseling for VA health
18 and VBA benefits. We have transition
19 counselors to help the families as they
20 transition from military to civilian life, and
21 they also support job fairs and employment
22 assistance. Our SFACs also offer access to

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1 numerous non-profit organizations that help
2 families. For example, Our Military Kids is a
3 non-profit organization whose information can
4 be found at some of the SFACs.

5 This organization helps National
6 Guard and Reserve families as well as recovering
7 warriors, gives grants to these families to
8 enroll their kids in art programs and sports
9 programs to minimize their separation anxieties
10 and to build their skill sets to increase their
11 coping and resiliency.

12 The Army, along with the other
13 services, has teamed up with such entities as the
14 USO and Sesame Street to help their children cope
15 with the wounds of war. These points of contact
16 can all be found at the SFAC and they can also
17 be found on our National Resource Guide which is
18 on our website.

19 CO-CHAIR CROCKETT-JONES: Can I
20 just jump in here because in the answer I'm not
21 sure you understood why we made this
22 recommendation.

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1 We're aware of HIPAA and we're aware
2 of the requirement for permission to have access
3 to health care. We are way more concerned with
4 the persistent problem we see when we go from
5 installation to installation with family
6 members having no real sense of who they can turn
7 to and what benefits they have.

8 They are largely unaware, I would
9 say almost completely unaware in our
10 installation visits, of benefits that they have
11 available to them. We see a minuscule percentage
12 having any concept of one or two benefits and no
13 one, I mean, we get completely blank stares about
14 many of these benefits that are specific to the
15 family members.

16 There's a heavy reliance in their
17 installations on sending information to spouses
18 via the service member, and especially with our
19 population that has PTSD and TBI, even when they
20 have great intentions for carrying that
21 information back to spouses it does not happen,
22 so this was the genesis of our concern. For

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1 instance, the rates at which family members are
2 successfully contacted, the rates at which
3 family members utilize the SFACs. Those rates
4 are dismal.

5 A few successes here and there that
6 are generally driven by personalities who are
7 proactive, but policy is not in place to help the
8 average installation get these family members
9 connected to the benefits that are specifically
10 for them. They have absolutely no relationship
11 with HIPAA permissions regarding the service
12 members' medical records. And on top of that, I
13 heard you say something about family member
14 daily contact with social workers.

15 I'm not sure what the context was but
16 I can honestly tell you I don't think in the
17 number of installation visits that I have
18 personally made and focus groups in which I have,
19 you know, either conducted or been seated, I
20 cannot recall more than two people over two years
21 who have known there was a social worker that
22 they could contact.

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1 So I'm interested in that one
2 sentence that you said about daily contact with
3 social workers because I'm not sure where this
4 is happening or who you are referring to. And
5 secondly we understand these services exist.
6 Our concern is that they are not being brought
7 to the family members.

8 CO-CHAIR NATHAN: The concern is
9 that we've experienced where the families are
10 failing. And the information is not getting to
11 us, either because of cultural reasons in the
12 service, because the active duty member is being
13 responsive to the chain of command or because of
14 stigma.

15 The active duty service member is
16 saying to the family, look, I'm the point of
17 contact here. You shouldn't be talking to them.
18 I'm not even sure what you'll tell them.
19 I'm worried about, you know, whatever, we had an
20 altercation, we had a fight. You know, I don't
21 want them to hear about whatever. And so in my
22 own personal experience commanding at Walter

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1 Reed Bethesda I would walk around and I would see
2 a family that's completely failing and we had no
3 idea.

4 And when we went to the service
5 member and said why didn't you let us know, it
6 was for a multitude of reasons. So you've
7 outlined some amazing, and this is what the
8 service does so well, has these amazing family
9 support mechanisms, but how do we make sure, in
10 spite sometimes of the active duty member or the
11 recovering warrior, how do we make sure that the
12 family gets intersected with these?

13 COL JONES: Those are great
14 questions, sir. Some of the things that we're
15 actually doing is from a larger picture when you
16 look at the Army and the things that we socialize
17 our families to at the very beginning. You know,
18 we're bringing those families in at an early time
19 to understand the culture.

20 We have FRSAs at those units prior
21 to their deployment or prior to them getting
22 injured so that they orient the families to the

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1 culture of the Army and so they're learning from
2 that methodology. Now, again, early on
3 soldiers create that distance and we're trying
4 to overcome that by using some of our family
5 readiness support groups to get them involved.

6 So within our own structure, we have
7 FRSAs assigned to our units so that they can
8 reach out to those families as well. The SFACs,
9 we do know that the SFACs that are co-located
10 with our WTUs, the families are satisfied with
11 them and they're using them. So we have a number
12 of MILCON projects that are going on that are
13 co-locating those SFACs with the WTUs.

14 From a CBWTU standpoint, ma'am, and
15 this is where it gets tricky, we do have to reach
16 out to those families and we're constantly
17 updating their contact information so that we
18 can reach out to them and continue to engage with
19 them. Our triad of care, which is our squad
20 leader, our nurse case manager and our PCM and
21 all of those entities, reach out to our families
22 so that we can involve them in the soldier's

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1 recovery plan.

2 So for social workers I didn't say
3 they had daily contact. I said we have the
4 ability for them to have regular and ongoing
5 contact. So our social workers reach out to our
6 families as well and numbers of our families are
7 involved with our social workers as they create
8 and help our soldiers with their immediate
9 issues and we get them involved with regular
10 therapies that happen at the MTF or the
11 behavioral health provider level.

12 So there are mechanisms and some of
13 the things that we're doing, we actually at the
14 WTC are creating a virtual website that'll
15 intrigue people to come to our website and get
16 them to continually use our website to get
17 information. And that website will have all of
18 the resources, all of the benefits and
19 everything that they need will be right on that
20 website so that they can continue to use that.

21 We do know that social media is one
22 of the primary mechanisms that we reach our

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1 families and that's the culture of today. Our
2 younger soldiers, that's what they use. They
3 text their families instead of actually talking
4 to them. So we're going down that road as well.

5 We want to be the ones to do
6 face-to-face contact with them, but we do know
7 that we have to use those social forms of media
8 to get out and reach out to them, so we're
9 creating a website that'll help that. Again, the
10 MILCON projects to co-locate SFACs right next to
11 WTUs, we know that's a hit. We know that works.
12 As soon as we can get those people close to WTUs
13 to know that the SFAC's right beside them, they
14 use it.

15 So we do know those are some of the
16 things that we're using to help our families get
17 to the resources that they need.

18 CO-CHAIR CROCKETT-JONES: And I do
19 want to say that at least we have seen a cultural
20 shift and there has been improvement in this area
21 as we've gone over these installation visits.
22 Especially there is a change from the chain of

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1 command and the providers. The shift has been
2 a very positive one. You know, we just still see
3 families really feeling a barrier.

4 And I will say this, though. Yes,
5 if you can get them into an SFAC once they get
6 a sense of this being an excellent resource.
7 Some of the most successful installations we see
8 walk every family that comes in through that SFAC
9 once. I wish every place did that.

10 MEMBER PHILLIPS: I just want to
11 re-emphasize that. I just feel compelled to do
12 that because we're on the ground every other week
13 visiting facilities and talking to folks. The
14 need is out there. We know that and the
15 resources are out there. I think we need to make
16 an effort, as you mentioned, to connect those
17 dots, a better effort to connect those dots.

18 BG BISHOP: Sir, if I may, I guess
19 we're kind of done with this comment but I'm out
20 there every other week as well. I can tell you
21 I agree with your assessment. The resources are
22 there, the emphasis is there, the desire is

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1 there, but we're not connecting people with the
2 programs.

3 So as the proponent for warrior
4 care, I think it's our challenge to reverse
5 engineer the dynamics so that people flock to
6 this stuff because they want to and they see it.
7 And what Colonel Jones mentioned was spot on.
8 We're going to try to do a lot of it virtually
9 by designing through our own portals a way to
10 attract more attention because of the value it
11 adds to the soldier and his family.

12 And we are emphasizing this. I go
13 to every cadre training course and I emphasize,
14 not just from a compliance perspective but from
15 a salesmanship perspective, you want the family
16 involved. And the cadre are getting that and I'm
17 glad to hear, ma'am, that you're seeing a culture
18 change. Now we've got to get the soldier and his
19 spouse or her spouse involved and seeing it as
20 well. I think a year from now we'll see a shift
21 in this.

22 MEMBER PHILLIPS: And, again,

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1 perhaps, and I know you're doing this. The
2 lower enlisted are really suffering. They're
3 like deer in the headlights of a car. They don't
4 advocate for themselves, they don't have enough
5 advocates for them, and we have to focus there.

6 CO-CHAIR NATHAN: General Stone.

7 MEMBER STONE: So, Dave, I'm
8 exactly where you are but, you know, the way we
9 wrote this recommendation is fairly
10 unfortunate. And the way you've answered it is
11 in response to the question of how do we as
12 experts provide to those who need us help.

13 But one of the things we've
14 recognized is part of the recovery is the
15 families coming back in and saying to us as
16 providers, well, here's how my soldier, sailor,
17 airman or Marine is really doing. I know they're
18 telling you, but let me tell you the truth of how
19 they interact with our 2-year-old or how we're
20 interacting at home.

21 And unfortunately HIPAA has
22 prevented us from really accurately seeking out

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1 that how are you doing? How have we attempted to
2 amend HIPAA releases during the initial intake
3 conference? How have we attempted to
4 manipulate HIPAA guidance in order to make
5 maximum integration of family input?

6 Now, before you answer let me tell
7 you that anecdotally every place we go lower
8 enlisted spouses are feeling terribly
9 disconnected of I know they say this is happening
10 but let me tell you the truth at 10 o'clock at
11 night or 11 o'clock at night on Saturday what's
12 happening in my home.

13 COL JONES: Sir, a couple of things.
14 You know, in reading actually the report prior
15 to coming here and preparing, we do know that the
16 Marines actively seek out a HIPAA release from
17 all of their Marines. When a soldier arrives at
18 a WTU, we do have a HIPAA release form for them
19 to sign, but it's not something we continually
20 pursue.

21 And so we will talk to our Marine
22 counterparts to see what their program is to see

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1 if we can engage with this. The other thing is,
2 you know, culturally across the nation right now
3 -- I don't take my spouse to my physician
4 appointments and we are asking our soldiers now
5 to take their wives and their husbands and their
6 moms to a physician appointment. We have to
7 bridge that gap.

8 That's part of the reason why we're
9 having difficulties is because we've treated
10 that soldier as an individual, the Marine,
11 anybody, as an individual and we expect them to
12 take care of their health.

13 They're in a different level now and
14 so one of the things that we do when they do come
15 in is we do surround them with the family and with
16 the triad of care so that they understand this
17 is now, I hate to say this, a group activity so
18 that we can help them get through. One of the
19 things that we've also done is created our
20 Comprehensive Transition Plan, and in that
21 Comprehensive Transition Plan one of the domains
22 is family.

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1 And so we have that soldier talk
2 about their family on a regular basis and the
3 social workers, the nurse case managers, the
4 PCMs, they all see what the soldier writes on
5 their self-assessment. And we give feedback to
6 the group, to our triad to say, you know what?
7 The soldier didn't truly articulate what's going
8 on with their family, and so then we can pull them
9 in and help that family overcome whatever their
10 difficulties are.

11 So we have taken steps to get the
12 family more involved and I think as we really
13 focus on the CTP and the self-assessment and use
14 it to its truest potential, we'll get there.
15 We'll show the soldier this is actually what you
16 need to do at this point in time.

17 MEMBER PHILLIPS: Would you help
18 us? Would you let us know where your specific
19 roadblocks are so that we can perhaps include
20 them in our recommendations? I mean, we're not
21 trying to beat up on you. We're trying to find
22 how we can best help the process.

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1 COL JONES: I will, sir. I think
2 right now, again, one of the largest things is
3 really culturally. In our American society
4 health care has always been an individual thing
5 that we've taken on. It's not until somebody
6 really becomes in crisis that they start
7 including their families.

8 And so we have to make that cultural
9 shift and have people bring their families in.
10 I think that's our biggest thing. The other thing
11 that we really need to focus on is those
12 families. I'm a soldier. My husband probably
13 could not tell you what I do on a day-to-day
14 basis. He probably couldn't tell you what
15 paperwork I have to fill out.

16 So we don't do that as the DoD. We
17 focus on developing a soldier and we have family
18 programs and family programs pull the families
19 in at certain points in time but they don't
20 culturalize our families to the DoD. And so
21 that's something that we have to face as well,
22 is that there's a culture that we need to change

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1 in bringing our families in sooner and that's
2 across the board. That's not just within
3 recovering warriors.

4 CO-CHAIR NATHAN: So you've
5 answered your own question, and maybe how we
6 should have better phrased the question is what
7 are you doing about removing choice from the
8 recovering warrior to have their family be
9 given, you know, services and support?

10 And you're correct in the Marines
11 and, Colonel Keane, feel free to jump in here,
12 but the challenge we have with the Marine Corps,
13 and the Army's not far behind, is stigma and the
14 concern, the fear of the Marine to have the
15 family talking about what's going on in the
16 family. We're getting better at that. We're
17 making strides at that, and I know the soldier
18 has the same problem. The fear of my family
19 talking. It's not something we grew up with in
20 the services.

21 So when the Marine comes in, the
22 Marine is told this isn't a choice. We've

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1 determined that you recover from your physical
2 and your invisible wounds faster with family
3 around, with family as part of the treatment,
4 with family as part of the diagnosis. If you go
5 to the NICoE, they will not interview the patient
6 by themselves, only with the family in tow,
7 because it has to be a comprehensive approach.

8 And so I think our challenge in the
9 DoD is to get over our own discomfort of sort of
10 pushing the recovering warrior aside for a
11 second and saying we're going to take great care
12 of you but we're also going to take great care
13 of your family. And we're not going to ask you
14 your permission to talk to your family about how
15 they're doing or how you're doing.

16 We're not going to tell your family
17 what your diagnoses are. We're not going to
18 tell your family what medications you're on if
19 you don't want them to know it. HIPAA hasn't
20 gotten to the point yet where we can do that. It
21 should, but it hasn't. But we're going to do that
22 and I know that's happening in pockets in various

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1 places where we've had the dramatic cases like
2 Walter Reed and Brooke and some others and
3 Campbell.

4 But as a disseminated culture,
5 that's what the genesis of this was, is that if
6 we try to figure out how to let the recovering
7 warrior give us an entry into the family we're
8 going to fall short in many cases. That's the
9 genesis of this.

10 CO-CHAIR CROCKETT-JONES: All
11 right, sir, I think we have one other comment.

12 MS. ADAMS: Sir, you asked us, you
13 know, what we can look at collectively to try to
14 improve relationships with families and units
15 and getting information, involving family. I
16 think one of our biggest challenges is working
17 with the families of National Guard and Reserve
18 soldiers. They're not at the units with the
19 soldiers and the WTUs.

20 And so many of them are separated
21 from their families so there's just that extra
22 layer of isolation and I think that's one of our

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1 biggest challenges, is in the Reserve Component.

2 CO-CHAIR NATHAN: Absolutely. No,
3 that's a very good point and we have the
4 recovering warrior workshops and those sorts of
5 things where we try to bring the families in
6 together and do the sort of one-time healing, but
7 that's a very good point.

8 MS. DAILEY: We should break very
9 quickly and I want to bring to the Task Force
10 members' attention also we'll need to move along
11 a little quicker.

12 Got the rest of the recommendations
13 to get through. Dr. Gliner will want to talk to
14 us about survey results and then I did ask the
15 Army to catch us up on three separate programs.

16 So we have them until 1 o'clock.
17 Lunch is at 1 o'clock, ladies and gentlemen.
18 But we need to get through all this material. I
19 don't have time to bring them back, so thank you.

20 (Whereupon, the above-entitled
21 matter went off the record at 10:41 a.m. and
22 resumed at 10:49 a.m.)

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1 CO-CHAIR NATHAN: I'd like to
2 recognize Colonel Anthony Henderson, who is the
3 Special Assistant to the Chairman of the Joint
4 Chiefs of Staff for Warrior and Care Support.
5 Colonel Henderson? How are you? Good to see
6 you.

7 (Off microphone comments)

8 CO-CHAIR NATHAN: I do remember
9 you. So it's good to see you.

10 COL HENDERSON: It's good to see
11 you, sir.

12 CO-CHAIR NATHAN: Thanks for coming
13 here.

14 COL HENDERSON: Thank you.

15 CO-CHAIR NATHAN: So I do that for
16 two reasons. One, I never miss an opportunity
17 to point out a great Marine.

18 And the second is we can no longer
19 blame anything on the Chairman of the Joint
20 Chiefs of Staff, at least for the rest of the day.
21 Because he has his eyes and ears here. So again,
22 thank you, Colonel, for being here, and for what

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1 you do on the Joint Chiefs.

2 So let's go ahead and continue now,
3 if we would. We'll dot the I and cross the T on
4 the second recommendation of 14, if there's
5 anything left to say on that?

6 COL JONES: No, sir.

7 CO-CHAIR NATHAN: Already done.
8 okay. All right, we'll go to 15.

9 COL JONES: Sir?

10 CO-CHAIR NATHAN: Oh, I'm sorry.

11 COL JONES: Recommendation 15 is
12 each service should clearly identify a readily
13 available principal point of contact for the
14 Recovering Warriors in every phase of their
15 recovery.

16 So this is two-phased answer that we
17 have right now. Currently the Army really uses
18 the team approach, as we've talked about before.
19 We've done this to ensure the most robust care,
20 management, and transition assistance for our
21 soldiers.

22 Each member of our team offers a

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1 specific set of skills, knowledge and guidance
2 that they can give to our soldiers and their
3 families. However, we have designated one person
4 that actually has the responsibility of having
5 daily contact with those family members. And
6 that is the squad leader.

7 Our squad leaders are trained
8 leaders that know how to elicit information from
9 our soldiers, and know how to communicate that
10 to the rest of the members of the team so that
11 we can ensure that the soldiers and the families
12 are having their needs met.

13 Having said that, the Army is
14 actually involved in the Lead Coordinator
15 Project. And so we've actually played a
16 significant role in developing the check list
17 the lead coordinator role will use, and how that
18 role will be established. And we're
19 participating in a pilot that actually is going
20 on at Walter Reed in the near future. So subject
21 to your questions --

22 CO-CHAIR NATHAN: Can you just, for

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1 the edification of the group here, some of us
2 have been in the middle of this, but not
3 everybody understands what Lead Coordinator is.

4 COL JONES: So the Lead Coordinator
5 will be a person who is actually the facilitator
6 of all the team to make things happen. So they
7 are the principal point of contact.

8 They will give their card to the
9 family member and say I am the person that you
10 need to come for all questions that you have, or
11 all references that you need, or resources that
12 you need. That person then will, if they don't
13 know the answer, or don't have the resource, they
14 will go to the correct resource and get that
15 information and that resource for that family.

16 As the soldier moves between levels
17 of care, for example if they start out in a DoD
18 facility and they move over to a VA, the lead
19 coordinator role will transition over to a VA
20 person. And we've done this because if the DoD
21 is responsible for that person within the DoD
22 facility, they might not have the daily contact

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1 with the family as they transition to the VA. So
2 that role will then transition.

3 The check list that we've created is
4 something that the lead coordinator will use as
5 they transition that soldier. And it touches on
6 every facet of resources, what's available to
7 the family, what's available to the soldier, so
8 that we make sure that everything is connected
9 before that soldier transitions between levels
10 of care.

11 CO-CHAIR NATHAN: That's a great
12 synopsis. As we've talked about before,
13 several years ago families would come in,
14 devastating injuries, long road ahead, wouldn't
15 know who to talk to. And they'd say I'm lost.
16 Now the families come in, we paratroop in 100
17 different people from different agencies. They
18 get a stack of business cards the first week
19 about a foot thick. And then they say, I'm lost.

20 So we're looking for some sort of
21 system that can be their point of contact to
22 negotiate, and navigate, and get answers from

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1 the various groups. And that's what the lead
2 coordinator premise is.

3 MEMBER EVANS: Yes, sir. And so a
4 couple of key points, hand-offs. So as they
5 transition DoD, and we're going to have IC3 to
6 come in. So I don't want to be spending a whole
7 lot of time. And I'm getting to cut it off on
8 the lead. But we do have one success story of a
9 family who left Walter Reed lost, unhappy, moved
10 to Alabama. And the family finally got
11 introduced to the VA lead coordinator with the
12 check list.

13 And she felt like now she has a
14 systematic process in place. And so we'll get
15 more briefing on the lead. We hope to provide
16 some data outcome. We have engineering working
17 with us to make sure we have supportive data, if
18 this comes up as working or not. But it is DoD
19 wide. It is looking at hand-off. It's looking
20 at transition, and it's moving the member from
21 in-patient, out-outpatient, into the VA system.

22 CO-CHAIR NATHAN: Nothing else on

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1 15, we'll go to 16.

2 COL JONES: All right, I'll
3 transition to Lieutenant Colonel Baker.

4 LTC BAKER: Always, sir, Lieutenant
5 Colonel Baker. I'm the Deputy Director for the
6 IDES service line for MEDCOM. On Recommendation
7 16, this is reference to the services should
8 educate their family members and care givers on
9 potential benefit changes upon separation.

10 Well, the good thing is we have, upon
11 referral into IDES for all COMPO soldiers, they
12 participate in what we call a multi-disciplinary
13 meeting. This meeting is with their PEBLO, it's
14 with their OSC, Office of Soldier Counsel,
15 representative, it's with their MEB provider.

16 As part of this, the family member
17 is encouraged to participate. And we reiterate
18 this with our PEBLOs and our downtrace units as
19 well. Now despite the fact that they are highly
20 encouraged, there are some that choose not to.
21 Now in addition, as a soldier is referred into
22 the IDES process, we also make available to them

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1 certain references, if you might call them. And
2 I apologize, I don't have enough, but we have a
3 hard flip-book. It's a smart guide on IDES.

4 Additionally -- one of my key guys
5 gave me their cell phone, with the ringer of --
6 is that we even have an app on a smart phone that
7 a soldier can take and put on their Blackberry,
8 or their iPhone. And this helps walk them
9 through the process. Now, your question also
10 refers to references that pertain to other
11 resources that they get, not just the IDES.
12 Soldiers go through ACAP as well.

13 And the PEBLO is inherently linked
14 to the EFMP, the TRICARE offices, what we call
15 the SFACs. And they refer the soldiers to these
16 entities. They go through a check list with the
17 PEBLO initially. It's called a soldier medical
18 evaluation board, physical evaluation board,
19 counseling check list.

20 And as part of that, they check off
21 with the soldier when they're counseling them,
22 hey, these are some of the benefits that are

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1 available to you. And here's how I'm going to
2 help you tie into those resources.
3 Additionally, when they're going through the
4 ACAP, they fill out a pre-separation counseling
5 check list. And that one's even more in-depth.

6 And I have a copy of that. But it
7 goes over all the benefits, from education, to
8 VA benefits, to insurance. And they link them
9 up with the appropriate resources.

10 CO-CHAIR CROCKETT-JONES: Do you
11 have an idea on at what rate, what percentage of
12 soldiers go through ACAP with an accompanying
13 family member?

14 LTC BAKER: No, ma'am. I do not
15 have an answer to that question. I don't.

16 CO-CHAIR CROCKETT-JONES: Do you
17 think that data is --

18 LTC BAKER: But I can see if I can
19 dig into that. Yes, ma'am.

20 CO-CHAIR CROCKETT-JONES: Because
21 I don't think we're going to know if we're
22 improving until we are tracking it.

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1 LTC BAKER: Yes, ma'am. Yes,
2 ma'am. Now, pending further questions, you'll
3 find that on Recommendation 17, next chart
4 please.

5 MEMBER MUSTION: If I can make a
6 comment?

7 LTC BAKER: Yes, sir.

8 MEMBER MUSTION: The VOW Act that
9 was implemented in November of '12 put a lot more
10 rigor into this program, and made it much, much
11 more detailed.

12 LTC BAKER: Good point.

13 MEMBER MUSTION: And the benefits
14 we're already seeing back on it from the Army
15 outside of the Recovering Warrior Program, is
16 it's a very, very effective program, and in close
17 partnership with VA, and close partnership with
18 DOL.

19 I think we probably have the data
20 point that you just asked for. The ACAP guys can
21 probably run that down.

22 LTC BAKER: Roger, sir. We'll

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1 reach out. Now -

2 MEMBER EVANS: Are you connected
3 with the National Resource Directory, your apps?
4 So does it refer back to that?

5 LTC BAKER: I'm not sure what you're
6 referencing, ma'am.

7 MEMBER EVANS: Okay, thank you.

8 LTC BAKER: I'm sorry. Okay.

9 CO-CHAIR NATHAN: Anything else on
10 16? We'll go to 17.

11 LTC BAKER: Now Recommendation 17,
12 this is closely tied to Recommendation 16 in
13 regards to how do we educate our families and
14 care givers enrolled in the Exceptional Family
15 Member Program on potential loss of TRICARE
16 Extended Care Help Option.

17 Again, through the
18 multi-disciplinary meetings that we have with
19 our soldiers, and through encouraging the
20 involvement of family members, we link up those
21 soldiers and their family members with the
22 associated TRICARE or EFMP offices.

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1 Now our PEBLOs aren't SMEs on every
2 aspect. There's this idea that we can continue
3 to put more on their shoulders. What we've done
4 is we've given them the systems; we've given them
5 the tools to reach out and plug into.

6 And they are very aware of those
7 entities. And they facilitate the link up with
8 EFMP and TRICARE. So they can understand the
9 potential loss of ECHO.

10 CO-CHAIR NATHAN: That's the
11 genesis of this as well, is that a family who's
12 on EFMP is receiving certain benefits while on
13 active duty, either in a recovering warrior
14 status, or in a non-warrior status.

15 They're getting certain things funded for
16 them. They're getting counseling on whatever
17 the EFMP issue is. And they don't recognize
18 that when they leave active duty, they assume
19 they'll be TRICARE eligible. And they are.

20 But they assume that TRICARE will
21 pick up the cost of the counseling, or the cost
22 of the special creature comforts that were given

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1 for the individual. And often it does not.

2 And so they're hit with this delta.
3 So you pointed out, Colonel, absolutely that the
4 PEBLO should not be the subject matter expert to
5 tell them what their benefits are or are not.

6 The PEBLO, and our system, should be
7 instrumental in making sure before they leave
8 active duty that they get to a health benefits
9 advisor to let them know of those issues, and
10 then if they want to appeal to TRICARE, the
11 mechanism to appeal to TRICARE, so that they can
12 see if any of those benefits can be reinstalled.

13 LTC BAKER: Yes, sir. And the
14 check list we do, the PEBLO goes down with the
15 soldier and checks off, actually has the
16 soldiers initialing on there that he's
17 requesting this assistance. And we encourage
18 them to do it as well, to seek that attention.

19 CO-CHAIR NATHAN: And the only
20 thing I would offer is, and again, I don't swim
21 in these waters very often. So I don't know the
22 footprint.

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1 But those people in our services who
2 were on active duty with the ECHO Program, EFMP,
3 who've left, if there's any sort of casual or
4 informal survey that's done -- to call them and
5 say how did we do in giving you a soft landing
6 when you left active duty to understand what your
7 benefits were and were not -- that may be
8 something we want to consider for our
9 population.

10 CO-CHAIR CROCKETT-JONES: There's
11 also multiple sources for those families to get
12 similar benefits, or substitute benefits from
13 local organizations.

14 And sometimes that is information
15 best obtained through, say the VA, who have local
16 resources, at least for where the information
17 lies.

18 But if those folks aren't triggered
19 early enough, a lot of these substitute services
20 have application processes, and there's a big
21 potential for gaps.

22 So the earlier an EFMP enrolled

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1 family has to know that they, wherever they plan
2 to transition to, they need to be in contact with
3 the local community for substitute services.
4 They need time.

5 So we need to catch them earlier in
6 the process than when they're walking out the
7 door and experience it. So that was the genesis
8 of this concern.

9 LTC BAKER: Yes, ma'am. We'll look
10 into that. Further questions, sir?

11 CO-CHAIR NATHAN: I don't think so.
12 We'll go to question 18.

13 LTC BAKER: I'm followed by Colonel
14 Jones.

15 COL JONES: It's me again.
16 Recommendation 18 talks about the services
17 should seek every opportunity to unify the
18 family and care giver with the recovering
19 warrior.

20 So this is outlined in a couple of
21 different ways. First, the Army believes that
22 soldiers healing and recovery is much better

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1 with their families right by their sides.

2 Prior to injury or deployment, just
3 as we discussed earlier, we tried to involve our
4 families in our soldiers' units through using
5 the FRSA, and really expose that family to the
6 Army culture and the Army systems, and help them
7 develop support systems right there.

8 So we try to engage before injury,
9 before deployment, so that the family becomes
10 comfortable with being in the Army.

11 We do engage soldiers or the
12 families at the time of injury. Our DA Casualty
13 Affairs reaches out and contacts them as soon as
14 there is an injury, and then starts working with
15 the family to make sure that they can be at the
16 bedside of the soldier if they're seriously
17 injured in theater.

18 So that is all laid out in the JFTR,
19 that gives us the authorities and the financial
20 backing to be able to move the families closer
21 to the bedside.

22 As the soldiers transition from

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1 in-patient to out-patient, the soldier can elect
2 to have a family member near them. This family
3 member is considered a non-medical attendant.

4 And those non-medical attendants
5 also are on military orders. And so they do
6 receive per diem reimbursement, so they can stay
7 by that recovering warrior.

8 Outside of financial assistance,
9 the Army makes every attempt to ensure that the
10 families are reunited with their soldiers and
11 they actively participate in their recoveries.

12 Our soldiers that are displaced from
13 their families, we make every attempt to move
14 those soldiers closer to their families.

15 One of the things that preclude us from
16 moving soldiers to their families right away,
17 especially for our Guard and Reserve, are their
18 medical conditions.

19 There are medical conditions that
20 can't be cared for, or we do not want them to be
21 cared for out in the civilian sector, because of
22 the nature of the injuries.

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1 And we believe that the DoD does have
2 amputee care as one of those things that we're
3 the best at. So we do keep those soldiers within
4 our DoD facilities. And then as they recover,
5 we can move them out to a community based warrior
6 transition program. We do try to move
7 those families, when a soldier has to stay at the
8 WTU we do try to bring those families in.

9 Now, some families can't, because
10 they are a dual income family. And they count
11 on the spouse's financial aid to help them with
12 paying the bills.

13 So we do everything that we can to
14 minimize those effects. We set up telecons, we
15 use Skype, we get our families in touch with some
16 of the non-profits that allow those families to
17 come and visit, and allow our soldiers to go
18 visit home.

19 So we do everything that we can to
20 involve those families in care and keep them
21 updated. One of the initiatives that General
22 Bishop has us working on is really moving those

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1 families as close to home as possible.

2 So from the onset, we look at them and we
3 say where should you be. If you're regulated to
4 Walter Reed, is there another MTF that can
5 provide the same level of care closer to home?
6 So we're working on that actively right now.

7 One of the other things that we've
8 done, through our CTP, we actually within the
9 first five days of a soldier being attached or
10 assigned to our unit, they have to be assessed
11 to be moved.

12 If they are Guard or Reserve, they
13 have to be assessed to see if they can move closer
14 to home. And then that is done on a regular
15 basis thereafter.

16 Within the first five days, if they
17 say that they can't be moved because of their
18 medical care, every time the triad gets
19 together, we look at those soldiers that have the
20 potential to move and see if we can move them as
21 quick as we can. So subject to your questions,
22 that completes the answer.

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1 MEMBER STONE: So there are 26,000
2 people today in the IDES program. There are
3 just under 10,000 in the WTU. Can you talk about
4 the other 16,000?

5 COL JONES: I'm sorry, sir, the
6 other systems?

7 MEMBER STONE: The other 16,000.

8 COL JONES: Oh, 16,000 that are not
9 involved in our program?

10 MEMBER STONE: Yes.

11 COL JONES: That are not involved.
12 So again, I don't have the subject matter
13 expertise to talk about those not in a WTU.

14 MEMBER STONE: Who would we go to that
15 would be able to assure us, with the same
16 confidence you just have, of the continuity of
17 care?

18 COL JONES: As our Guard and Reserve
19 soldiers demobilize, they go through a reverse
20 SRP. They go through demob sites. And those
21 demob sites are actually run by First Army.

22 So we could contact them to see what

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1 methodologies they have in place to ensure those
2 soldiers are moved closer to home.

3 MEMBER STONE: Are you suggesting
4 then that the other 16,000 people in IDES are
5 Guard and Reserve?

6 COL JONES: Oh no, sir. I
7 apologize. I was just thinking about moving the
8 soldiers closer to home.

9 MEMBER STONE: So one of the things
10 that we've seen in our visits are service members
11 held in the line. It's difficult. Because
12 their primary mission is not to get better.

13 The primary mission of small
14 organizations, within the Army anyway, and the
15 Marine Corps, is mission success. And
16 therefore, service members are often pulled in
17 a couple of different directions while trying to
18 be good Marines and good soldiers.

19 How do we approach the rest of this
20 group, actually the very complex smaller group
21 is within WTU. What about the rest?

22 COL JONES: Right. So, sir, a

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1 couple of things that the Army has done, again,
2 I don't have all the subject matter expertise.
3 But we've set up medical case managers at some
4 of our MTFs, to handle soldiers that are in IDES,
5 some of the soldiers that are in IDES that have
6 somewhat complex case management needs.

7 And that's one way of managing those
8 soldiers. Again, the other issue that needs to
9 be addressed is we are raised as soldiers to put
10 mission first.

11 And so as we get into looking at our
12 healthcare, we often put it off, and say, you
13 know what, I'm going to get my physical as soon
14 as I get back from my deployment.

15 So some of that has to be a cultural
16 shift in the way we look at healthcare, and
17 really move levels of health into our everyday
18 life, and understand that a soldier needs those.

19 And getting those periodic health
20 exams isn't just something to check the box off
21 with. But it really is something that our
22 soldiers and our commanders need to engage in on

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1 an everyday basis, so that everybody understands
2 that health is a part of our life, and that
3 sometimes health needs to come before mission,
4 because it's just at that critical juncture.

5 MEMBER STONE: So are you
6 suggesting in that that everyone that we've
7 reached a clinical decision point that they
8 should go through IDES should not be held in the
9 line? Now realizing, if you answer that in one
10 manner, your commander's going to have chest
11 pain in just a minute.

12 (Laughter)

13 COL JONES: He is. I think I'm
14 having a little chest pain, sir. No, sir, it
15 really is on an individual basis. I think that
16 when soldiers reach an MRDP it really depends on
17 what they reach the MRDP with, and what point in
18 time they reach that MRDP.

19 So if somebody is getting ready to
20 retire and has a busted knee, that for some
21 reason or another they no longer are fit for
22 military service, I don't know that that soldier

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1 needs to be necessarily in a WTU. I think that
2 --

3 MEMBER STONE: So how then do we
4 assure that that service member gets the same
5 level of service that is so robust from what we
6 see in front of us today?

7 How do we make sure that service
8 member held in the line, and transitioning out
9 of the military, is protected in the same manner
10 that you've wrapped your arms around the service
11 members and families you've just described?

12 COL JONES: That's a difficult
13 question. I think that it's something that
14 needs to be looked at systematically. I,
15 sitting up here with my subject matter
16 expertise, don't have the answers. I think that
17 --

18 MEMBER STONE: Well, this is the
19 point you say well, sir, you're the Deputy
20 Surgeon General, figure it out.

21 COL JONES: Yes, sir. Roger that.

22 (Laughter)

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1 MEMBER STONE: All right, look,
2 we've chosen a model in the Army that's a very
3 expensive model to manage, this population of
4 very complex battle injuries, and very complex
5 disease processes.

6 But it's expensive, it's big, it's
7 tough to manage. We have a line general officer
8 that helps us manage that process and act as
9 advocate.

10 The other services have chosen much
11 different models, where a much larger percentage
12 of wounded Marines are in the line than in the
13 Army.

14 In some of the populations we've
15 gone and visited, as much as 90 percent of people
16 going through the IDES program who are Marines
17 may still be in the line. It's a different
18 model.

19 How do we know we've got it right in
20 the Army? How should we think about this? And
21 if you were advising me on how to make changes,
22 what should we think about, about the rest of

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1 this population?

2 COL JONES: That's something to
3 ponder on. I do think --

4 MEMBER STONE: And it's okay to come
5 back. You can call me tomorrow with a
6 comprehensive answer.

7 (Laughter)

8 COL JONES: Thanks for that, sir.
9 So just really quick, I do think that to look at
10 this we really do need to look at who are in IDES.

11 So I don't know that we have the
12 demographics, meaning ICD-9 codes and
13 everything else, to really study that population
14 and understand where they're at. I
15 think we have to do some digging and figure out
16 what is that IDES population. What does it
17 mean? Where are they at? Are they all junior
18 officers, or junior enlisted, that are going to
19 need more robust hand-offs to the next level of
20 care, or their next lives?

21 And I don't know that we know that,
22 at least I don't. And I don't know if we know

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1 that from an IDES population. We just know that
2 there are disqualifying conditions, what they
3 are.

4 But we need to study that and
5 understand what it is, and what it means to them.
6 And I don't think we have those metrics right
7 now.

8 CO-CHAIR NATHAN: And that's the
9 crux of where we are in wounded warrior care.
10 Here's what all the services have in common.

11 We know that from the First World War
12 through as late as Vietnam, if you had
13 catastrophic injuries, on average, by the time
14 you came home to a tertiary care facility or a
15 VA, it was 45 to 60 days.

16 Now if you're in the Helmand
17 Province, and you're a soldier, or a Marine, or
18 an airman, or a sailor, and you receive a
19 catastrophic injury, on average you'll be back
20 in an ICU in the States in three to four days.

21 So the families which had almost two
22 months in the past to prepare themselves for the

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1 injuries have now three days. Because we do a
2 great job of getting them to the patient.

3 These are the catastrophic
4 injuries. And it creates a whole different
5 dynamic. So the evolutionary change in
6 survival is because of technical and protective
7 mechanisms.

8 The evolutionary change in healing
9 is because the families are now alongside at the
10 very beginning of the healing process. And it
11 makes a huge difference.

12 And then you bring up where we
13 separate among service cultures, Rich, is that
14 now the Marine Corps, which has this very -- and
15 I'm not defending one over the other -- but the
16 Marine Corps which has a very strong unit
17 integrity type thing.

18 And the Marines say to the doctors
19 and the hospitals, you can have my Marine for as
20 few or as little a time as humanly possible. I
21 want that Marine back in the unit. So once they
22 can limp, have them limp back to the unit.

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1 And oh, by the way, don't
2 necessarily let their families move in with them
3 for a long time. Because I want them to get back
4 to their families, back to their unit.

5 The Army says, you know what; this
6 is going to be total warrior/family care. We're
7 going to attach you to a WTU that works at the
8 healthcare facility.

9 And you'll work for that chain of
10 command that relies on a resident in the
11 healthcare facility, where the Marines say no.
12 And each one has, in my opinion, its pros and its
13 cons.

14 But the question you raised is
15 really, I think, the world hunger question. And
16 this is where we have problems.

17 When people say, well, why don't we
18 send our catastrophically injured patients to
19 the RIC in Chicago, or to Hovda in UCLA, or to
20 Baltimore, or Hopkins, great care, marquee care,
21 but they're not set up to take care of the family
22 environments as we are in DoD. And that's one

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1 of the things that we have to work on.

2 But the better question is, okay,
3 what about those that aren't simply mildly
4 injured, those that aren't seriously injured,
5 but those that are in some sort of rehabilitative
6 process, which is probably going to result in
7 them being separated from the service.

8 And they're going to need chronic
9 care for awhile. And how do we assure them when
10 they're not driving through the gate at Walter
11 Reed, or SAMMC, or San Diego, or Hood every day?

12 How do we ensure that they're
13 getting the continuity of care, they're meeting
14 their wickets, they're getting their family
15 support?

16 That's really, I think, the
17 evolutionary change that has to occur from here
18 on in. We've done the heavy work on most of our
19 catastrophically injured wounded warriors.

20 Every once in awhile, one falls
21 through the cracks and it creates a dramatic
22 ripple. And we all rush in to see what went

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1 wrong.

2 But those little ripples are
3 occurring every day outside our gates. And
4 General Stone asked the question how do you, and
5 I would ask the same of the Marines and the same
6 of the Navy, how do we look at those people who
7 are not reporting to somebody every day in a
8 squadron.

9 And he's pointed out the Marines
10 tend to, more so than others, back to their line
11 commanders, do that prior to discharge. So
12 that's what we wrestle with, I think. That's
13 the problem.

14 As we speak right now, there is a
15 family out there in the interstices of Iowa, or
16 Kansas, or Montana, that's failing, and a
17 wounded warrior that's, a recovering warrior
18 that's failing.

19 And we don't have the aegis over them
20 to control their environment. And so we're
21 trying to do it remotely with policies.

22 And so I think that this was the genesis

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1 of the question. How do we preserve the family
2 dynamics and keep the family engaged in recovery
3 processes where we can't observe the family
4 process?

5 MEMBER EVANS: Sir, you always give
6 us these, both of you, always give us these
7 thought provoking and unique questions.

8 CO-CHAIR NATHAN: You need to know
9 you're way more appreciative than this group up
10 here.

11 (Laughter)

12 MEMBER EVANS: No, sir. So one of
13 the things that I would challenge the task force,
14 we need to look at the DoDI instruction, that
15 task is recovery care coordination.

16 Because the DoDI says identify the
17 Category 2s and 3s. But what about our Category
18 1s? So we have no mandate out there to say track
19 your Category 1s.

20 We have plenty of Category 1s going
21 through the IDES system. So every time we talk
22 about our systems that we have in place, so here

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1 I am. What about the Category 1s we have out
2 there?

3 The answer is there, but we're not
4 mandated to track those. I could care less
5 about mandate, we have to find these folks. And
6 so that's where we have to start.

7 We have got to go back and change the
8 DoDI so we can say our recovering warriors, no
9 matter what category, they will be placed in a
10 system.

11 You can label them Category 1s, 2s,
12 and 3s, but they will be tracked, and they will
13 have either a non-medical case manager or a
14 medical case manager, but someone looking in
15 that system and following up on that patient.

16 So it's just not even IDES. We have
17 our mild PTSD out there. And then all of a
18 sudden we hear family involved in some type of
19 murder case. And how do we track that member?
20 Do we follow-up on them? So that's where we have
21 to go back and change that DoDI.

22 MEMBER STONE: So here's my fear.

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1 We come to the end of this ground war. We bring
2 the troops home. We are all prayerful that
3 America will not need its ground forces, Marine
4 or Army, for some period of time, and we can
5 recover.

6 Do we keep this model? Do we keep
7 a warrior transition command? And do we have it
8 right to keep some in this system and some out
9 of it? And how do we make sure that we take care
10 of all equally?

11 And, Dave, I'm not asking you to
12 really answer this. But I'm going to tell you
13 that this is the nidus of most of my questions.
14 How do I know I've got this right in a disparate
15 Army across all of America?

16 And I'm especially cognizant of
17 COMPO 2 and 3 that are dispersed across some
18 fairly remote areas.

19 BG BISHOP: Sir, we're asking the
20 same questions. Warrior Transition Command did
21 a strategic posture review in the fall to ask all
22 those questions.

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1 What we came up with was a
2 recognition that the most complex cases do
3 require more close management. And the case
4 management that we've had for a few years has
5 yielded a lot of success in terms of readiness
6 for our war fighting units to stay part of the
7 deployment cycle.

8 But it's also returned to the force
9 50 percent of the 50,000 who have gone through
10 it. And the question is, you're right, the way
11 ahead.

12 We estimate that this is an enduring
13 problem. Not that it's a problem, but it's an
14 enduring requirement. So we're looking at
15 different models.

16 The Reserve Component Managed Care
17 Program, which is fairly new, offers potential
18 for a different model for those Reservists,
19 Guardsmen, and Reservists, who do not have
20 complex case management requirements, but have
21 the same need for the high standards of medical
22 care that everyone else gets.

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1 That is one model that we can look
2 at. I think the Air Force also has a similar
3 model. So we're looking at that.

4 Recently, well, actually last year,
5 Installation Management Command opened up all
6 SFACs to all IDES soldiers, every soldier in
7 IDES, regardless of whether in a WTU or not.

8 So we are looking at expanding the
9 concertina wire out to include everyone in the
10 same high quality of care that the WTUs are
11 getting. And we're examining all
12 possibilities.

13 CO-CHAIR NATHAN: Okay, great
14 discussion. And as much as I know you all would
15 like to stay and dwell on this one, we're going
16 to move to number 20.

17 MS. TUDDENHAM: I'm Colleen
18 Tuddenham. And thank you, sir, for the
19 transition back to SFACs. A little of what you
20 are about to hear is a little redundant.

21 Colonel Jones, thank you very much for
22 mentioning about half the things that I was going

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1 to talk about, because you were questioned.

2 The bottom line question was who
3 provides the services, from the family center's
4 point of view, to the recovering warrior. And
5 for Army you know that's SFACs. And your
6 recommendation was to fully fund SFACs.

7 And they are funded at Fiscal Year
8 '12 level. So that's continuing. Last year
9 IMCOM reinforced the mission of SFACs by
10 publishing an op order which reminded the
11 installations that they could, in fact, hire
12 that staff.

13 And they provided extensions to
14 employees that were terms. And their term
15 appointments were expiring last year. SFACs
16 hires are exempt from the current hiring freeze.

17 And like Colonel Jones mentioned,
18 they are now on WTU campuses by increasing
19 numbers. We opened an additional 11 last year.
20 We now have 19 campuses.

21 SFAC reachback is to Army Community
22 Services, for those services that are not

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1 provided in the SFAC, like Exceptional Family
2 Member.

3 And also, as Colonel Jones
4 mentioned, utilization increased significantly
5 in Fiscal Year '12 over Fiscal Year '11, we think
6 probably because of all those new campuses
7 opening, proximity.

8 Client satisfaction, as you've
9 mentioned, thank you very much, is very high,
10 very high. Our survey had 97 percent. And the
11 IMCOM headquarters is working with Manpower to
12 try to finally obtain some permanent
13 authorizations for those staff members.

14 MEMBER KEANE: Ma'am, what was the
15 increase of utilization from '11 to '12?

16 MS. TUDDENHAM: I don't have an
17 exact percentage. IMCOM has not analyzed it.
18 But it was very large. And I can ask IMCOM to
19 give you something more precise.

20 I'm sorry, who asked that? We can
21 get back to you. If there are no other
22 questions, I'm followed by Colonel Dudek.

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1 LTC DUDEK: Again, I'm Lieutenant
2 Colonel Danny Dudek. I currently work on the
3 Warrior Transition Command operations, as the
4 chief of policy and procedure.

5 And I get to provide a
6 recommendation or a response to Recommendation
7 Number 23. Upon receipt of the Fiscal Year '12
8 Recovering Warrior task force recommendations,
9 we concurred with the recommendation that each
10 out-processing Reserve component recovering
11 service member needs to out-process with their
12 home unit.

13 We viewed our response in three
14 ways. First, HRC needed to continue the orders
15 process in their same way to a Reserve component.
16 But we agreed that more redundancy was needed for
17 a successful transition from Title 10 status.

18 So the WTC and CBWTU leadership
19 recognized that they need to engage with the
20 soldier's home unit as early as possible, but no
21 later than the out-processing.

22 So we added another requirement on

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1 the out-processing check list in September and
2 October of 2012. This was after the publication
3 of our comprehensive transition plan guidance.

4 We put that out with a summary of the
5 changes to the CTP guidance. And this
6 requirement established the need to contact the
7 home unit with a point of contact, the unit name,
8 contact, and information, telephonically and
9 via email, and through other supporting
10 automated systems like DTMS and AHLTA.

11 Thirdly, the soldier can also
12 enhance their transition by actively
13 maintaining contact with their home unit, and
14 enabling a collaborative discussion between the
15 home unit, and the WTU and CBWTU leadership
16 inter-disciplinary team.

17 We believe redundancy and redundant
18 processes provide the greatest opportunity for
19 successful transition from Title 10 status.
20 And I'm sure there are questions. And I'd love
21 to answer them at this time. Thank you; I'll be
22 followed for Recommendation 33 to Lieutenant

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1 Colonel Jon Baker.

2 LTC BAKER: Always, sir, ma'am. On
3 Recommendation 33, the key point there, the
4 current PEBLO staffing formula is inaccurate.
5 And we should develop new and more accurate PEBLO
6 work intensity staffing models.

7 I think we are in the process of
8 doing just such a thing. MEDCOM, we've stood up
9 a work group where we actually created what we're
10 calling a case regulating model.

11 And what we're doing is we're
12 weighting the cases by what phase they're in, in
13 the IDES process, with collaboration with the
14 RMCs and the people in the field.

15 We are seeing that your average work
16 load for a case changes as the case progresses
17 through. As such, the standard one to 20, or one
18 to 40 model, just doesn't possibly fit anymore.

19 And we're looking at this from a
20 PEBLO perspective as well as the provider, and
21 the VA MSC as well.

22 Now, we also have two studies that

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1 are ongoing as well. The RAND Group is doing a
2 study looking at IDES as an enterprise, looking
3 at future projections. But they're also
4 looking at our staffing models as well to see if
5 we have the right modeling that we're utilizing.

6 We also have warrior care policies,
7 also finishing up a study where they're looking
8 at PEBLO ratios, and PEBLO training. And what
9 we hope to do is take our three efforts and inform
10 recommendations on how we can adjust our
11 recommendations on the appropriate staffing
12 model and ratios.

13 And I think it's not going to be
14 something set in stone. It has to be flexible,
15 because of how many cases you have, your case
16 load changes.

17 If you go to a ratio and you have
18 30,000 this month, but you have 28,000 two months
19 from now, well, your ratios are going to change
20 drastically. So it needs to be flexible. And
21 we understand that.

22 Additionally, the key concern up

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1 there of having two PEBLOs at each site, we've
2 accomplished that. Every site has two PEBLOs.
3 And in conjunction with this, we have Contact
4 Reps with each of the PEBLOs, which are their
5 assistants.

6 Both of them work as a two man or
7 three man team to maintain the contact with the
8 soldier to make sure they are handling the case
9 as it goes through the enterprise.

10 So if a soldier, I'm sorry, if a
11 PEBLO, or the Contact Rep, has to go on leave,
12 sick call, whatever, there's somebody there that
13 still understands that case and can help make
14 sure it's making it through the wickets.
15 Pending your questions?

16 MEMBER MUSTION: Do you have any
17 idea what the annual attrition rate is of PEBLOs?

18 LTC BAKER: No, sir. I do know we
19 do have turnover. That's something I have not
20 dug into. But we can do some research.

21 MEMBER MUSTION: Is that a problem?
22 Do you see it as you look at it that you're in

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1 a continual state of bringing in additional
2 PEBLOs and retraining them, and having a
3 compounding problem?

4 LTC BAKER: Sir, I don't think we
5 have a --

6 MEMBER STONE: I may help you on
7 that one.

8 LTC BAKER: Yes, sir.

9 MEMBER STONE: Yes, our turnover
10 rate exceeds ten percent. Much of the turnover
11 is promotion within the system to leadership
12 roles. So it's turnover, but it's not because
13 they're leaving the system.

14 As we stood up IDES, this was a
15 fairly immature business model. What Jon is
16 describing has really worked beautifully with
17 his team. And we're all really proud of him, a
18 dramatic improvement in our ability to manage
19 this system.

20 There are 55 sub-processes that
21 these PEBLOs work service members through.
22 What we're seeing is just a maturing in our

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1 understanding of where the touch points, and key
2 points are.

3 Where this group was engaged was,
4 gee, it seems like we need to adjust PEBLO ratio
5 based on the intensity of care, the number of
6 claimed conditions.

7 That is really what Jon is evolving
8 beautifully at this point. What I think we're
9 going to see is some tremendous personnel
10 efficiencies.

11 We have, in the Army, over 1,400
12 personnel engaged in this process today,
13 dedicated to the IDES system for the MEB process.

14 I think we're going to see some
15 substantial improvements in the efficiencies
16 related to that, as we redefine the roles of each
17 of these individuals.

18 In addition, as we move from a paper
19 based system to an electronic based system --
20 which frankly the DoD is well on its way to, VA
21 is still struggling through the firewall issues
22 of that -- as we move to that, the need for

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1 substantial numbers of PEBLO assistants will
2 virtually go away.

3 Now, every PEBLO assistant
4 listening to this is going to go, oh, my gosh,
5 my job is going away. We have plenty other work
6 to do.

7 MEMBER TURNER: Colonel Baker?

8 LTC BAKER: Yes, sir.

9 MEMBER TURNER: In your model of two
10 PEBLOs or more at each IDES site, what is your
11 manning fill for those? And how are those jobs
12 classified?

13 LTC BAKER: Our manning fill? Sir,
14 I'm going to ask you to rephrase that. I'm not
15 sure I understand.

16 MEMBER TURNER: You have these
17 position numbers, the positions.

18 LTC BAKER: Oh, PDs, roger.

19 MEMBER TURNER: Yes. And so of
20 those PDs how many are actually filled at any one
21 time? And then how are they classified, like GS
22 what?

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1 LTC BAKER: Sir, I think our fill
2 rate is up in the upper 90s right now, across the
3 MEDCOM. I can't remember exactly. I think
4 it's 97 percent across MEDCOM on PEBLO fill.

5 But, again, I don't know exactly the
6 ten percent turnover piece. I wasn't up on that
7 100 percent.

8 MEMBER TURNER: And they're GS?

9 LTC BAKER: Yes, sir. They're
10 seven to nine, roger. And I think there is some
11 flexibility. I know that in Europe, for
12 instance, they go a little lower, but yes, seven
13 to nine, on average.

14 CO-CHAIR NATHAN: I'll ask you a
15 couple of questions. But you're fortunate in
16 that the hardest working man in PEBLO, or in IDES
17 show business, is sitting to my right, right
18 here.

19 And General Stone and I have had many
20 conversations about this. But there's probably
21 very few issues that are more germane or salient
22 to the recovering warrior than how they're going

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1 to navigate and migrate into the VA disability
2 system, and get their continuity of care from the
3 VA, and get their disability rating.

4 And I say again, out front, the Army
5 has an orbital number of veterans returning,
6 compared to the other services. And so even
7 though the Navy is within spec in its milestones,
8 and the Marine Corps is very close to being
9 within spec, the Army is still pretty far out
10 there.

11 Again, I say that the Army has so
12 many more numbers than we do. So I recognize the
13 herculean task it has. I'm concerned because,
14 General Stone, you've got somewhere to 80,000
15 soldiers coming off the roles in the next five
16 to ten years, many entering the disability
17 system.

18 In the Navy we'd say are we going to
19 be taking water in over the side faster than we
20 can bail it. And I would ask your question on
21 process.

22 There are some inherent differences

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1 in process in the IDES system between the way the
2 services do it. It has to do with who dictates
3 the narrative summary, it has to do with which
4 physical ailments and afflictions are
5 determined at the time of discharge by the
6 service vs. by the VA.

7 Have you looked at your process?
8 And you can certainly look at General Stone and
9 say, Daddy, Daddy, make the bad man stop. But
10 have you --

11 (Laughter)

12 CO-CHAIR NATHAN: Have you looked
13 at your process to, as General Stone said before,
14 hey Marine Corps, hey Army, do you have your
15 process right to begin with?

16 Or are you throwing more people and
17 more money at a process that needs to be
18 retooled, in concert with some of the other
19 services, to try to create a faster and more
20 concise and expedited IDES process.

21 LTC BAKER: All right, sir. I'm
22 not going to cry Daddy, Daddy yet. But we have

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1 looked at the other services' process. I'll be
2 honest though. A majority of our effort has
3 been in refining and fine tuning our existing
4 process, and getting compliance with it.

5 Not that there isn't lessons to be
6 learned from the other services, but it's hard
7 to diverge from our existing process when we're
8 not executing it to standard.

9 And as we're getting more
10 intolerance to achieving what our established
11 process is, I think it'll lend itself better to
12 the tweaking.

13 Because we are making progress.
14 This last month was the first time we hit over
15 50 percent meeting timeliness. Now in the
16 civilian side, most of us would have been fired
17 for that, I understand.

18 But the progress we made over the
19 last eight months, even before I came on the
20 service line, is tremendous. We've shaved
21 months off the process. We found efficiencies;
22 we've been meeting the standards for a very large

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1 population.

2 And we're doing it while also
3 implementing some novel ideas, such as
4 complexity based MEB processing for low
5 complexity cases, and implementing remote
6 processes so we can handle these cases.

7 So, sir, I think there is areas where
8 we could refine this. Right now our primary
9 effort, and I know mine as one of the new guys
10 on the team, has been to focus on how do we get
11 our existing process optimal. But again, there
12 is room for improvement. And that's something
13 we can look into, sir.

14 COL BERRY: And sir, if you would,
15 Colonel Priscilla Berry. I work for the
16 Assistant Secretary for Manpower and Reserve
17 Affairs. Colonel Baker, you're speaking kind
18 of from an MEB side. I am involved in the entire
19 process.

20 I would say that, yes, there's been
21 a great deal of process review, and process
22 improvement, especially at the individual MEB,

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1 the individual PEB levels. I think everybody is
2 looking at how can they improve this.

3 Over the last year we've seen a great
4 effort, leadership starting at the very top,
5 monthly VTCs held with the Vice Chief of Staff,
6 with all of the MTF commanders, the regional
7 commanders, the line commanders, the major
8 command levels, everyone looking at what are we
9 doing, what can we do better.

10 We have worked with OSD in getting
11 exceptions to some policies, or getting changes
12 to policies, for example use of the
13 psychologists to assist with writing NARSUMS,
14 the two-person PEBs, those kinds of things.

15 We have looked at everything that we can
16 to improve the process. Yes, we have invested
17 a lot of manpower to this, both on the MEB and
18 on the PEB side. And we are seeing already the
19 results of that investment. And I
20 think that over the next few months, we're going
21 to see that start to display itself in improved
22 processing times, as we start to clear out the

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1 oldest cases.

2 And we're looking at those oldest
3 cases right now individually to see what do we
4 need to do to clean those up, and then also
5 working with our VA partners to ensure that they
6 have what they need from us as the soldiers get
7 to the very last stage, and to get their benefits
8 letter in a timely fashion.

9 CO-CHAIR NATHAN: So that's great.
10 And I'll turn it over to Rich in just a second.
11 But first of all, thank you. It sounds like
12 you're really looking hard at the process.

13 One of the superficial concerns was
14 that the Army came in and said, hey, if you give
15 us, what, \$360 million and 1,000 FTEs to throw
16 against this, I think we can get you there.

17 The problem is, in this current
18 environment, the reality of that is probably
19 very small. And so that's why, I think, process
20 change has to be the center of gravity.

21 Because I don't think you're going
22 to see that kind of cavalry coming over the hill

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1 in those numbers, or those dollars, to buy them.
2 And with that I'll say my piece and --

3 COL BERRY: And yes, sir, I would
4 say that in a process that is this complex, that
5 it's more than just manpower. It is a number of
6 things.

7 And I think we've addressed it from
8 a number of approaches, both from what our
9 standards are, and refining those, and
10 standardizing our standards, if you would, to
11 process improvements, to policy refinements.

12 So I think we have tried to come at
13 it from a number of angles, not relying solely
14 on just throwing more people at it.

15 MEMBER STONE: And, Priscilla, the
16 answer is we've thrown a lot of people and a lot
17 of money at it. And it is an inherently broken
18 system. We all recognize that. And our senior
19 leaders have articulated that up on the hill.

20 There's very little interest to
21 create a system that is more proper. A proper
22 system to us is one in which we in the services

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1 determine fit for duty or unfit, and then pass
2 to our VA colleagues a decision on how much
3 disability and how it's handled.

4 The problem we have, there's very
5 little willingness on either department's
6 positions that would allow them to get out of a
7 siloed approach to that solution, and who pays
8 the bill.

9 Whereas the cost to the American
10 people is virtually the same, other than some
11 benefits on access to healthcare, as well as
12 access to commissary privileges. But it's
13 virtually the same cost to the American people.

14 Until there is substantial change,
15 we will throw, sir, what is almost \$200 million
16 a year at this thing, in the Army. So it's a
17 billion dollar over our POM that we will throw
18 at this.

19 And it will get way better. We'll
20 make it go away faster. We'll be prayerful that
21 the numbers of people that need these services
22 will go down, as we hopefully find pieces I

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1 mentioned before.

2 But until our senior elected
3 leadership decides this is a system that bears
4 changing, we're not going to have that. We're
5 not going to have that.

6 COL BERRY: And we completely
7 concur, sir. And we would gladly participate in
8 any effort designed towards legislative reform.

9 CO-CHAIR NATHAN: And this is where
10 the public affairs person says what the Colonel
11 meant to say was --

12 (Laughter)

13 CO-CHAIR NATHAN: But at the end of
14 the day, this is where, again, you use us to
15 leverage your leadership, the nation's
16 leadership, the VA leadership, DoD leadership,
17 to look for changes in our progress.

18 I recognize the cultural inertia of
19 a Marine Corps, of an Army; I recognize that
20 those things are hard to change.

21 And you just heard the Deputy
22 Surgeon General for the Army talk about, boy, if

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1 we could sort of change the end game of what we're
2 required to do in a disposition at the service
3 end, we could expedite the process.

4 So again, we're here to help you do
5 that, if that's what you want to do. But the
6 first way, you have to ask for help, right,
7 before you can get it.

8 So we're willing to weigh in on that
9 for you, recognizing that you do have, I think,
10 a relentless number of people coming back into
11 the system. And you're just trying to catch up
12 with where you are now. And there's a tsunami
13 coming over the next several years.

14 And so we're all in, in trying to
15 figure out how we can work this jointly and use
16 whatever lessons learned we've had in the other
17 services, admittedly for a smaller scale of
18 personnel, but whatever lessons we've learned,
19 to try to import and overcome perhaps some of
20 the cultural inertia that may exist in the Army
21 service. With that, any more --

22 MEMBER TURNER: I'd just like to

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1 echo one of the things that you said. I think
2 you bring up actually the entire purpose of the
3 task force.

4 If the purpose of this task force is
5 meant to see how we're doing in taking care of
6 wounded warriors, and how we can improve, then
7 first thing we should identify is what is the end
8 game.

9 And let us all identify what the end
10 game is. And only after an end game is
11 determined, can we measure what we're doing.

12 Most of our metrics are just
13 measured on intuitive standards. And that's
14 fine for a start. But as everyone has said here,
15 until there is a definite joint end game
16 determined by our senior leadership, we can't
17 really give you a good measurement of how we're
18 doing as a whole. That is all.

19 CO-CHAIR NATHAN: Okay, next
20 recommendation.

21 LTC BAKER: Yes, sir. Now, for
22 Recommendation 34, the services should ensure

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1 that 100 percent of recovering warriors are
2 individually contacted by an MEB outreach
3 lawyer, in person, phone, email, upon
4 notification to the PEBLO that their narrative
5 summary will, or has been, completed.

6 Now again, each soldier member who's
7 referred into IDES, he is introduced to his OSC
8 counsel member, or what we call his soldier MEB
9 counsel member.

10 And the PEBLO ensures that through
11 the process, as there are key link ups, he
12 advises the soldier of their rights. And right
13 at the end of the MEB phase when the narrative
14 summary is completed, that is one of those key
15 points.

16 Obviously he meets them during the
17 referral, at the narrative summary, that's
18 another key point, and then at the informal PEB
19 findings, when it's passed off to the PEB.

20 So as the narrative summary is finished,
21 the PEBLO advises the soldier of his rights to
22 seek an IMR, an impartial medical review, or to

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1 appeal the results of the findings of that
2 narrative summary.

3 Now, those are three key nodes, but
4 the soldier is advised that he always has access
5 to his soldier MEB counsel member.

6 So if there's questions about the
7 process, or his rights during that process, he
8 knows he can tap into what we call the SMEBC. He
9 can talk to that counsel to get that legal advice
10 throughout the whole process.

11 Now, we are making additional
12 efforts across MEDCOM to hire more OSC for the
13 IDES. We understand that this is a key node in
14 advising and ensuring the soldiers understand
15 their rights through this process. So
16 we're continuing to grow that. And the process
17 is established. And we think it's working
18 halfway decently. So pending your questions.

19 LTC DUDEK: Sir, I was going to wait
20 until the end to throw this in there. But across
21 all these recommendations, and across the two
22 years of focus groups, I think what it comes down

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1 to is we throw a lot of check lists, we throw a
2 lot of flip charts, we throw a lot of money, we
3 throw a lot of personnel at a lot of things.

4 When the focus groups come down, and
5 the questions are asked, what's actually given
6 to us versus what's actually being briefed as to
7 what's happening, I think there's a disconnect.

8 In my thought process, what it comes
9 down to is actual Leadership 101, and are we
10 inspecting versus expecting. Families are
11 telling us different things on all these
12 recommendations.

13 And like I said, we wouldn't have
14 written these recommendations had all these
15 check lists, flow charts, and everything else
16 been working the way that they should.

17 Because the families wouldn't be
18 telling us that they're being disconnected.
19 Service members wouldn't be telling us that
20 they're disconnected from legal services.

21 So when it comes down to it, like I
22 said, I was going to hold this until the end. I

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1 think we need to, instead of just throwing money,
2 products, and anything else, is look at it from
3 the perspective of what are we truly inspecting
4 down to the soldier level, and what truly is
5 happening at the soldier and family level.

6 LTC BAKER: You hit the nail on the
7 head. If you put something out there, and there
8 is no backwards mechanism to check on it, you
9 don't know what's going on out there. So that's
10 something we can look at as well.

11 MEMBER STONE: Sergeant Major,
12 we're short 37 attorneys across IDES to what
13 we're staffed at. We just approved the hiring
14 of 13. Frankly, for awhile I thought I was going
15 to hire the entire graduating class in America
16 from law schools.

17 Jon's right. There are certain key
18 points in which service members need help, right
19 in the beginning of IDES, right before the NARSUM
20 gets created, right after the NARSUM gets
21 created, and then in that final phase, in order
22 for them to feel confident that their rights have

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1 been protected.

2 We've seen varying levels of
3 requests for independent medical review; we've
4 seen varying appeal processes done. But always
5 we are better off with good attorneys
6 representing service members' rights.

7 And so these have been difficult
8 hires in some areas, specifically some of our big
9 platforms we've had trouble getting attorneys to
10 go to. And we've tried a lot of different
11 things.

12 But you are exactly correct. The
13 way to measure this is are service members happy
14 with what they're getting, not that they got the
15 exact answer they wanted, but they felt that
16 there was somebody there being their advocate.

17 CO-CHAIR CROCKETT-JONES: And I
18 also just want to point out that in our trip to
19 San Antonio there was a model that, instead of
20 relying on reference by the system, referring a
21 soldier to legal, that legal was more proactive
22 in its outreach.

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1 And it was choosing to -- no, it was
2 not San Antonio, it was Fort Bragg -- it was
3 choosing to get contact information from the
4 person who basically did the administrative
5 onset of the MEB/PEB process of all of IDES.

6 So if someone entered into it, just
7 that first administrative entry created a
8 database for legal outreach to folks to say you
9 are entering this and you have access to counsel
10 from minute one.

11 And it was interesting to see it,
12 because it facilitated some real dynamic
13 increase in information for those folks who took
14 advantage of it.

15 And we're going to be briefed, I
16 believe, at some point, on that model. But I
17 just want to throw it out that changing it from
18 a referral -- letting legal do its outreach by
19 giving it the data eliminates the inconsistency.

20 CO-CHAIR NATHAN: Any further
21 follow-up? Going once, going twice?

22 MEMBER MUSTION: If I could, I agree

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1 with the Command Sergeant Major's comments.
2 Over the last three or four years I've seen a lot
3 of packets come out through the MEB and the PEB
4 side.

5 And about half of it is useful
6 information to make decisions. The other half
7 of it is a series of check lists, or statements,
8 signed by a soldier that said I got this, or I
9 reviewed this, or I reviewed that.

10 And I'm not sure that, while those
11 are good, I guess I'm not exactly sure we're
12 really internalizing it. The Sergeant Major's
13 point, I think, is a good point, something that
14 we should consider as a task force.

15 What's the best mechanism to
16 communicate? And how do we make sure that that
17 communication is taking place on all of these,
18 whether it's benefits, whether it's right to
19 legal counsel, whether it's rights to this, or
20 benefits for that?

21 And that's been a source of
22 discussion in the last three meetings. How do

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1 we best communicate and best confirm that
2 communication is taking place across the full
3 spectrum of things. And I think that's
4 something the task force should take on and look
5 at.

6 MS. DAILEY: And that was the reason
7 for that recommendation, which was a 100 percent
8 face-to-face. That's what you all voted on.
9 Because you felt that that 100 percent
10 face-to-face with an MEB was the best way to
11 communicate these very important concepts about
12 their rights in the IDES.

13 CO-CHAIR NATHAN: Great comments.
14 Okay, we'll go to Recommendation Number 35.

15 LTC BAKER: Yes. And I'll be
16 followed by Mrs. Nancy Adams at this time.

17 MS. ADAMS: Good morning, I'm Nancy
18 Adams. I am the branch chief for Career and
19 Education Readiness Programs at the Warrior
20 Transition Command.

21 I've been asked to address you all
22 on your Recommendation Number 35, that all

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1 military members, upon entering the service,
2 begin a relationship with the VA, and that the
3 VA services should be marketed widely to
4 soldiers, DoD leadership commanders, et cetera,
5 and that all active and Reserve component
6 soldiers should be encouraged to register in VA
7 eBenefits.

8 We concur with that and I would like
9 to let you know that our soldiers are all
10 required to enroll in VA eBenefits. A little
11 history on that, our soldiers in the Warrior
12 Transition Command have been required to enroll
13 in eBenefits since the publication of our
14 comprehensive transition plan in December of
15 '11.

16 All of the Army active and Reserve
17 component soldiers have been required to enroll
18 in the eBenefits since the publication of HQDA
19 EXORD 054-12, which came out in December of '11.

20 Right now, the enrollment in
21 eBenefits is verified and documented by ACAP
22 prior to separation. This is coming out in the

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1 form of a commander's report at ACAP as soldiers
2 participate in various activities through their
3 ACAP and separation process with the
4 requirements of the VOW Act.

5 And our WTU commanders are getting
6 copies of those reports to push down to the
7 companies and the squad leaders to ensure that
8 the soldiers are progressing through their
9 transition activities appropriately, and that
10 they're doing them.

11 And then the last thing I would add
12 to that is that enrollment in eBenefits can be
13 done by way of DS Logon and the CAC card.

14 And by November of this year, all
15 soldiers will be required by guidance that's
16 being put out by ASA M&RA to establish a DS Logon
17 account, so that they can more easily get into
18 several different electronic systems that they
19 need to process information for themselves on
20 their healthcare and their VA benefits.
21 Subject to your questions or comments?

22 CO-CHAIR CROCKETT-JONES: The only

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1 thing I want to ask is, is there any way for us
2 to know what ratio of spouses are also enrolling
3 at the time, if spouses can enroll in eBenefits.
4 I'm wondering if there's any way for us to find
5 out that information?

6 MS. ADAMS: We do have that from a
7 DoD's level. And that is tracked.

8 CO-CHAIR CROCKETT-JONES: Thank
9 you.

10 CO-CHAIR NATHAN: Now, clearly
11 there's been tremendous effort made by both the
12 DoD and the VA to improve situational awareness
13 and connectivity.

14 I used to joke when I would go to
15 grade schools to do career day, about being a
16 doctor or being in the military. I'd encourage
17 any of the young children in the class who were
18 thinking about going in the military to start
19 their VA disability process then.

20 Because in the good old days it just
21 took forever. And then we started IDES, and
22 then we started the RIDES, and we started all

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1 these various aberrations to try to figure out
2 how to shorten the connectivity into VA rating,
3 disability transition.

4 I think the services are doing more
5 now with transition assistance. We're seeing
6 an impetus for more service members who are
7 mandated to go through transition assistance
8 classes.

9 We are going to dedicate more time
10 to it. It's at a cost. It's at a cost to the
11 services to take a soldier, or a sailor, or a
12 Marine, or an airman, out of pocket for a few
13 extra days.

14 But I think there's a genuine
15 sincere desire on the Department to better
16 acquaint service members who are transitioning
17 with what their VA benefits are, and what they're
18 eligible for.

19 And it gets back to your point,
20 General, about this all centers on one, giving
21 people a simple way of navigating the system so
22 they're not lost, either a point of contact, a

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1 navigator, an avatar, something, a lead
2 coordinator, who can hold their hand and sort of
3 take them through the process.

4 The second is to give them an
5 understanding of what the expectations should be
6 of the milestones they should reach, meaning I'm
7 a family and I'm transitioning.

8 Either I'm transitioning through normal
9 circumstances, or I'm transitioning through
10 illness or injury. And what are the milestones?
11 At what time should I expect them? When should
12 I come back and get worried?

13 The famous sign on the doctor's
14 office that says, "If you have not been called
15 in 20 minutes, or 10 minutes, come up and talk
16 to us."

17 To a family, if you have not received
18 this from the VA, or from the Federal healthcare
19 coordinator, or from the care manager in two
20 weeks from your time of entry into the system,
21 contact this number.

22 We need to offer them that. We need

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1 to put some of the burden on the families and the
2 warriors to manage their own affairs. But we
3 need to make it effortless for them to do so.

4 And again, I think I applaud the VA
5 and the Department, where their heart is, for
6 trying to do this. And eBenefits is another
7 thing.

8 And once we get to a more facile
9 electronic communication between the DoD and the
10 VA, a lot of this will really, I think, will take
11 off, both from an IDES standpoint, as you pointed
12 out, once each system can see the others, and
13 from a continuity of care. I think that was our
14 last recommendation?

15 MS. DAILEY: Yes, sir. And we do
16 have another block for Dr. Gliner, their survey
17 program, which is very important. I'd like to
18 get through that.

19 The last three topics, last three
20 questions in there, we will not get to. But I
21 would like to give Dr. Gliner the next hour.

22 Lunch is at one o'clock, ladies and

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1 gentlemen. And I'm pushing you hard here. I
2 apologize. But there's a lot of material I
3 wanted the Army to get through.

4 And I think the Army Survey Program,
5 and how they look at their WTC, and what they're
6 measuring, and how they're using it to improve
7 their programs, is significantly important to
8 you guys.

9 MEMBER PHILLIPS: Just one real
10 quick question related to the VA. Is there an
11 effort to actively bring back in roughly 20
12 percent of the folks that didn't start applying
13 at grade school?

14 (Laughter)

15 MEMBER PHILLIPS: There are a lot of
16 people out there, one-fifth or so.

17 CO-CHAIR CROCKETT-JONES: I think
18 we need to ask the VA specifically.

19 CO-CHAIR NATHAN: I think it'd
20 probably be our best point. We'll take that for
21 the record, for the VA to ask.

22 We'd like to welcome Dr. Melissa

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1 Gliner, who is the senior health policy analyst
2 with the Decision Support Center, who's now
3 going to brief us on service satisfaction
4 responses and program changes. In March
5 of '12, Dr. Gliner provided information to the
6 task force regarding warrior transition unit,
7 and medical evaluation board satisfaction. And
8 we look forward to hearing the updates from that
9 presentation. You can find her presentation at
10 Tab D.

11 DR. GLINER: Okay, thank you. And
12 I assume everyone can hear me okay back there,
13 great. I'm very aware, I know that I stand
14 between you and lunch. So I'll go through these
15 at whatever pace. And I assume you guys will ask
16 questions throughout.

17 So last time when I talked to you,
18 I presented the WTU survey. But we had just been
19 getting started on the MEB survey. So this time
20 I'll have results on that survey as well.

21 This question talked about the
22 methodology for the WTU survey, who's eligible

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1 for it, what are the current results? So it's
2 soldiers are surveyed at anniversary dates. So
3 they're eligible to receive a survey after
4 they've been in the WTU for 30 days, 120 days,
5 280 days, and 410 days.

6 It's conducted fully by telephone.
7 In a couple of slides though I'll show you how
8 that's going to change. It's a census, so it's
9 not a sample.

10 And the response rate is about 40
11 percent, which if you've seen other surveys
12 that's very good. And it may just be because
13 this is a captive audience. They have phones,
14 and it's a telephone survey, which tends to get
15 a higher response rate than a mailed survey.

16 And the question of your focus areas
17 on the triad, things like living quarters,
18 orders, transportation, finance, and then we
19 later added questions about pain management.

20 Results, satisfaction has remained
21 steady over the past two years. That was an
22 improvement though from when we first started

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1 the WTUs. And it's actually, as I'll show you
2 on the next couple of slides, it's gone up a few
3 percent over the past five or six months.

4 Soldiers are very satisfied with their
5 case manager, less satisfied with access to
6 care. And they rate pain management very low.
7 But they're open to things like acupuncture,
8 biofeedback.

9 We have those on there. We ask them
10 have you tried these other things. And if not,
11 would you be willing to try them.

12 And then the way ahead, we'll
13 continue to work with the WTC, and to look at
14 changes in satisfaction over time, and by COMPO.
15 And I'll show you the results of satisfaction by
16 COMPO.

17 Okay, so there was a question about
18 the distribution of responses. And I'll just
19 point these out, because I know this slide's a
20 little tough to see. But this is percent over
21 here.

22 So the percent of responses that we

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1 get of those, 30 days, 120 days, 280 days, and
2 then as we'd expect, we don't get as many
3 responses. And there's just not as many
4 soldiers in after 410 days.

5 Over 85 percent are male, then less
6 than 15 percent female. And then this on the
7 right shows by COMPO. So regular Army, then
8 National Guard, then Army Reserve.

9 Did we assess, basically did we do
10 a non-response bias test? And the GAO asked
11 this. And results were provided them, in March
12 2011 and they accepted the results.

13 So we conducted a non-response
14 analysis. A lot of times with non-response bias
15 tests, you'll go ahead and call those people who
16 didn't respond by mail. Since this is already
17 a telephone survey, we said it just doesn't make
18 sense to do one of those.

19 So we looked at what's the sample,
20 what's the eligible population? How did they
21 respond, and are there differences? So the only
22 thing we found was that the responses that we get

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1 are for people that are slightly older than in
2 the general WTU population.

3 But we found that there was a
4 representation of all demographic categories,
5 and that the bias was consistent over time. So
6 it wasn't changing. And so as I said, GAO
7 approved of the analysis.

8 Okay, how did you modify your survey
9 this year? We haven't modified it since last
10 year. But as I mentioned, with that telephone
11 survey we are switching to a totally email survey
12 next year.

13 And I know there's a lot of issues.
14 Telephone surveys, and I'll just put it out
15 there, telephone surveys are the most expensive
16 survey you can do, more expensive than mail. So
17 we will save a lot of money. But
18 that's not the main reason going there. There's
19 a lot of reason to expect that we'll get just as
20 high of a response rate, or even higher, with
21 this population with an emailed survey.

22 On our regular patient satisfaction

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1 surveys, for just active duty only, because we
2 were getting such a low response rate, we
3 switched to email. And we've already seen over
4 a 50 percent increase.

5 So there's no reason to believe that
6 we wouldn't see that with this. Okay, just the
7 results, this is satisfaction with the overall
8 WTU is that blue line.

9 Satisfaction with the provider is
10 the green line. And as I said, soldiers are very
11 satisfied with their case managers, so the red
12 line right here, above 90 percent.

13 The next slide shows satisfaction
14 with our access to care question. So this blue
15 line down here is satisfaction. And it asks
16 about when you needed care right away, urgent
17 care.

18 The red line asks about when you
19 needed non-urgent care, how satisfied were you
20 with when you got it. And then this green line,
21 it just says treatment down there. But that's
22 actually treatment for counseling and other

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1 behavioral health issues.

2 Okay, this slide shows satisfaction
3 by the number of days in, those days, 30 days,
4 120 days, 280 days, and 410 days.

5 And so on the left we have active
6 component. And it shows that they actually get
7 less satisfied the longer they're in a WTU.

8 And Guard, we do see a bump up at the
9 410 days, and the same we get with Reserve, a
10 slight drop at 120, 280, and then a bump up again
11 at 410 days.

12 Okay, before I go on to the medical
13 evaluation board survey, are there questions
14 just on the WTU survey?

15 MEMBER MUSTION: Can I ask one
16 question? Looking back at your access to care
17 chart?

18 DR. GLINER: Sure.

19 MEMBER MUSTION: It's like, I don't
20 know, a five percent drop between the period of
21 March of 2012 to August of 2012, just in the
22 urgent care, with a similar line for the

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1 non-urgent care, although not as significant of
2 a dip.

3 DR. GLINER: That drop right there.

4 MEMBER MUSTION: Did something
5 happen during that six month window? Because it
6 looks like it --

7 DR. GLINER: Yes.

8 MEMBER MUSTION: -- rebounded
9 effectively to about where you started the
10 survey over a year ago, towards the end.

11 DR. GLINER: Yes. I can ask my
12 counterparts in the WTC if there was anything
13 significant, whether we had a surge right there
14 of people entering.

15 But I wasn't aware of, it may be
16 looking at access to care in just our regular
17 surveys to see if we saw a drop.

18 BG BISHOP: I can't say that this is
19 the case, sir, but we did have a large influx of
20 OCONUS IDES transfers who don't require WTU
21 care. But they needed a home. So that may have
22 overburdened the cadre, which may have led to a

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1 drop.

2 DR. GLINER: Thanks, sir.

3 MEMBER PHILLIPS: Just a question
4 on the cohorts, from 30 out to 410 days. Do you
5 know are these the same people that are answering
6 the surveys? Or are they coming in and out?

7 DR. GLINER: Sir, that is a good
8 question. When we've looked at that, they are
9 some of the same people, some different though.

10 Since it's not the same as when I
11 talked about the IDES or the MEB survey, it's
12 actually a cohort study. So we'll be surveying
13 the same people across time. But these are
14 some, but others no.

15 It could be a new person that didn't
16 answer the survey, even though they would have
17 gotten the phone call. At 30 days it's not
18 necessarily them that were there answering it.
19 Very good question, thanks.

20 MS. DAILEY: No way to break this
21 out by grade, Doctor Gliner?

22 DR. GLINER: Yes, ma'am. I

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1 definitely can break it out by grade.

2 MS. DAILEY: Okay. We'll take that
3 as a follow-up. We would like it broken out by
4 grade.

5 DR. GLINER: Okay, sure. My
6 hypothesis, or at least what we find in our
7 patient satisfaction surveys, is that there are
8 differences by grade.

9 But it more relates to age. I know
10 in healthcare the older you are the higher you
11 rate your satisfaction. So I'm not sure if we
12 would see that here too. But I can absolutely
13 provide that as a follow-up.

14 Okay, now I'm going to transition
15 over to talking about, actually we call it the
16 medical evaluation board survey. We're
17 switching that to become the IDES survey.

18 And the reason for that is that, as
19 I mentioned, this is a cohort survey, so that we
20 survey soldiers at three points in the process.
21 That's after about 30 days, after about 90 days,
22 and then at about 250 days.

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1 So what we were seeing is that, wait
2 a second, a lot of these people have been through
3 the PEB process at that point. And so we have
4 some of those questions on the third contact.

5 We have some base questions on each
6 of the contacts, but then some that are just
7 specific to where they should be at that phase,
8 or after that number of days.

9 So as I mentioned, we surveyed at
10 three different points in time. The first
11 contact is done by phone. And the second and
12 third are done by email, with a link to the
13 questionnaire on the Web.

14 And part of the reason for that is
15 we can get buy-in on the telephone, but we can
16 also confirm their email address.

17 So the surveys, we started out as a
18 census, but we just had more people coming in
19 than we thought. So right now it's dropped to
20 a stratified random sample.

21 So it becomes a census at a location
22 that may have a smaller MEB or IDES population,

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1 like a Fort Jackson, or a Puerto Rico, or just
2 those smaller places.

3 And the response rate for the first
4 contact is approximately 35 to 40 percent. We
5 don't know yet about the second and third
6 contacts. But it's certainly lower than that,
7 which was a little disappointing, we thought.

8 But we know that in any panel sort
9 of study that just happens. So if we continue
10 to see that though, with low response rates in
11 the second and third contact, we'll look at
12 different ways to possibly do that, whether this
13 population may just respond better by telephone.

14 So the questionnaire asks about the
15 PEBLO, the physician, the legal counsel, the
16 IDES Handbook, the fairness of the process, and
17 then outcomes and expectations.

18 There's also a knowledge test on
19 there. And we ask true or false questions.
20 When we tried this survey, and I'll talk about
21 that a little, back in 2010 I guess, it's been
22 a long time, we found that knowledge of the

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1 system was a big predictor of satisfaction, and
2 helping you go through the system.

3 So our results, satisfaction is
4 currently at 72 percent. That's actually,
5 we're improving.

6 And I know that OSD will brief on the
7 survey of ill and injured soldiers, maybe in a
8 couple of months. I believe they're supposed to
9 brief the task force. And they find a little bit
10 lower overall satisfaction. Top

11 predictors, fairness of the system, the PEBLO,
12 and then knowledge of the system. Legal counsel
13 and use of the Disability Handbook are also
14 important. I don't know how to get rid of that
15 square on the screen. Oh, thank you.

16 The way ahead, continued
17 collaboration with the IDES task force, and look
18 at changes in satisfaction over time, as well as
19 outcomes related to PEBLO training. So
20 working with the IDES task force so we can see,
21 okay, which areas have gone through PEBLO
22 training, and then is satisfaction at those

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1 locations increasing. Same with the WTU
2 survey, this is the break-out of responses. So
3 male, 86 percent, female a little over 13
4 percent. COMPOS 1, 2, and 3, and then this one
5 does have a break-out by rank.

6 The MEB survey is still too new to
7 determine issues with non-response. So if we
8 see that it's low, in the future we will
9 absolutely do a non-response bias test.

10 Now, this question, similar to the
11 WTU question, asked if we've modified the
12 survey. Since it's new, we haven't modified it.

13 We did implement, as I mentioned
14 earlier, an MEB survey in the summer of 2010.
15 However, it was only to those soldiers who were
16 also in a WTU. So we really weren't getting a
17 representation of soldiers in the IDES process.

18 And the questions were really
19 becoming outdated, due to the IDES. So the
20 survey was modified, of course, to include all
21 soldiers going through the process, and changed
22 to a cohort study.

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1 And in the future we'll look at
2 response rates, especially with those second and
3 third contacts, because they dropped off. So
4 far that's what we're seeing from the first
5 contact.

6 So some of the results now, overall
7 satisfaction was highly correlated with PEBLO
8 satisfaction, understanding of the process, and
9 perception of fairness with the process. And
10 PEBLO training teams are currently conducting
11 training of PEBLOs. So we'll see if that makes
12 a difference.

13 This chart gives an example, I'll
14 point, I know it's a lot of squiggly lines. This
15 black line looks at the first contact only. And
16 these are when soldiers started the process.

17 And then this dotted line so far is
18 Army's second contact. So we see that that
19 actually is improving over time. And then we
20 just put one MTF up here, San Antonio.

21 It's hard to make any conclusions
22 right now, because the number of responses is low

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1 at each individual MTF.

2 Fairness of the MEB process, those
3 scores are lower than satisfaction with the
4 PEBLO. And I know this looks very low. This is
5 the San Antonio second contact. But the end
6 right there is really low.

7 So again, just really hard to make
8 conclusions about that. But we can see that
9 their perception of fairness with the process is
10 lower than some other things, like satisfaction
11 with the PEBLO.

12 The MEB knowledge test, these were
13 questions, again, that we added to see are these
14 predictors of satisfaction. And we want to know
15 are these getting, we can look at the same
16 soldiers and see if their answers to these are
17 improving over time.

18 If a soldier disagrees, he or she has
19 seven days to submit a rebuttal. The impartial,
20 actually that's changed to impartial medical
21 review, the PEBs, what are some of these others?

22 The soldier has ten calendar days to

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1 concur, non-concur. And the Army only rates
2 those conditions that result in the soldier
3 being unfit for duty. Whereas the VA rates the
4 soldiers for all conditions incurred, or
5 aggravated by military service.

6 And then up here are the results of the
7 knowledge test. Most did fairly well. Actually
8 one of those questions on the knowledge test is
9 incorrect. I'm not going to ask anyone to say
10 which one of those is incorrect. But we
11 couldn't put them all as answers to be true.

12 And then just some conclusions down
13 here. So that if we want to increase scores,
14 soldiers must feel that the process is fair, and
15 be satisfied with their PEBLO.

16 A key factor is knowledge of the
17 system. To increase knowledge, soldiers should
18 be asked about the MEB Handbook and
19 understanding. That's one thing we found,
20 because that is a question on the first contact
21 survey.

22 Did you receive the Handbook, the

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1 IDES Handbook? And did you use it, if you needed
2 answers to questions? And those that rated
3 those positively had actually better
4 understanding of the system. So that was good
5 to see.

6 And I believe that's it. Are there
7 questions either about the MEB or IDES survey,
8 or back at the WTU survey?

9 CO-CHAIR NATHAN: So, Doctor, if I
10 could ask you, what would be your cocktail party
11 sound bite that you took away from this survey?

12 If somebody came up to you and said,
13 hey, after all this work in the statistical
14 analysis, and the great response rate you got,
15 and everything else, what can you tell us about
16 the health of the questionnaire? What did you
17 glean from this, as far as what people like and
18 don't like?

19 DR. GLINER: Well, and I have to
20 admit that there are some things that aren't
21 shown up there. But I would say that soldiers
22 very much, I've seen improvement, that soldiers

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1 feel like they're more taken care of as far as
2 their provider, both the PEBLO and the case
3 manager with the WTU survey.

4 The other thing that I didn't show,
5 I just can only show so many slides, are some of
6 those satisfaction with the non-medical issues.
7 So that's definitely a sound bite.

8 I would say when we first started
9 doing this, living quarters, things like
10 transportation, and it wasn't only that the
11 percentages were down, but that we got a lot of
12 comments.

13 People said, I don't have
14 transportation to my medical appointments, to
15 this, to that. And so we've seen a lot of those
16 verbatim comments from soldiers just either go
17 away or disappear.

18 And one of the lowest that we used
19 to see was satisfaction with orders. So we
20 changed that. We said what type of orders, and
21 orders processing. That's also improved quite
22 a bit.

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1 As far as the MEB process, and I
2 think that's been acknowledged, we're
3 improving. But there's this perception that it
4 might not be a fair process, and that that's
5 related also to having knowledge of the system.
6 So do we need to do a better job with educating
7 our soldiers as they go through the process?

8 The things that we're looking at
9 that we haven't seen yet are in that third
10 contact. Because if I was out at a party right
11 now, someone would tell me, well, mostly you have
12 it all wrong. The only thing they want to know
13 is their final percentage. And that's it.

14 And we haven't seen that yet. But
15 we haven't analyzed the third contact data yet.
16 We don't ask them what their actual percentage
17 was.

18 But we do ask if they received both
19 the Army and the VA, and if what they received
20 met their expectations. So we'll see if that's
21 ultimately then on that last survey, if that's
22 really the satisfaction measure.

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1 MEMBER PHILLIPS: Just related to
2 the surveys, they're all reported percentages,
3 and you did mention. Would it be possible to get
4 some of the raw numbers to see? Are we talking
5 about 50 or 5,000?

6 DR. GLINER: Sure, absolutely.
7 You mean like to look at the number of soldiers
8 that represent those responses? Absolutely.
9 In fact, I can re-submit those with just a
10 spreadsheet at the bottom.

11 And when I say percent satisfied, I
12 guess I didn't really mention that. These are
13 typically Likert type five point scales, so
14 usually satisfied means putting four or five on
15 a five point scale.

16 CO-CHAIR NATHAN: So overall,
17 basically good news. Quality of life issues
18 seem to have improved significantly.

19 DR. GLINER: Yes, sir.

20 CO-CHAIR NATHAN: That area that
21 centers around what my pay may be, after the
22 service, still invites a lot of scrutiny,

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1 suspicion, and some discontent, which doesn't
2 surprise me. Other questions?

3 CO-CHAIR CROCKETT-JONES: Just
4 when we do finally get an idea of that third
5 contact, it would be interesting to see how that
6 particular question you're saying you asked, did
7 you get what you expected.

8 DR. GLINER: Right.

9 CO-CHAIR CROCKETT-JONES: That
10 would be very interesting to see it by the rank
11 differentiation on that question. I'm very
12 interested.

13 DR. GLINER: Sure. Yes, ma'am. I
14 can absolutely do that. We're looking forward
15 to getting those data in.

16 MS. DAILEY: And I didn't expect to
17 get an MEB layout. Thank you, Doctor Gliner.

18 DR. GLINER: You're welcome.

19 MS. DAILEY: However, at the same
20 time I know that the Warrior Transition Office
21 at OSD does a survey. And then we'll get another
22 one from Health Affairs, all touching on MEB.

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1 What drove you all to do another
2 survey for MEB? And what about these other
3 surveys that aren't meeting your requirement,
4 that you started another one?

5 DR. GLINER: That's a very good
6 question, especially when people say, oh my
7 gosh, isn't this population just so over
8 surveyed.

9 MS. DAILEY: As a matter of fact,
10 you said that before.

11 DR. GLINER: Oh, did I. Okay, I
12 guess I should take it all back now. So, let's
13 see. One thing, we have actually talked to the,
14 I guess it's OSD that's doing that separate MEB
15 survey.

16 The results that we were getting, we
17 couldn't get results down to the level that we
18 wanted. And I don't know if I can say that here.
19 I guess I will. They're actually talking about
20 maybe stopping that survey.

21 We spoke with them about a month ago.
22 They were retooling it, because I believe it

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1 stopped for at least a year. And whether they
2 were going to start it up again was a question.

3 Now, the ill and injured survey, I
4 believe Doctor Bannock will come speak with you.
5 We sit on the survey committee together. And so
6 that's certainly hitting a different
7 population.

8 So he's surveying soldiers, airmen,
9 sailors, that have been medevaced out of
10 theater, and then may have gone through the
11 process, may have not. And so he just asks, I
12 think, one question about the MEB process, and
13 one question about the PEB process.

14 MEMBER STONE: Melissa, let me tell
15 you, these surveys help us tremendously from a
16 management standpoint. We just talked about a
17 question of do we have the right number of
18 attorneys.

19 That is anecdotal. It's a huge
20 investment. But it's anecdotal unless you are
21 able to come back to us and say, look, you are
22 correct in putting attorneys at this level and

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1 at this point. Here's where it delivers
2 satisfaction.

3 One of the things we've questioned
4 is the dissatisfaction with the system in the
5 active component. We go this way in the active
6 component, and this way in the Reserve
7 component.

8 At 410 days are we really looking at
9 an unemployed COMPO 2 and 3 service member? And
10 therefore, their satisfaction relates to the
11 fact that they still have a source of income,
12 having nothing to do really with this process.

13 But it's really about taking care of
14 their families. And so these are very valuable
15 to us as we look at how to make the investment
16 in the system.

17 DR. GLINER: Yes, sir. Thank you.
18 And that slide always brings up some under the
19 breath talk when I show the differences in COMPO.
20 But yes, I think it's a good point.

21 MS. DAILEY: And then your finding about
22 a low satisfaction with pain management,

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1 anything being done to fix that? What's the
2 outcome of that finding?

3 DR. GLINER: We're working very
4 closely with the pain management task force.
5 And so they're working at getting these
6 different modalities at the different
7 locations.

8 And it wasn't so much of a surprise
9 that those were going to be lower scores. But
10 we provide them with the data every month. So
11 they're really taking that on and trying to make
12 big improvements.

13 MS. DAILEY: And then my last
14 question would be is this helpful? Is the WTU
15 survey helpful to you, General Bishop? Are you
16 able to use it at its current level of fidelity?

17 BG BISHOP: Ma'am, frankly I'm
18 satisfied that our soldiers are being cared for
19 properly, and that they're registering an 80
20 percent satisfaction rate with their care.

21 But that's mostly medical care, as it's
22 represented right now. And I think it also

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1 gives indications in time as to whether or not
2 actions or decisions that are made are impacting
3 the overall impact of the program.

4 For example, last summer we had so many
5 soldiers from Europe come in. I think that had
6 an impact. I would like to get into some of the
7 rubber meets the road satisfaction detail, that
8 I'll work with Doctor Gliner to help drive our
9 training.

10 MS. DAILEY: So would we. So if you
11 do that, and go down those roads, we'll ask you
12 back for that information.

13 BG BISHOP: Absolutely, thank you.

14 MEMBER MUSTION: Can I ask a
15 question? Does your survey on the fairness of
16 the MEB process, looking back at that data a
17 couple of charts back on the first time year,
18 they are at your first contact somewhere around
19 a 50 percent, I guess it's a fair kind of answer.

20 DR. GLINER: Yes, sir.

21 MEMBER MUSTION: The second time
22 you contact, a drop of about, I don't know, 20

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1 percent, 15 to 20 percent. But in your
2 questioning are you able to identify why
3 soldiers don't believe it's a fair process?

4 DR. GLINER: Sir, that's a very good
5 question. That's one of those questions,
6 actually, that we had talked about, especially
7 on the second and third contacts it makes it a
8 little easier since it's on the Web, to put an
9 open ended box.

10 Because we've added a couple open
11 ended boxes to some of those, like overall
12 satisfaction with the PEBLO on the second and
13 third contacts.

14 So I'm not sure if that's one of the
15 ones that we did. But that will certainly help
16 us, just getting verbatim comments from
17 soldiers.

18 But other than that, there's not a
19 lot of, since it is just one single question,
20 that we don't have a follow-on right now.

21 MEMBER MUSTION: Okay. I think
22 that would be very instructive, if we ever get

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1 to that level of information.

2 Another question I was going to ask
3 you, in your WTU survey, the population that was
4 surveyed, or that you indicated was surveyed, is
5 about 80 percent active component.

6 But yet the WTC is only about 40 to
7 50 percent composed of active component
8 soldiers. Dave, correct me if I'm wrong, but I
9 think was from an earlier discussion.

10 BG BISHOP: That's right, sir.

11 MEMBER MUSTION: So are you
12 over-surveying the active component?

13 DR. GLINER: This is a --

14 MEMBER MUSTION: Are you trying to
15 stick to a --

16 DR. GLINER: This is on the WTU's
17 survey, right?

18 MEMBER MUSTION: Right.

19 DR. GLINER: So I guess we get
20 about, well --

21 MEMBER MUSTION: Okay, I was
22 reading it backwards.

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1 DR. GLINER: Oh, okay, yes.

2 MEMBER MUSTION: So it makes sense.

3 DR. GLINER: It's about --

4 MEMBER MUSTION: That's about
5 right.

6 DR. GLINER: Yes.

7 MEMBER MUSTION: And the other
8 question, maybe you answered this earlier. But
9 are you talking to the same person at each
10 particular point?

11 DR. GLINER: Some of them are, but
12 some of them are not. In the MEB survey, they
13 are, absolutely, because it's a cohort. We
14 follow them at three points in time.

15 But not in the WTU survey, for
16 example, some of them yes, so that this soldier
17 at 410 days may have also responded at 210, 120,
18 and 30.

19 But they're not all the same. So,
20 yes. But I believe a lot of them are. Because
21 there's a good chance that if we were able to
22 contact them once that we're able to contact them

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1 again. The phone number's good.

2 CO-CHAIR NATHAN: Thank you very much,
3 Doctor Gliner. This is informative, it's a
4 great update, and we look forward to the next
5 update as you give us the third parts. Thank
6 you.

7 At this time we still have a little
8 bit of time left. We won't be able to get into
9 all of the questions. But I think a couple of
10 them are significant.

11 As we look at the family caregiver
12 support, one of the discussions, in family care
13 and family satisfaction in how they're doing,
14 that came up one day in the tank at the Joint
15 Chiefs, was the fact that now when somebody --
16 and we've talked about people who have been hurt
17 since 10 or 12 years ago that we're still
18 following -- but now when somebody suffers an
19 injury, a family suffers a injury or a severe
20 illness, it comes after many of them have been
21 on recurrent deployments.

22 Many of them are already exhausted.

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1 They ran out of their reserve maybe two to three
2 deployments ago. And they're on their last one.

3 And all of a sudden they get hurt.
4 And now the families that we see, and the
5 caregivers that we see taking care of wounded
6 warriors and recovering warriors, in 2013 do not
7 have the same energy level in many cases as those
8 families that had to respond in 2001.

9 And so this is something that I've always
10 been very interested in. How are we monitoring
11 what we're doing to take care of our families and
12 our caregivers for recovering warriors? So if
13 we could, I'll ask the group that's still here,
14 Colonel Jones?

15 COL. JONES: Yes, sir. So there's
16 a couple of things. We do use the surveys that
17 Doctor Gliner discussed. We could break that
18 down by region, and I can tell that a nurse case
19 manager in one region may not be doing well, as
20 far as taking care of the families and the
21 soldiers.

22 So we can identify and pinpoint, and

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1 say, you know what, is there a burnout issues?
2 Is there some other issue going on? So we can
3 use that fine detail to help out the individual
4 units.

5 But the other things that we do is
6 we really work and encourage our leaders to get
7 out and talk to the soldiers and their families.

8 And that's one thing that we found
9 is really increasing our knowledge base of
10 what's going on with our families and our
11 soldiers.

12 Surveys can provide you with an
13 overall viewpoint, but getting to the
14 granularity and figuring out what's going on,
15 that involves leader engagement with our
16 soldiers.

17 So we really have encouraged our
18 leaders to get out from behind the desk, go talk
19 to the soldiers, do command climate surveys, do
20 sensing sessions, do all of those things that are
21 going to get you the information to understand
22 where our deficits are so we can fix them.

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1 Some of the other things that we've
2 used, we have a number of senior leaders that go
3 out on visits and visit our WTUs at our
4 installations.

5 We use all of the data that they
6 bring back to see if we can enhance our program.
7 For example, in the summer of last year, we had
8 a number of leaders that went to several
9 different units and brought back information.

10 One of the things that they brought
11 back was that our soldiers were very unfamiliar
12 with IDES, and their families were unfamiliar
13 with IDES from the very beginning. So
14 one of the things that the WTC did is we created
15 a IDES familiarization brief. And that is now
16 briefed to all of our soldiers. And we track
17 that, and their families.

18 And we track it through our AWCTS
19 system, which is our Army Warrior Care and
20 Transition System. So we know who's actually
21 received that brief.

22 And then later on we're going to get

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1 to is it beneficial. We can tie that into the
2 IDES population to see if it's helping them or
3 not. So we do use all of the data that we can
4 to see where we need to enhance our programs.

5 The other thing is we, at the WTC,
6 are now tracking some of the individual cases
7 that come up to the WTC level to see if there's
8 any systemic issues going on.

9 So we're monitoring our families and
10 our soldiers in many different ways, so that we
11 can come up with solutions and fix systemic
12 problems. Subject to your questions, sir.

13 CO-CHAIR NATHAN: Okay, questions,
14 comments? Thank you. So basically what we
15 hear is you're trying to create a culture of
16 leadership, being sort of intrusive leaders
17 going out, talking to the families, talking to
18 the caregivers.

19 You've got also some active programs
20 going on where you can survey the families
21 through the WTC survey. We would call that
22 active sonar versus passive sonar, active sonar,

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1 I'm pinging you to try to get a response back.

2 And these are important. Because
3 oftentimes the first time we notice that the
4 family really fails, or the caregiver fails, is
5 when they break.

6 They don't bend. We don't see them
7 bending. We see them break. And so we're
8 always looking for something that can give us
9 some clue that people are in distress.

10 And again, as I say, it's after 12
11 years of this. I think a lot of people who get
12 hit with this for the first time now they're
13 running on battery.

14 I think we have time for the next
15 question as well, which is PTSD services.

16 LTC BRUSHER: Yes, sir. The
17 question was, essentially, will changes in the
18 proposed DSM-5 specific to PTSD cause, I think,
19 an increase in diagnoses and then an increase in
20 our demand signature for the services that we
21 currently provide.

22 I've listed the primary changes that

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1 are expected to be published. DSM-V is expected
2 to come out in May of this year. Bottom line is
3 the overall prevalence between the DSM-IV, and
4 what's going to be expected to be published in
5 DSM-V is we don't think that it's going to
6 significantly change the number of PTSD cases
7 that will be diagnosed.

8 The most significant change, other
9 than the categorization shifts, is the
10 elimination of Criteria A2, which under DSM-IV
11 is when you're exposed to a traumatic event then
12 post-event you experience some type of fear
13 response that then becomes a symptom that's
14 required in order to qualify for a PTSD
15 diagnosis.

16 That has been removed in DSM-V. So
17 theoretically potentially could generate new
18 PTSD diagnoses, because they meet the
19 requirements of all other categories, and now no
20 longer will have to have a fear response.

21 But within Army we already published in
22 April of 2012, in our policy guidance that I

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1 mentioned earlier, that we effectively
2 authorized our providers to go ahead if you meet
3 all the criteria for PTSD, with the exception of
4 A2.

5 Because we know that soldiers,
6 because of training and the way we process them
7 through, don't often experience the fear
8 reaction that civilians might when they're
9 exposed to a trauma.

10 So we already wrote in to our policy
11 that if you meet all the other criteria, we
12 authorize you, essentially, the diagnosis of
13 PTSD.

14 So that was intended to be in
15 alignment with the coming changes for DSM-V.
16 And so at the end of the day we don't think that
17 it's going to generate a substantive increase on
18 our demand related to the clinical services that
19 we currently offer.

20 CO-CHAIR NATHAN: So what you said
21 is the prevalence will be similar to what it
22 currently is in the DSM-IV. Bottom line, with

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1 the new classification system, five versus four,
2 do you see us picking up new diagnoses?

3 LTC BRUSHER: Not significantly,
4 no, sir.

5 CO-CHAIR NATHAN: Do you see us
6 dropping any diagnoses?

7 LTC BRUSHER: It'll be about the
8 same.

9 CO-CHAIR NATHAN: Okay. And in the
10 private sector, do you see any incentives for
11 pay, or for fee for service as they code the E&Ms,
12 and the CPTs, and the ICD-9s?

13 Do you see any change in how any of
14 our soldiers that are migrated to the private
15 sector being followed by a private physician
16 will be handled any differently, or diagnosed
17 any differently, based on fee for service of the
18 classification?

19 LTC BRUSHER: It's beyond my
20 ability to respond to, sir. I'm not familiar
21 with the compensation on the purchased care
22 side.

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1 The diagnosis itself, we don't think
2 it's going to be increased. And if there is any
3 increase at all it'll be minimal. If they are
4 diagnosed with PTSD because they meet the new
5 requirements, then certainly they'll be
6 eligible for care under that diagnosis.

7 CO-CHAIR NATHAN: Okay. Not too
8 much to worry about then, apparently. Thank
9 you. And then our last question under
10 vocational services.

11 MS. ADAMS: Yes, sir. I was asked
12 to respond to the question about how many
13 recovering warriors are currently eligible to
14 participate in career and education activities,
15 specifically apprenticeships, internships, and
16 educational opportunities, and to respond too to
17 interest in NDAA '12 as it relates to internships
18 with private companies.

19 When I spoke to you all last year,
20 I let you know at that time that we've
21 established criteria for somebody to be
22 considered eligible to participate in career and

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1 education readiness activities.

2 They have to be determined eligible
3 by both the medical team and the command team to
4 participate in CER activities. It is a
5 disciplined process that's reviewed in the
6 triad.

7 And a decision is made and passed to
8 the transition coordinator that soldiers are
9 eligible to participate in activities.

10 Right now, in our units,
11 approximately 50 percent, excuse me, I'm sorry,
12 72 percent of the soldiers were eligible to
13 participate in January in career and education
14 activities.

15 And of that, 613 of those were
16 participating in what we would call a Federal,
17 or an Operation War Fighter internship
18 opportunity.

19 We are working with Warrior Care
20 Program Office under Defense Under-Secretary of
21 Personnel and Readiness in warrior care policy,
22 USSOCOM, and other DoD agencies in drafting the

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1 DoD instruction to interpret the law with NDAA
2 '12 regarding internships in the private sector.

3 It hasn't been signed yet. We're
4 still awaiting signature on that. So that's
5 still in process.

6 There are significant risks
7 associated with non-Federal internships. So
8 while we would like to put soldiers out in
9 private workplaces, and work in state and local
10 Government, we're holding back on doing that so
11 that we do this thing right, and not quick.

12 MEMBER EVANS: I'm sorry, I thought
13 last year we were briefed that was signed.
14 That's not signed?

15 MS. ADAMS: Pardon?

16 MS. DAILEY: The DTM was signed in
17 December. The DTM for this was signed in
18 December, implementing the VOW. It mirrors the
19 language of the NDAA '12. What were you
20 expecting? Because the DTM has been out on the
21 street since December.

22 MS. ADAMS: Referring to DoD

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1 1300.jj.

2 MS. DAILEY: Yes. It's now a DTM.
3 It was published in December. That's our
4 interpretation that opens the door for service
5 development of their implementing instructions.
6 And I'll send the DTM to you. And we'll see if
7 we're talking about the same guidance.

8 MS. ADAMS: I think we're talking
9 about different documents, ma'am. But yes, we
10 can confirm that.

11 MS. DAILEY: We're under the
12 impression of the task force that, that DoDI
13 1300.jj has been implemented in a DTM published
14 in December. But I'll send it to you and you all
15 can take a look at it.

16 MS. ADAMS: Okay. We have been
17 continuing to work almost every single week with
18 Warrior Care Program Office. So last word we
19 got, and perhaps we are talking about different
20 DoD instructions, is that we do not yet have the
21 guidance to go out and allow soldiers to do
22 private internships.

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1 MS. DAILEY: Yes, the last time I
2 talked with them they had punted that over to the
3 Task Force for Implementation of the VOW Act.

4 And that's where that guidance would
5 be coming from. So you would find it coming from
6 the Transition Office, the Office of Transition,
7 coming out of the initiatives to implement VOW.

8 MS. ADAMS: Okay.

9 MS. DAILEY: So I'll send you that
10 DTM. We are getting a little concerned.
11 Everywhere we go your soldiers want access to the
12 civilian sector for internships.

13 And we do keep telling them it's
14 coming. But we're under the impression that it
15 came in December. But I'll send you the DTM.

16 MS. ADAMS: Okay, thank you.

17 CO-CHAIR NATHAN: A quick question.
18 You say 72 percent of the soldiers who are
19 eligible participated in career and education
20 readiness program. What's your definition of
21 participated?

22 MS. ADAMS: They have an

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1 opportunity to choose from a variety of
2 different activities. Those that are staying
3 in the Army can work in what we call a Remain in
4 the Army Work Assignment.

5 That would typically be doing a job
6 on post or in a Guard Armory that a green suiter
7 would be doing, that they would be doing in their
8 own MOS.

9 They can do an Operation Warfighter
10 assignment. We have a few soldiers that are
11 doing coming home to work assignments as part of
12 a VA program that mirrors the Operation
13 Warfighter Program.

14 And a large portion of our soldiers
15 are doing education. They're taking college
16 classes using tuition assistance, sir.

17 CO-CHAIR NATHAN: Okay. Again, we
18 were talking about this at the break, some of the
19 members here. And one of the problems is that
20 we have some of these folks sitting around
21 spinning their wheels being assigned to various
22 activities where they really don't find

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1 themselves usefully employed, or feel they're
2 making forward motion.

3 So anything we can do from the task
4 force standpoint to try to accelerate the
5 socialization, the interaction, the ability of
6 the recovering warrior to feel that either
7 they're getting useful skill, or they're being
8 productive, or they're gainfully employed, or
9 they're making better use of their time,
10 anecdotally I think most of us who've been around
11 that, that's a world of good.

12 Plus we want to try to capture what
13 I think is America's intent right now to try to
14 embrace and take aboard recovering warriors into
15 the workplace, under internships.

16 There will come a point, I worry,
17 that will start to extinguish as time goes on.
18 And right now there's a hunger out there in the
19 American workplace to try to engage and embrace
20 our recovering warriors and give them a hand up,
21 a leg up, a boost.

22 So whatever we can do to support, so

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1 that we don't get bogged down in red tape, or
2 waiting for every light to turn green before we
3 send these folks out.

4 MS. ADAMS: Yes, sir. One of the
5 things that we have started actively engaging on
6 is making sure that our soldiers are making that
7 mandatory appointment with a VA VR&E counselor,
8 that have been put on the installations, to start
9 their vocational rehabilitation process if
10 they're eligible to participate in that program.

11 Part of that interview and office
12 visit, if the soldier decides that they want to
13 participate in VR&E services, is some career
14 assessment and testing, and counseling to help
15 them get a little more focused on what it is that
16 they might want to do.

17 So we've started actively doing
18 that, so that we're focusing them and moving them
19 through that process.

20 CO-CHAIR NATHAN: Any other
21 questions, comments, concerns, questions?

22 MS. DAILEY: Just looking through

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1 my source of all knowledge here, my Blackberry,
2 we have DTM-12-007, which addresses TAP. And we
3 think the implementing instructions for
4 civilian opportunities is imbedded in that DTM.

5 And the DoDI 17jj, we're under the
6 impression that's the Department of Defense
7 instruction for Federal internships. And the
8 non-Federal piece and civilian piece is imbedded
9 in the DTM-12-007.

10 MS. ADAMS: Okay. I'll go back and
11 check that with the Warrior Care Program Office.
12 Thank you.

13 CO-CHAIR CROCKETT-JONES: I think
14 we covered all the questions, even though we
15 weren't sure we were going to have time. I think
16 that's pretty impressive.

17 MS. DAILEY: Thank you. Well done.

18 CO-CHAIR CROCKETT-JONES: You can
19 breathe a sigh of relief, Denise.

20 CO-CHAIR NATHAN: Anything else
21 administratively before lunch?

22 MS. DAILEY: Thank you all very

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1 much.

2 CO-CHAIR NATHAN: Thank you very
3 much for your participation.

4 MS. DAILEY: Appreciate you sitting
5 there for three hours --

6 CO-CHAIR NATHAN: Thank you for the
7 information.

8 MS. DAILEY: -- four hours. Thank
9 you.

10 (Whereupon, the above-entitled
11 matter went off the record at 12:45 p.m. and
12 resumed at 1:58 p.m.)

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1 Sir.

2 MR. LARRY: Yes, sir, thank you.
3 And thank you for the slight knock on, take on
4 the Air Force there. We are honored to be here
5 with you. Honored because we look at your great
6 careers and contributions, and sacrifices.

7 I'll tell you, thank you for the
8 opportunity just to be in your presence today.
9 And we're thrilled because we get an opportunity
10 today to link back to, follow on to our sessions
11 last year.

12 And I know that in between there you
13 had an opportunity to visit the Air Force
14 Personnel Center at Randolph, at least some of
15 you. So we thank you for that. Because that is
16 truly, to us, one of the foundational elements
17 of what we are all about, and the way that we go
18 about delivering what we do every day in terms
19 of taking care of our team.

20 So today, I'm really honored to be
21 here with you. My boss is Lieutenant General
22 Darrell Jones, an A1 for the Air Force, a

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1 director of manpower, personnel, and services.
2 He has to be off site. He's in Maxwell, Alabama,
3 along with my direct boss, Brigadier General
4 Eden Murrie.

5 And part of the things they are doing
6 there is talking through our next round of
7 installation and group commanders, partially
8 about how to take care of wounded warriors.
9 What it means, what the constructs are, and how
10 we do it, in excruciating detail.

11 Recognizing that what we do is not
12 only the right thing to do for our Airmen, but
13 a smart thing to do for our Air Force. So that's
14 the post that we have from our Secretary, to our
15 Chief of Staff on down, in terms of recognizing
16 these members deserve the very best, regardless
17 of the color of uniform or their situation.

18 And that's what we are focused on
19 every day. So today what we'll do, especially
20 as we respond to your questions, we have captured
21 them kind of in a briefing format, to ensure that
22 we are spot on in responding to your questions.

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1 And we are readily available and
2 alert in responding to any follow on questions.
3 Those ideas or concepts you may have or want to
4 discuss.

5 So to lead us off today we have
6 Colonel Nick DeMarco. Nick has about 31 years
7 in the Air Force. He grew up in the track of
8 taking care of airmen and family. And his role
9 now is the Chief of our Airman and Family Care
10 Division.

11 Nick DeMarco will start off, and be
12 followed by, over here on my right, Colonel Todd
13 Poindexter, who is one of our great medical pros
14 in the family practice arena.

15 And I notice in looking at his bio
16 again that he's not only a great family
17 practitioner, he's also a family practitioner
18 diplomat. You'll hear a bit about that later
19 on.

20 And then from there of course we'll
21 have, per your request, a RAND with just some
22 information regarding the study they conducted

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1 about taking care of our wounded, ill, and
2 injured. And that will primarily be led by Ms.
3 Carra Sims.

4 So with that, again, we're awfully
5 glad to have this opportunity. We know and
6 truly recognize that everything that we do is all
7 vetted towards providing that care of continuum,
8 that care over life cycle from the day that our
9 member may be injured, until we transition them
10 to the civilian sector, or back to the civilian
11 life.

12 And then what do we do from there to
13 make sure that they have opportunity to be as
14 productive as they can, as good old U.S. American
15 citizen. So with that, again we thank you. And
16 we turn it over to Colonel DeMarco.

17 COL DEMARCO: Thank you, Mr. Larry.
18 Mike, remind me to leave the number of years I've
19 been in the service out of my comments for Mr.
20 Larry. For some reason it doesn't sound too
21 good, 31 years in the Air Force. I have been for
22 a while. I've seen a lot of things.

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1 I'm glad to be here, sir. Thank you
2 for having us today. I am Colonel Nick DeMarco,
3 the Chief of Airman and Family Care Division.
4 And I'm going to have the opportunity to discuss
5 our Air Force program today. We've made some
6 great strides since last year. And we look
7 forward to sharing our updates with you today.

8 On a personal note though, I just got
9 here a few months ago. I was out at PACAF
10 Headquarters for three years as the Chief of
11 Services there. And I had the opportunity to
12 work alongside an RCC there, Colonel, Retired,
13 Rosemary Norman.

14 And I've got to tell you, working
15 with her for the last couple of years, the care
16 and dedication she brought to her job makes me
17 feel good of the type of folks we have working
18 in the RCC field. Determination,
19 consideration, care, that's what the RCC program
20 is.

21 With me I have a couple of subject
22 matter experts with me. They're going to handle

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1 the hard questions today. Easy questions, hard
2 questions, okay. I have Lieutenant Colonel
3 Mike Wyatt. Mike's the Branch Chief in charge
4 of Warrior and Survivor Care.

5 Mr. Tim Townes, Program Manager for
6 Air Force Survivor Assistance Program. And Ms.
7 Tamara Newton, the Program Manager for the Air
8 Force Airman & Family Readiness Centers.

9 Okay. Here is the nine
10 recommendations you provided us for a status
11 update. I think you'll be pleased with the
12 results. We worked very hard this last year to
13 give you what you need.

14 First recommendation concerning
15 policy guidance. I think as we were here last
16 year there was a gap in guidance. As a matter
17 of fact, the guidance was in final review for
18 signature. AFI 34-1101, the Air Force Warrior
19 Survivor and Care, was published on 21 June 2012.

20 In addition to that, AFI 36-3009,
21 which provides guidance for Airman and Family
22 Care Centers, including support for recovering

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1 warriors, was provided out, was, excuse me,
2 published in March of 2010.

3 Also, not to steal the thunder from
4 the Surgeon General, AFI 41-210, which provides
5 guidance for TRICARE Operations and Patient
6 Administrations was published in 2012, June.
7 These three AFIs provide the basis for
8 standardized care for recovering warriors. Is
9 there any questions?

10 MEMBER STONE: Was 1101 informed by
11 DoD policy that was published?

12 COL DEMARCO: I'm sorry, I didn't --
13 Sir?

14 MEMBER STONE: Was 1101 informed by
15 DoD policy that was published? That
16 recommendation was specifically directed at
17 DoD's failure to publish unifying policy.
18 Therefore, the services have each gone their own
19 way, all well intentioned. Was your 1101
20 informed by published DoD policy?

21 LTCOL WYATT: Yes, sir. Our AFI, a
22 lot of that based on recovery care coordination.

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1 Any directives from the DoD is taken from the
2 DoDIs that are provided from DoD.

3 MEMBER STONE: To my knowledge
4 there is no unifying guidance from DoD at this
5 point.

6 MS. DAILEY: The two items we called
7 out for DoD was the clinical care management, and
8 I can't remember the other one off the top of my
9 head. These three were called out.

10 Our main concern with the AFI was
11 that there had been practice in the AFI, in the
12 Air Force for a very long time. And it had not
13 been captured ever in the updated. So the Task
14 Force's recommendation was to update this AFI so
15 it was capturing its current practices.

16 COL DEMARCO: The next
17 recommendation speaks to the providing access,
18 hard copy documentation of the Comprehensive
19 Recovery Plan to the recovering warrior and
20 their families. We were doing that per our
21 recently published AFI 34-1101.

22 The RCCs are directed to provide

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1 hard copy CRPs to recovering warriors and their
2 families. Now we use the recovery program
3 support solution as the IT program to capture
4 that data, at the moment the recovering warrior
5 and their family's only access to that program.

6 We're still working through some of
7 those things. Though the key thing here is that
8 the Recovery Care Coordinator, the RCC, works
9 very closely with the family and the recovering
10 warrior to make updates to their Comprehensive
11 Recovery Plan, either by hard copy, by email, by
12 fax back and forth.

13 So the family is ensured, the
14 recovering warrior was ensured. They have a
15 hard copy document in their hand as they move
16 through the continuum of care. So our guidance
17 is to make sure the RCCs are providing a hard
18 copy, and they're doing that.

19 What we're looking for here is
20 basically is a constant coordination loop
21 between the family, the recovering warrior, and
22 the recovery team, to ensure they have the

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1 updated CRP in position at all times.

2 The last bullet you'll see there,
3 regarding the ICCC, Mr. Tim Townes is involved
4 in the IT to kind of look at better processes
5 right now with OSD members, to find out ways for
6 the recovering warriors and their families to
7 have access to the RCP-SS solution.

8 So the answer to this question is
9 yes. We're providing hard copy; we're working
10 with the recovering warrior and their families.
11 And whenever there's a change going on through
12 the process, and they're getting hard copy in
13 their hand. Is there any questions?

14 CO-CHAIR NATHAN: So other than the
15 fact that you have, I think somebody used the
16 term earlier today, which I liked, which was
17 inspection versus expectation.

18 Other than the fact that you have a
19 policy that says RCCs are instructed to attach
20 emails confirming receipt of CRPs, do you have
21 anything that goes active sonar to find out if
22 you, how well you're doing in that regard?

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1 COL DEMARCO: You mean whether the
2 family members and the recovering warriors have
3 the actual updated? Sir, that's a constant
4 feedback loop with the RCCs. If there's a
5 metric that has that data available, we do not
6 have that metric.

7 We just rely on the RCCs and the
8 recovery team to continue that. As the
9 recovering warrior are going through the phases
10 of care they're constantly updating that. So
11 it's a constant process. Now if you're asking
12 to find out and develop a metric to look at that,
13 we can.

14 CO-CHAIR NATHAN: I'm just, you
15 know, just wondering if you have a QA process
16 that goes through the files and looks to see if
17 the email is in there that says, I've got it.
18 That's all. I mean, you know, what's your sense
19 of confidence that it's being done?

20 LTCOL WYATT: Sir, we have, under
21 the recovery care coordination contract there's
22 a program manager managing the RCCs for the Air

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1 Force. And under the new contract that was put
2 into place over the past year, we created a
3 position under that contract as for quality
4 assurance and metrics.

5 And the sole purpose of that
6 position is to provide assistance to the program
7 manager. And to gather and track and follow up,
8 and make sure that these things are being taken
9 care of as per the direction to the contract.

10 So that's, as far as a lot of the
11 metrics that are being gathered now, because of
12 the fact that was new at the beginning of the
13 contract, we're still gathering information.
14 But that is definitely a function now that we
15 have.

16 CO-CHAIR NATHAN: Thank you.

17 COL DEMARCO: Sir, I just wanted to
18 provide kind of a new, a good news story, a great
19 initiative we've got working. Right now we
20 provided iPads, actually iPads to our 43 RCCs.
21 It's kind of a great way for us to leverage
22 technology.

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1 So now, when the RCCs are meeting
2 with the recovering warrior and their families,
3 they can actually work through the CRP in front
4 of them with the member, with the family, to go
5 through and input data. It's a great
6 initiative.

7 They have a CAC reader. So this is
8 basically connected to the RCP-SS main server.
9 There's some limitations right now with it
10 though, with the software. Some of the blocks
11 in the iPad information database can only take
12 so many characters.

13 We're working through, it's a new
14 thing, we just turned it, we just provided these
15 in the last six months. But it's still a great
16 initiative. They have the iPads to work with
17 the family. We're working on some solutions to
18 make sure.

19 Our goal is that the RCC will be in
20 front of the family, with the iPad, typing up all
21 updates they have, the family needs to provide
22 during the continuum of care. And this is then

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1 VFR sent to the web server.

2 Right now parts of the CRP in the
3 software can only take so much data, say 15
4 characters, 20 characters. So it's a new
5 process. We're excited about it.

6 And we're working through to our
7 final solution, again, would be the iPad in front
8 of the family, typing in all the data, updating
9 the data, and then having that data sent to the
10 server. So kind of a new initiative. We're
11 kind of excited about it.

12 MEMBER EVANS: That's a great
13 initiative. But, so here we go with the
14 disparity. Do we have that across all services,
15 or just one service?

16 COL DEMARCO: I think it's just the
17 Air Force right now. I'm not sure if the Army
18 or Navy have that.

19 MEMBER EVANS: You have it too,
20 Army?

21 MEMBER STONE: What's your
22 supporting population?

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1 COL DEMARCO: For the recovery, for
2 the wounded warriors in the process now?

3 MEMBER STONE: Yes. I think you
4 said you have 43 RCCs.

5 COL DEMARCO: Yes.

6 MEMBER STONE: How many people do
7 they support?

8 COL DEMARCO: Current numbers?

9 MR. TOWNES: Yes, sir. Currently
10 we're supporting approximately 920 in the RCC
11 program. So our case load ratio right now is
12 about one to 23.

13 MEMBER EVANS: So that's wounded,
14 ill and injured. So you have more, if you did
15 a breakdown of your population, you take care of
16 the injured?

17 MR. TOWNES: Yes, ma'am. We deal
18 with all the wounded, ill and injured. Combat
19 wounded right now in our RCC program is
20 approximately 300, 320. And then the rest are
21 our wounded, seriously ill, and injured.

22 COL DEMARCO: This next slide asks

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1 for training statistics or updates for our
2 training. Currently have 100 percent of our
3 RCCs have been trained at the OSC training site
4 here in the National Capital Region.

5 And about 85 percent, or 23 of the
6 27 non medical case managers have been
7 completing their training. So for the four non
8 medical care managers that are in Randolph that
9 haven't had the training yet, what we're doing
10 is, we're having their lead coordinators at
11 Randolph give them certification training on
12 site there at Randolph, so they can still
13 continue the job.

14 The next training class is in June,
15 this coming June of 2013. We'll get together
16 for NMCM folks trained up. So far we got good
17 training for us. And we're on board to have all
18 the NMCMs trained up by this summer.

19 This next recommendation discussed
20 the support to the recovering warrior and their
21 families. However, we're specifically about
22 the families, without requiring the recovering

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1 warrior's permission.

2 I'll tell you, in the Air Force we
3 encourage them to meet with base support
4 agencies, as I have listed here on the screen,
5 starting from the Commander, all the way down
6 through the chaplain.

7 We have great support networks
8 within the Air Force. We pride ourselves on
9 focusing on the family, and establishing a
10 culture of care for the families. We've got a
11 long history of supporting family programs, such
12 as Year of the Air Force Family, and the Caring
13 for People Forum.

14 And I think one of the key things
15 here, if I can use this pointer without stabbing
16 Mr. Larry in the eye with this laser thing, is
17 on the bottom, the needs assessment. This for
18 us is a key; it's a baseline I believe.

19 This is where the recovery team can
20 work with the family and the member to find out
21 what support elements are necessary. And try to
22 funnel those family members to the appropriate

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1 position.

2 Say there's financial issues, or
3 marital issues. Our role is to try to find the
4 gaps in support that they need, and kind of
5 funnel the families to there. However, the
6 bottom line is, we do not require the recovering
7 warriors permission to meet any of these
8 personnel or agencies.

9 CO-CHAIR NATHAN: Let me just push
10 on that a little bit. The panel this morning,
11 the Army, came in here and again, also very
12 robust family support mechanisms available.
13 The question was, you know, how do we make sure
14 that the families are engaged?

15 Because sometimes the concern is
16 that the active duty sponsor, the recovering
17 warrior, the ill or injured individual, does not
18 want to, or necessarily prone to connect the
19 family to the chain of command, or to the support
20 center, or to anybody who might know their
21 business, or who might --

22 Because in their mind they

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1 confabulate the stigma that if the command knows
2 something about my family that's not going well,
3 that could be adverse to me. When usually just
4 the reverse is true.

5 Usually, you know, today we do
6 everything we can to support the family, no harm,
7 no foul to the individual. What do you do?
8 Because what you said, as you closed that slide
9 out was, we do not need the, anybody's permission
10 --

11 COL DEMARCO: Absolutely.

12 CO-CHAIR NATHAN: -- to talk to the
13 family. But that doesn't say what you do to talk
14 to the family.

15 COL DEMARCO: Yes, sir. We have a
16 couple of different outlets for that, which is
17 not on a slide. It's under the Airman and Family
18 Readiness Center. It's a Community Readiness
19 Consultants. That's a person on the base that
20 works in the recovery team with the RCC, to work
21 with the family to identify some of those needs.

22 Basically, when you're talking

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1 about the needs assessment here, they first meet
2 with the family and the recovery team to find out
3 what issues are going on, financial, marital,
4 whatever they are. Then the CRC, Community
5 Readiness Consultant, on the base, talks with
6 the family.

7 Because you're absolutely right.
8 Servicemen may not want their family to
9 participate in one of our great programs. All
10 we can do is offer. But the CRC and the FLO on
11 the base are discussing these issues with the
12 family member. Ma'am, we have opportunities
13 available for you. Sir, we have opportunities
14 ready we can offer them.

15 It's basically the base with the
16 CRC. It's really up to the family members to
17 take part in that. So we are actively engaged
18 with the family, basically through the center
19 of gravity for us is the Airman and Family
20 Readiness Centers in that CRC position,
21 Community Readiness Consultants.

22 MS. MALEBRANCHE: Could you just

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1 talk to me a minute about the Family Liaison
2 Officers? How do they fit in here? And who are
3 they?

4 I mean, are they paid employees of
5 the Air Force? Where do they work from? And
6 how do they reach out? And how do they get their
7 information?

8 COL DEMARCO: Yes, ma'am.

9 LTCOL WYATT: The Family Liaison
10 Officers are appointed by the commander of the
11 wounded or injured airman. And there will be,
12 they're military personnel. We looked at the
13 grade based on, okay, whatever the grade of the
14 injured. We try to keep them equal to or a
15 little higher.

16 They are the unit commander's
17 representative to make sure that the families
18 are taken care of. While we have a RCC and the
19 non medical care managers focusing on the
20 recovering service member, that FLO is, their
21 main objective is the family.

22 And they're the conduit of

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1 information. Kind of like a Recovery Care
2 Coordinator for the family. And they, you know,
3 they're put on orders. Or they're directed to
4 provide that service.

5 MS. MALEBRANCHE: And so, kind of an
6 other duties as assigned? I mean, is that their
7 primary function?

8 LTCOL WYATT: That is their primary
9 function for a specific period of time, directed
10 by the unit commander.

11 COL DEMARCO: 30, 60, 90. It's on
12 orders for the period of time. And they work
13 hand in hand with the CRC on the base to help
14 through these issues.

15 MS. MALEBRANCHE: Okay. Thank
16 you.

17 MEMBER EUDY: Sir, my question
18 regarding that, and I've been through 34-1101
19 plenty of times. You have a standard checklist
20 in there of what the duties and responsibilities
21 are stated of a FLO.

22 However, my concern is, across the

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1 Air Force, how do I know that Airman and Family
2 Readiness Centers are providing the same level
3 of training at that installation level?

4 I know that we sent out the training,
5 and it's done at an annual, you know, meeting.
6 Assumption of commands, or commanders, or chiefs
7 or first sergeants are receiving it.

8 My main concern is, how do we make
9 sure that the FLO at Base X is getting the same
10 level of training to assist that family? Some
11 of these installations, you know, in the FLO
12 model you have the RCC to fall back on.

13 COL DEMARCO: Right.

14 MEMBER EUDY: However, you know,
15 what are we doing to make sure that's not so --
16 The FLO program I know, as we were in San Antonio
17 last week, that our working group is going to be
18 placed in order to update the FLO program and
19 policies, as well as training.

20 Is there anything more you can speak
21 on that, sir? Or in regards to standardizing
22 FLO practices to make sure we put the right

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1 people --

2 COL DEMARCO: For one thing, I know
3 the FLO AFI is going out right now. I think it
4 should be in draft for update right now. We're
5 working through that. We might want to expand
6 on the FLO processes.

7 LTCOL WYATT: We've been in a period
8 of transition over the past year. And we stood
9 up the Warrior and Survivor Care Directorate at
10 AFPC. And we're shifting.

11 We used to have what we called the
12 FLO for fatalities, the FLO for wounded, ill and
13 injured. We're shifting into moving the FLO
14 program, Family Liaison Program, under the Air
15 Force wounded warrior program at AFPC, that's
16 been currently managed out of another office.

17 But now that we've stood up the
18 Airman and Family Care Directorate, it's just a
19 good fit to have the FLOs managed out of AFW too.
20 That is centralized management. Decentralized
21 execution will be through the Airman and Family
22 Readiness Centers and the CRCs at the

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1 installation.

2 Those CRCs will, based on that
3 decentralized execution of this program, will be
4 responsible for providing the training that is
5 established and directed by Higher Headquarters
6 and the Air Force Personnel Center.

7 Part of that holding them
8 accountable, or following up on making sure that
9 the training is taking place and things are
10 standardized across the Air Force, will be the
11 UCIs and other mechanisms that we can have.

12 And also, there's constant
13 communication with the centers from AFPC. So
14 that's a new development. And we're just
15 getting on line right now. And as Colonel
16 DeMarco stated, there's an AFI that's about
17 ready to be signed to put that in place.

18 MEMBER MUSTION: Just going to ask
19 a question. I'll paraphrase the Admiral's
20 words from this morning. Excuse me. How are we
21 going about eliminating the airman's choice in
22 having a family member participate in this

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1 effort, particularly in the assessment and
2 determining what assistance is needed?

3 I mean, how do you, how are you
4 enforcing mandatory attendance and eliminating
5 the option that a family member can or cannot
6 participate?

7 MS. NEWTON: It's still a choice,
8 sir. But it's not really an issue in the Air
9 Force. We have families that want to
10 participate. We have, when our Airman and
11 Family Readiness Centers Community Readiness
12 Consultants reach out, the families respond.
13 It's not really an issue for them.

14 We do have something we use for
15 deployment support, which is the yes-no form
16 that all spouses have to sign before there's a
17 deployment. So as far as our combat wounded,
18 we're already engaged with the families before
19 there's an injury.

20 So for the ill and injured, that's
21 just a program that we've expanded to include
22 them. We don't have them sign a formal form.

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1 But typically our CRCs reaching out to the family
2 members goes with a positive connection.

3 CO-CHAIR CROCKETT-JONES: When we
4 were at San Antonio, I cannot remember whether
5 it was an RCC or a CRC who gave their experiences
6 as an example. And they had 100 percent actual
7 contact, not send out, not contact information,
8 but responsive contact, which is not the
9 experience that we've had with the field of
10 services.

11 So there is perhaps a cultural
12 component to that family contact that is
13 different for the Air Force. So we're seeing
14 slightly different, at least from what we got at
15 Randolph.

16 MS. DAILEY: Yes. I think it's
17 important to visualize. The RCC generally has
18 very early and initial contact with the family.
19 They do that because they take this iPad into
20 that home.

21 And they are able to then ensure
22 initial contact with the family as they start the

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1 process. There is no chain of command that you
2 find that might be a barrier, or intimidating to
3 the airman and family. That RCC is creating
4 that process up front.

5 And you, many of the things we see
6 in the Army that are barriers to families, coming
7 to the office, or coming on post, the RCC
8 eliminates by being physically there and walking
9 in their house.

10 COL DEMARCO: And I wanted to add
11 just one more comment. This is a great slide.
12 But I wanted to add a comment about the key
13 spouses. I'm not sure if the other services
14 have those folks in there.

15 In the Air Force, each squadron
16 identifies a key spouse. It's really a conduit
17 of information from leadership to the airmen in
18 their squadron. And when there is a tragedy,
19 this spouse within the squadron works along with
20 the Airman Center, the FLO, other POCs to help
21 that family through that issue.

22 With a lot of -- So how does

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1 information get into them? A lot of times it's
2 maybe the squadron commander's wife, the first
3 sergeant's wife, senior NCOs or senior officer's
4 wives in the squadron that helps the families
5 through some tragedy by passing information.
6 So it's a wide network of folks helping the
7 family through the tragedy.

8 The next recommendation was to
9 discuss identifying POCs through the continuum
10 of care. We did that. This slide here actually
11 shows we had an IPT back in January of last year.
12 Mr. Tim Townes was part of that.

13 We looked at, basically the process
14 through the continuum of care, all seven phases.
15 And really, who did what, and when. This is the
16 slide they came up with. Looking at, we kind of
17 broke it down by primary, secondary and then
18 tertiary POCs.

19 And it kind of helps take some of the
20 confusion out of each of the areas of care, and
21 who is in the lead, who is an assist. Not only
22 helpful to the families, but also helpful for us

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1 as part of the recovery team.

2 MEMBER EVANS: On that slide you
3 have, you start with the medical case manager as
4 the primary. And then as they transition to
5 recovery, and I would tell you, into rehab. So
6 you have a RCC as the primary. Are your RCCs
7 medical?

8 COL DEMARCO: No.

9 MEMBER EVANS: So just because they
10 move from primary to recovery to rehab, we're
11 saying they're not, they don't require that
12 medical?

13 COL DEMARCO: Let me change, this
14 slide was kind of a building block for this
15 slide. If you want to, we'll go back and forth
16 if you'd like to discuss. But we're trying to,
17 it's tough to put --

18 You're right. Some things overlap.
19 Some things are together. See if this slide
20 here, which shows the actual phases of care, the
21 next slide. Starting from when they first enter
22 into the wounded warrior program, through the

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1 phases, the activities involved, these two
2 phases.

3 And you can see overlapping POCs
4 that have parts to play in each of the phases.
5 So if you're saying one's medical, one's -- Well
6 it's more of a, not a set in stone, black and
7 white, but basically folks working together.

8 Some may have a solid lead; some may
9 have a tertiary lead or secondary lead. This
10 kind of gives a better depiction, Captain. I'm
11 not sure if this helps.

12 MEMBER EVANS: So most of the Task
13 Force members know my agenda. When I talk to a
14 service member, I don't care what uniform. Who
15 has the lead? Who's responsible for
16 communicating with that family and with that
17 service member?

18 So when I looked at the slide, I see
19 primary. So I assume the primary would be your
20 RCC. And the burning part with that, when they
21 go into recovery and rehab they still are
22 medically, you know, require a lot of medical

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1 requirements.

2 So, you know, I would beg to differ
3 with the services on RCC as being identified as
4 that lead. When we talk to the families and we
5 talk to the recovering service member, we across
6 the board ask you, who's the most significant
7 member of the team? I think that's one of our
8 research questions.

9 And, you know, depending on where
10 they are in care, some of them will say physical
11 therapy because of the therapist. Because they
12 are receiving a lot of rehab.

13 Some would say, if they are
14 receiving heavy behavior health treatment, they
15 would say their psychiatrist or their social
16 worker. And then the rest will say my clinical
17 case manager.

18 So again, I would go back and look
19 at who is the primary contact on this slide. And
20 when you talk about who has the responsibility
21 of communicating with that recovering service
22 member, and that clearly needs to be identified

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1 across the board.

2 COL DEMARCO: Understand
3 completely. The IPT consists of the Surgeon
4 General's personnel, our own staff, RCCs,
5 medical case managers. So it was basically a
6 good group of about 25 folks together for the
7 medical field, non medical field, working
8 together.

9 Again, when you see this, you're
10 right. We're saying that certain folks are
11 POCs, they're the lead, they're secondary and
12 tertiary. I understand your point, Captain.
13 This was our, basically our best, I don't want
14 to say the word best guess. But this is what we
15 came up with for a lead.

16 If you want to, like again, that's
17 why I want to transition to the next slide, to
18 get off this slide. To kind of look and see
19 where really, you do see the blending of the
20 POCs. And when you're pointing, well this guy
21 is the lead, you're right. But other folks are
22 in the same lane, working also simultaneously.

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1 So could you swap one POC for the
2 next? Absolutely. Some folks are still
3 working together during a certain phase of care.

4 MS. MALEBRANCHE: Only because
5 Captain Evans and I are also, and actually
6 Colonel Wyatt, sitting on another Task Force.
7 But how do you do the handoffs?

8 When you say, you're swapping them
9 out from here to here, how does the service
10 member and family know? Is that, how do you do
11 that handoff process? Is it clear to them?

12 LTCOL WYATT: Sometimes, like when
13 we talk about, say for a good example, RC3, say
14 the lead coordinator concept. I mean, we have
15 to have kind of a, we have to have an
16 understanding with the family and the recovering
17 service member at any given time, who that might
18 be.

19 It might switch back and forth. If
20 you look at the slide here, as you're on the left
21 side of the continuum, you have the Recovery Care
22 Coordinator working with the family. For the

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1 most part, we look at that as a hub and spoke type
2 concept.

3 So when we work with a Recovery Care
4 Coordinator, they're coordinating non medical,
5 medical care, all things that need to be taken
6 care of for that airman. From the beginning, on
7 the left side of that continuum are the RCC.

8 As you move towards the right side
9 of that continuum of care, once the
10 Comprehensive Recovery Care Plan is complete,
11 which is the main objective of that Recovery Care
12 Coordinator, then the non medical care managers
13 will start to pick up more of that.

14 And there is a time when the airman
15 and family are definitely told by the Air Force
16 Wounded Warrior staff at AFPC, that there has
17 been a shift in the lead for their care.

18 Not saying that that RCC won't
19 always be there throughout the rest of the
20 continuum to support them. It's just that there
21 is a definite time when the personnel at AFPC,
22 for employment and education, all the different

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1 things they're going to need help with, that
2 office becomes more of the lead than the RCC.

3 And I think that once the completion
4 of that Comprehensive Recovery Care Plan is a
5 very good indication of when that handoff takes
6 place.

7 COL DEMARCO: And there's a
8 constant feedback with the recovery team
9 themselves. The team members of the recovery
10 team, the RCCs, non medical care, medical care
11 managers, they're all talking together too
12 internally, to do the, know who's in first, who's
13 in second.

14 MEMBER STONE: So there's a daily
15 coordination conference, during which time
16 somebody says, well look, it's time for us to
17 take this over, because we've finished X phase.
18 How does the service member know that?

19 LTCOL WYATT: Well the Recovery
20 Care Team is continuously meeting. You know, we
21 have from the wounded, ill, and injured cell at
22 the personnel center, you know, to the base

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1 level.

2 The RCC, being the lead coordinator,
3 I guess, for lack of -- The lead coordinator at
4 the time will inform the family. From an NMCM,
5 non medical care perspective, the Airman and
6 Family Readiness Centers have that
7 decentralized execution at the center. So they
8 have a Community Readiness Consultant.

9 If the Recovery Care Coordinator is
10 no longer that main contact, then the CRC at the
11 Airman and Family Readiness Center becomes that
12 main hub for the family. So that's a definite
13 transition to that person.

14 They always have that. Because the
15 Air Force Personnel Center, a lot of your subject
16 matter experts and resources are there in San
17 Antonio.

18 MS. MALEBRANCHE: I understand the
19 part about the resources. But I guess what I'm
20 trying to make sure is, how does that patient
21 know? Because they're all talking internally.
22 Is that passed on?

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1 COL DEMARCO: Yes, ma'am. I wanted
2 to just show. I'm sorry, I didn't want to cut
3 you off.

4 MS. MALEBRANCHE: Okay. Well
5 that's, I guess that's what -- How would they
6 know if we were to ask them who it is? Because
7 you know how when you go and talk to a patient,
8 they've got a dozen. Do they know at what point
9 this changes, so they know who to go to? And how
10 is that conveyed to them, I guess?

11 COL DEMARCO: The Comprehensive
12 Recovery Plan, that's the Bible. That's what it
13 is. This is what the RCC works with the
14 recovering warrior. And if you want me to go
15 through all the continuum of care processes and
16 steps and time lines.

17 That's why the RCC is talking to them
18 daily, to say, well guess what, you're care is
19 ending on this, we're now changing it to this.
20 Update the CRP, send it to the system.

21 So they're constantly being told, in
22 the CRP, discussing that with the patient and the

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1 family, what's changing in their process,
2 constantly.

3 And within the recovery team itself,
4 that internal dialogue is feeding into this,
5 which is going back to the recovering member and
6 his family to say, this is changing.

7 We're going to this now. Let's
8 update your document. And by the way, here's a
9 hard copy of the document showing you the
10 changes. That's how it works.

11 MEMBER STONE: Who is handing that
12 piece of paper off?

13 LTCOL WYATT: The RCC is handing
14 that paper off. And if they can't do it, if it's
15 not a face to face at that time, then there are
16 other means, through PDFs and other
17 communication. But the RCC will communicate
18 with the recovering service member and the
19 family.

20 COL DEMARCO: Sir, that was that
21 iPad I was talking about, where they go to the
22 house with the iPad, and kind of works it on the

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1 computer.

2 MEMBER STONE: So how do I meet the
3 new person in charge of my stuff?

4 LTCOL WYATT: Okay. So when you're
5 assigned a Recovery Care Coordinator initially,
6 that individual, that RCC will contact,
7 sometimes the family before the recovering
8 service member.

9 Because if the recovering service
10 member is heavily medicated, you know, if
11 they're not quite to the point where they can
12 make decisions for themselves, then that first
13 contact from the RCC might be with the family
14 members.

15 Once this relationship is
16 developed, and you have the needs assessment
17 that Colonel DeMarco discussed, then that's when
18 the Recovery Care Plan is initiated. Further
19 along in that continuum of care, that NMCM, non
20 medical case manager, the CRC at the base will
21 make personal contact with that individual.

22 We have the luxury of having the CRC

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1 at each base. So that way we have face to face
2 communication. The individual, the recovering
3 service member, no matter what base they are
4 close to, has the ability to interact directly
5 with the CRC.

6 MEMBER STONE: So your satisfaction
7 surveys show you that your service members are
8 pretty satisfied with these three handoffs
9 during this time?

10 LTCOL WYATT: Based on feedback
11 from the RCCs --

12 MEMBER STONE: No, I'm not talking
13 about the RCCs. I want, when you survey your
14 recovering service members, you're doing at
15 least three handoffs in these seven phases,
16 between who's primary.

17 Are your service members saying they
18 are satisfied they understand who's in charge,
19 who their primary contact is, and they're
20 satisfied with the process?

21 LTCOL WYATT: Sir, my answer to that
22 question right now is based on the fact that we

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1 just established this new directorate under the
2 Personnel Center. And it put all of this in
3 place within the past year.

4 And put that individual under the
5 Recovery Care Coordination Contract to track
6 these metrics, and to report on these things. I
7 don't have enough data at this point to answer
8 your question.

9 COL DEMARCO: What I do have from
10 the RAND study just says, a couple of encouraging
11 results from RAND, which we're going to talk
12 about later. Is that the service members that
13 were surveyed had high satisfaction in the
14 overall program, and the Recovery Care
15 Coordinator program.

16 MEMBER STONE: And let me guess,
17 they proposed that next year they study it again?

18 COL DEMARCO: So noted. Is someone
19 writing that down, what the General just said?

20 MEMBER EVANS: And so I have one
21 more question before, and then I'll -- GAO
22 reports to handoff from DoD to VA. So I look at

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1 this slide, and most of our handoff, I believe,
2 would be in that recovery rehab, and then once
3 we get down to the reintegration transition.

4 So we have all our service member to
5 go back to VA and come back to DoD. So who has
6 that responsibility when they are in that
7 medical phase, to do the handoff? Is that, are
8 you doing a handoff to the VA, or to --

9 How is that handled? Because right
10 now we have medical case managers or, so for the
11 Air Force, who picks up the phone and says that
12 transition plan is coming your way? Or, it's
13 coming your way.

14 Other than our docs, do we have a
15 provider, we have, I get all the medical side.
16 But then there's another handoff that's done to
17 the VA case manager. Who is doing that for the
18 Air Force?

19 LTCOL WYATT: Okay. For the Air
20 Force, that's Colonel DeMarco will get into more
21 of the transition phase here. But we have the
22 CRCs, that they are in the Family Readiness

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1 Center, kind of a one on one transition
2 assistance program.

3 So you'll have the CRC individually
4 working with the recovering service member to
5 make sure that there is a smooth transition.
6 And every bit of information that needs to be
7 passed on to the VA is transferred. So they have
8 their own personal assistant at that point, to
9 make sure that there's a smooth transition.

10 And if there's an issue where they
11 need to come to back to the Air Force, then they
12 also have a way to come back for any personnel,
13 you know, type information. Anything they need
14 back from us. They'll also make sure the VA
15 understands who to talk to in return.

16 MS. MALEBRANCHE: So you don't have
17 any trouble then? Who in the VA do you get a hold
18 of? Or how is that working? I guess, I know I'm
19 drilling down. But that's my area, and I want
20 to know.

21 MR. TOWNES: Sure. When we have
22 the catastrophically injured, or we have someone

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1 that has a need, we're going to reach out to the
2 FRCs. We're going to get them involved very
3 quickly.

4 The RCCs will do that, will actually
5 have a working relationship with the FRCs. So
6 we make it a high priority to take care of that
7 on the, from that perspective.

8 MS. MALEBRANCHE: So you're going
9 to the FRCs via the national program, connecting
10 that way?

11 MR. TOWNES: Yes, ma'am.

12 MS. MALEBRANCHE: And if they don't
13 need an FRC, then who do you connect with?

14 MR. TOWNES: If they don't need an
15 FRC specifically --

16 MS. MALEBRANCHE: But you're still
17 going to hand off to the VA. But they're not at
18 the critical, they're not the CAT 3, as we call
19 it now. Then how do you connect?

20 MS. NEWTON: Ma'am, we have VA in
21 each one of our centers. They're either there
22 every day, or once a week. But that's where we

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1 do our positive handoff between the Air Force and
2 VA. As far as making that connection, that VA
3 rep will give them who their local VA rep, who
4 their local VA case manager will be.

5 MS. MALEBRANCHE: So are you
6 talking a VHA health case manager, or a VBA case
7 manager? Who is at those sites, a VBA person?

8 MS. NEWTON: Yes, ma'am.

9 MS. MALEBRANCHE: Okay.

10 MS. NEWTON: Yes.

11 MS. MALEBRANCHE: Okay. So if it's
12 a health person the VBA person is responsible to
13 get to the VHA. That's what I was trying to
14 figure out.

15 MS. NEWTON: Yes, ma'am.

16 MS. MALEBRANCHE: Because the
17 differentiation for patients sometimes is not
18 there.

19 MS. NEWTON: Absolutely.

20 MS. MALEBRANCHE: Okay.

21 MS. NEWTON: And it's part of what's
22 on there, pre-separation counseling. And part

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1 of that Recovery Care Plan is which offices
2 they'll be engaged with, and which local VA
3 personnel they need to be engaged with.

4 MS. MALEBRANCHE: Okay. Thank
5 you.

6 COL DEMARCO: The next
7 recommendation was recording separation
8 benefits and providing the information to the
9 family member and the recovering warrior.

10 Our medical treatment facilities,
11 our Airmen and Family Readiness Centers and our
12 VA reps, as we just mentioned in the last few
13 minutes, are providing briefings or updates on
14 separation benefits as the recovering warrior is
15 progressing through.

16 And as the Captain was mentioning,
17 as we're going through the continuum of care,
18 they're getting those briefings. I know
19 Colonel Poindexter may talk about the medical
20 treatment facilities.

21 But once the recovering warrior
22 enters into the IDES system, the family members

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1 are educated on the benefits while they're --
2 Tamara, Ms. Newton, and the Airman Family
3 Readiness Centers, provide transition
4 counseling to the seriously wounded and ill and
5 injured, and through the DTAP program.

6 Our VA reps are co-located with Ms.
7 Newton, who was just mentioning about either
8 being co-located on the base or in a local
9 facility, also providing benefits, briefings.

10 And then a non medical care managers
11 are ensuring that the recovering warriors have
12 all required transition briefings, and is aware
13 of TRICARE as appropriate. So I think we have
14 it pretty covered through all four agencies.

15 The key is getting the right
16 briefings to the recovering warrior and their
17 family at the right time. I think we're doing
18 that.

19 The last part I have here before we
20 transition to the next slide, unless there's any
21 comments, is the third, is another avenue, which
22 I think is big. And part of the iPad purchase

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1 for my staff. Kind of lead us into the social
2 media lane. Because I think we provide in the
3 briefings, via the agencies and POCs involved.

4 The one aspect that I want to discuss
5 briefly though is that the convenience of the
6 house in the recovering warriors and their
7 families to be able to access information at
8 their own convenience.

9 We know we have the iPad. We
10 provide it to our RCCs, which I think is a great
11 tool for them. But we also have the Air Force
12 Wounded Warrior web site and newsletter. So
13 this is dot com accessible now. So when at the
14 home they still have access to getting on to the
15 web sites.

16 We have a Recovery Care Coordinator
17 Facebook page. So at home our recovering
18 warriors can check up information. We also have
19 a hard copy now, in case some of our recovering
20 warriors don't have computers or laptops. We
21 still provide a hard copy newsletter that goes
22 to the recovering warrior and their families,

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1 with information.

2 So I think between the helping
3 agencies on this slide providing information as
4 necessary, and the social media, which I think
5 we need to leverage more, I think we're getting
6 the information, or the information's
7 accessible to the family members and the
8 recovering warriors.

9 Okay, sir. This next
10 recommendation was concerning unifying the
11 family and making sure the family unit stays
12 solid. We obviously know that this is a
13 traumatic time, a lot of tension, a lot of
14 anxiety. Understand that.

15 In the recovering warrior care
16 program the sole focus is keeping the successful
17 recovering airman to maintain the family
18 dynamic. The Recovery Care Coordinators and
19 the non medical care managers in the recovery
20 team work together during the development of the
21 needs assessment which I mentioned earlier.

22 It sounds the baseline for care, to

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1 encourage them, encourage the family members to
2 use some of that care. The Air Force Warrior and
3 Survivor Care joins the DoD in their pledge to
4 make every effort to keep the families together
5 and manage their stress through the continuum of
6 care.

7 And I think the key part, a couple
8 of slides ago, was that needs assessment.
9 Again, early on when the member first joins the
10 wounded warrior program, is the recovery team
11 working together with the family to identify
12 what type of help they need. And then
13 encouraging the family to use that help. So I
14 think that's a big goal for us. We're working
15 hard to satisfy that request.

16 CO-CHAIR NATHAN: One concept that
17 came up this morning was, it's one thing to
18 monitor and maintain the family dynamic in your
19 seriously ill categorization patients, wounded
20 warriors.

21 It's another when you have those
22 that are processing through IDES out in the

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1 hinterlands. Going back, I guess, to where we
2 were a couple of slides ago, I'm still a little
3 confused as to where the warm handoff is at that
4 point for the family.

5 In the process, at that point who's
6 out, now attached to -- It's one thing if you've
7 got them at SAMMC. It's another if you've got
8 them at Walter Reed-Bethesda. It's another if
9 you have them at Minot, North Dakota. What do
10 you do about the family at Minot, North Dakota?

11 MS. NEWTON: We have a Airman and
12 Family Readiness Center there, sir. And we do
13 engage with the airman and their, and all their
14 family members.

15 You know, we do make that reach out
16 to them within 48 hours of the case manager
17 notifying the center that they're in the area.
18 So there is that positive reach out to the
19 warrior and to the family members.

20 We have a data system where we track
21 all our contacts with the warrior and his family
22 members. We also have, what we do, is called a

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1 PRI, a Personal Readiness Inventory, that we ask
2 them to do periodically as we engage with them.

3 And it's just a series of questions
4 that ask how their feeling about family and
5 communication, and finances and readiness for
6 life. So that's also a tool that we use to kind
7 of monitor how the family dynamics themselves
8 too. And that's for the warrior and his family
9 members.

10 CO-CHAIR NATHAN: Right. And I
11 appreciate that. And I forget that the Air
12 Force considers Minot civilization. Let's take
13 it one step further. Long pole in the tent for
14 the Army is Guard and National Reserve.

15 MS. NEWTON: Yes, sir.

16 CO-CHAIR NATHAN: And National
17 Guard, because they are scattered, not even near
18 facilities where you have a family center. What
19 are you doing for those folks that are reservists
20 that are now back near Topeka or someplace else?

21 MS. NEWTON: We, I know Lieutenant
22 Colonel Lanuzo's here. So he can talk to the

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1 Guard issues. But we do have family program
2 managers through, in our total force. We still
3 identify those and the closest Airman and Family
4 Readiness Center to them.

5 So for instance, we actually have
6 some members that are in Samoa. And so we
7 actually have our Airman and Family Readiness
8 Centers in the Pacific that make contact with
9 them and are assigned them.

10 Even though they're not physically
11 located with them, they are assigned to them in
12 the area and are made aware of resources. We use
13 Military OneSource, which provides a lot of
14 information and resources as well.

15 COL DEMARCO: Do we have any
16 comments from the back there, from the Guard?
17 That's good.

18 LTCOL LANUZO: I have received the
19 program for the Air National Guard. They're
20 exactly right. We use the active duty Airman
21 and Family Readiness Center. But we also have
22 Airman and Family Readiness Program Managers in

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1 90 of our guard wings.

2 But we heavily use the Recovery Care
3 Coordinators that's in the regional area, as
4 well as we have Transitional Assistance Advisors
5 in every state, to help out the wounded warriors
6 and their families as well.

7 So we stay heavily coordinated,
8 pretty much through the family programs out of
9 the house, with the people geographically
10 separated throughout the Air National Guard.

11 Same process. Ours is just one
12 deeper than the Airman and Family Readiness
13 program manager. But we also have TAAs within the
14 state to support them.

15 CO-CHAIR NATHAN: I'm not
16 challenging, I'm just asking. You're
17 comfortable that there's enough active contact
18 from Air Force or Air National Guard side to the
19 family? As opposed to just simply, we've got
20 some great programs.

21 We've got OneSource they can hit if
22 they want to go on line. We've got this, we've

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1 got that. But how well are we doing it actually?

2 If a family falls off the radar for
3 six months we have a tickler system that says,
4 you know what, I haven't heard from them. I
5 don't know what's going on. I need to contact
6 them.

7 LTCOL LANUZO: We depend heavily on
8 the RCCs and the Family Liaison Officers. We
9 use Family Liaison Officers as well in the Air
10 National Guard.

11 And that's our main point of contact
12 to stay in contact with them, probably a little
13 longer than the active force. Because they are
14 separated from their unit. And we may not see
15 them but once a month, if that.

16 So we really depend on that Family
17 Liaison Officer to be the conduit, as well as the
18 Airman and Family Readiness program manager. I
19 feel confident that we only have, well only does
20 not, good word. But we have a little over 300
21 that we are tracking in the Air National Guard.
22 And I feel comfortable.

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1 I've been in this job for five years.
2 That we stay connected to the ones that want to
3 stay connected. We do get some, especially from
4 the very beginning; I appreciate everything
5 you've done for us. We'll contact you.

6 And in those cases we try to follow
7 up maybe once a year just to say, hey are you
8 still okay type of conversation. I feel
9 comfortable enough from where I sit, sir.

10 CO-CHAIR NATHAN: Thank you.
11 Other questions, concerns on recommendation 18?
12 Okay.

13 COL DEMARCO: Okay, sir, today this
14 is one of my lovely programs, the Airman and
15 Family Readiness Center. And I appreciate your
16 comments regarding it and making it a best
17 practice, when you were here last year. Great
18 support, great programs.

19 I think I saw the slide, a few slides
20 ago, that showed all the great programs in our
21 Airman and Family Readiness Center. The
22 partnership between the Warrior Survivor Care

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1 and the Airman and Family Readiness Centers was
2 codified in an AFI.

3 Now there's a link between the
4 Airman Centers and our Wounded Warrior Program.
5 We do everything we can in our power to minimize
6 the impacts right now of financial constraints.

7 We know we're in some budgetary
8 issues. A lot of questions we're getting, Mr.
9 Larry's getting in our shop at the Pentagon is,
10 what impacts you're going to have on these
11 programs? I can assure you the Airman and
12 Family Readiness Center is working hard now to
13 minimize some of those.

14 And for instance, if there's
15 furloughs happening at the Airman and Family
16 Readiness Centers, what gaps will exist there,
17 and how will those gaps be filled? The Airman
18 Centers are working hard with the staff that's
19 inside the center to almost cross pollinate with
20 information, so that folks can pick up the job
21 and move with it.

22 If there is a furlough, hopefully

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1 there's not, still a staff can take the job and
2 keep going with it. We're afraid of what the
3 gaps were. But working with the centers, the
4 folks are taking care of business at the centers
5 by just training folks to do multiple jobs.

6 We don't want to have any gaps in
7 service for the recovering warriors and their
8 families. And that's what the center is doing.

9 I want to make a comment on this one
10 here, because I was personally involved in this
11 when I was in PACAF. I went through the
12 Executive Transition Assistance Program myself,
13 as I'm ready to retire after 31 years in the Air
14 Force. About 45 people in class. Great class.
15 A week long class for the Executive TAP Program.

16 What they do at the Airman Center
17 though, it's one on one training for recovering
18 warriors, one on one training five days. And
19 they're also encouraging that the family members
20 and the care givers attend this training with
21 them.

22 Great program. One on one training

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1 with the, going through all the briefings with
2 the VA, Department of Labor. Airman and Family
3 Readiness Center is a great program for us.

4 MEMBER EUDY: Sir, if you could
5 please discuss the ease of access of use by
6 recovering warriors? I know this was mentioned
7 last week at San Antonio.

8 But is a specific priority given to
9 the Air Force recovering warrior population in
10 order to receive those services? Especially
11 because you have these Airman and Family
12 Readiness Centers of different sizes at
13 different installations.

14 MS. NEWTON: Sir, wounded warriors,
15 ill or injured, they're our priority at our
16 centers, along with our active duty population.
17 We are staffed to, based on the active duty
18 population for the community. So that's our
19 priority.

20 When we're contacted by, or our
21 Recovery Care Coordinator, or even the CRC
22 that's working with the wounded warrior, they

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1 are the priority for our programs.

2 CO-CHAIR NATHAN: Thank you. Next
3 recommendation.

4 COL DEMARCO: So your
5 recommendation was regarding the relationship
6 with the VA. I know I think I heard it this
7 morning at the brief. I think the Army was
8 briefing about the VOW-VEI for us.

9 Based on the VOW-VEI Act, the Air
10 Force has been directed to have all airmen,
11 officers, and enlisted, signed up for e-Benefits
12 by 1 October 2013. We're on track to do that.

13 I know Ms. Newton and the Airman and
14 Family staff, our staff's working hard. So we
15 have a timeline of 1 October 13 to have all of
16 our airmen into eBenefits, signed up with a log
17 in and password.

18 Tim Townes I know has been on about
19 five or six different IPTs. He's already on an
20 IPT to integrate. I think I heard earlier about
21 the Federal Reserve coordinator. Tim's on an
22 IPT right now to try to link that VA FRC as part

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1 of the recovery team itself.

2 You made good comments about that.
3 Tim's going to, I think you're on about three or
4 four IPTs. It's one specifically addressing
5 the VA to make that FRA assigned to the recovery
6 team itself, so there's more of a coordination
7 between the whole team members.

8 And finally, on the bottom line
9 there, our Recovery Care Coordinators are the
10 key person in the recovery of that recovering
11 warrior and their family. They're constantly
12 going through training, the latest up to date
13 briefings on the VA and programs and benefits,
14 as is our non medical care managers. So the
15 constant process of education.

16 CO-CHAIR NATHAN: Questions,
17 concerns?

18 MS. DAILEY: Before we go on, just
19 to highlight and remind the Task Force that you
20 did lay out the Air Force Family Readiness
21 Centers last year as a best practice, because of
22 their very tight relationship with the Wounded

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1 Warrior Program.

2 The Army has a whole separate
3 organization in the family services program.
4 So it's unique in itself. But overlaying a
5 model like the Air Force on the Marine Corps and
6 the Navy was really your intent.

7 You really asked them last year to
8 take this very formal relationship between the
9 family and the Airman and Family Readiness
10 Centers, and do, export it to the Navy and the
11 Marine Corps. So that the training is specific
12 in their family centers to assist wounded
13 warriors.

14 So that the priority is identified
15 specifically in their family centers for wounded
16 warriors. And to basically ask the other
17 services to truly tighten up a relationship
18 between the wounded warrior programs in their
19 services and their family services
20 organizations.

21 CO-CHAIR NATHAN: Thank you.
22 That's helpful to understand the perspective of

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1 all this. It's no surprise. The Air Force has
2 always been very people centric, taking care of
3 their people.

4 You have a little bit of an advantage
5 in that you're such a base centric organization,
6 where your people go to and come back to the base.
7 And then one of the things we have to wrestle with
8 is the economies of scale.

9 You've got 900 and something or
10 other people enrolled in your wounded, ill, and
11 injured, about 320-ish combat related injuries,
12 as I understand it. Army's got 26,000. So
13 you've got a little bit of a difference of scale
14 as to how you can apply some of these.

15 But nonetheless, clearly the Task
16 Force has been impressed by the center of gravity
17 you put in connecting a direct linkage between
18 your family support centers and the airmen.
19 Other concerns or questions before I move on?

20 MS. MALEBRANCHE: No, I was just, on
21 this last slide where they talk about
22 participating to integrate the FRC as a member

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1 of the recovery team. I guess the FRC program
2 continuously likes to be known as the VA-DoD FRC
3 Recovery Program. And not just a member of the
4 recovery team.

5 But I was wondering, in light of what
6 you've done in one of these best practices, if
7 you have, was this an effort? Are you going to
8 request, like, because they're looking in a
9 consultant role of an FRC being assigned in that
10 area as an overarching national consultant,
11 which is something. I mean, I just wondered if
12 you had.

13 Because when you said a member of the
14 team, I thought, there's going to be a bunch of
15 teams. And we don't have but 26 FRCs. So I was
16 wondering if, just the way that was stated, if
17 that was meant in a different way? Or you meant
18 for each team? Because we don't have many.

19 MR. TOWNES: Yes, ma'am. We're
20 aware that there's a limited number. What we're
21 talking about there is having the ability to
22 reach out to that FRC and have --

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1 We've already identified the FRCs to
2 the RCC and the non medical care managers down
3 in San Antonio. So that they can reach out
4 through the program to get assistance if they
5 need it.

6 MS. MALEBRANCHE: Okay.

7 MR. TOWNES: Because as much as we
8 try to train our RCCs and our non medical care
9 managers on VA and VA care, we don't know as much
10 about it, obviously, as the FRCs. And the FRCs
11 understand our business very well. So it's an
12 easy fit to look to them for assistance.

13 And what we want to do is get that
14 assistance involved early on, not to give cases
15 and overload the FRCs, but to take advantage of
16 their knowledge in our business.

17 MS. MALEBRANCHE: And I guess just
18 a little marketing here maybe too also, or
19 education on the VA. Because I notice every
20 time you talk VA it's very, it seems to be very
21 VBA, benefits association, the non medical
22 component. And the FRC has both the VHA and the

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1 VBA.

2 And the VBA piece usually comes a
3 little bit later. So as far as the FRC and the
4 health component, like you're talking about
5 eBenefits. But eHealth, and how you can
6 actually go in as an active duty member and
7 register, even though you don't enroll in the VA.

8 So just to kind of keep that in mind
9 as you're going through and doing your programs.
10 That the health -- I hate to say it, but the VA
11 is somewhat stovepiped, as Army, Air Force, Navy
12 and the DoD. We've got VBA, you know, and VHA.

13 So just keep the health component in
14 there. Because there are different times where
15 that piece I think is more paramount, especially
16 initially. So just a little comment. Thank
17 you.

18 MR. TOWNES: Thank you.

19 COL DEMARCO: Next up now is Colonel
20 Poindexter with some Surgeon General
21 recommendations.

22 COL POINDEXTER: Admiral Nathan,

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1 Ms. Crockett-Jones, members of the Task Force,
2 I'm Colonel Todd Poindexter. I'm from the Air
3 Force Medical Support Agency, Healthcare
4 Operations Division. By training I am a doctor.

5 And today I would like to take just
6 a quick second and give you a perspective also
7 though from a patient. In the last two months
8 I've had the opportunity to visit Tri-Service
9 Medical Care as an inpatient at both Walter
10 Reed-Bethesda and Fort Belvoir.

11 And I can tell you, from the
12 patient's perspective, though I love to rave
13 about Air Force medicine, I have a lot of kudos
14 to give to Navy and Army medicine as well. It
15 was also interesting, when you're at those
16 facilities, they really are Tri-Service. And
17 you saw every single uniform.

18 So as we start out we go, though I
19 love military medicine, I know that we're not
20 exactly everywhere we need to be in all areas.
21 And you made some great recommendations. And
22 we're going to talk today in some of the areas

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1 where we can actually improve.

2 The first recommendation, that was
3 recommendation number 8. And this was ensure
4 100 percent of our mental health providers are
5 trained in evidence based treatments for PTSD.
6 And also that our primary care providers receive
7 training in identification.

8 And we definitely support this
9 recommendation. And support the concept of
10 making sure that everyone is trained. And we're
11 working with DoD. And we'll work with them to
12 craft the appropriate initiatives to make sure
13 that this actually does occur.

14 Currently the Air Force does train
15 our incoming mental health residents in evidence
16 based treatment. We use the Center for
17 Deployment Psychology. And we send them there,
18 and they would receive the training.

19 Our contractors and GS employees
20 also can get the training. They either get it
21 through a local resources through the CDP, or
22 also through other community resources. At

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1 this point we are at an 80 percent trained rate.

2 And through further initiatives and
3 efforts, especially working at changing some of
4 the contract language to ensure this is part of
5 the contract, we hope to boost this up to 100
6 percent.

7 Regarding our primary care
8 providers, they do receive training at our
9 professional staff meeting. Every facility has
10 a professional staff meeting of all of the
11 credentialed staff. And it is a requirement
12 that mental health brief annually. And one of
13 those briefing items is PTSD.

14 In addition they also receive
15 training due to any updates, or when they first
16 come on board, with their clinical practice
17 guidelines, and the DoD, VA clinical practice
18 guideline for PTSD.

19 And in addition, we do a lot of
20 training for people as they become new providers
21 in relation to identification of PTSD as part of
22 our pre-deployment and our post-deployment

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1 screening processes.

2 Finally, one of the things that
3 actually, that working on -- The Air Force is
4 currently the Executive Agent for Tri-Service
5 work flow. And this is actually a way to
6 maximize the use of AHLTA. I'll try not to say
7 too many things, since this is public record.

8 But about AHLTA, which I actually do
9 like as a provider. And what Tri-Service work
10 flow does do is, it creates a framework for a note
11 or an encounter. And in that it also serves as
12 prompts.

13 So as a provider if you are going
14 through and you have someone who you think may
15 have PTSD, you can click on this particular
16 screen. It will then prompt you in a series of
17 questions and evaluations that you can actually
18 ask.

19 Also, once you've done that, it will
20 give you some prompts for physical exam or
21 interview things. It will then turn into a
22 note. This note will be adequate to basically

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1 officially document the PTSD encounter. You
2 will then be able to make the diagnosis. And
3 then you can also refer.

4 So we're hoping that with this new
5 tool, which we've used really well, and it's been
6 very well receptive with the low back pain
7 Tri-Service work flow that has been put out. We
8 hope that this will actually be another aid in
9 helping our primary care providers with
10 identification. Any questions?

11 CO-CHAIR NATHAN: No. I think we
12 can go to number 9.

13 COL POINDEXTER: Okay. The next,
14 number 9, the DoD should do an audit of military
15 treatment records for those patients with PTSD,
16 looking for an assessment of completion of
17 evidence based treatment.

18 Looking for lessons learned.
19 Hoping how that they can be incorporated,
20 included in clinical practice guidelines. We
21 definitely will work with DoD to make sure that
22 we do an effective audit of records.

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1 We currently do peer review. Peer
2 review of course is random clinical encounters.
3 And some of those encounters would be of PTSD
4 patients. And we're assessing for quality of
5 care.

6 In addition though, what we are
7 getting ready to start is, at Wilford Hall
8 they're going to do a pilot project with Penn
9 State University Clearinghouse.

10 And what they're working on is
11 actually creating a data repository that will be
12 looking at clinical processes, the treatment
13 that's given, treatment outcomes, follow up.

14 Putting this into a data repository,
15 running analyses of it, checking for the
16 effectiveness of the treatment, the process, and
17 the flow of that treatment, looking for lessons
18 learned.

19 And then so that we can then
20 replicate that to other MTFs. And also share
21 potentially with our civilian colleagues. And
22 so this is actually going through the IRB

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1 process. And hopefully, once it's finished
2 with the IRB process, they'll be able to get
3 started with this.

4 MEMBER EVANS: So are you working
5 with DCoE?

6 COL POINDEXTER: My understanding
7 is that, yes. But I would have to take that back
8 to confirm.

9 MEMBER DEJONG: I know we addressed
10 this last year, and possibly the year before,
11 about, I guess, what drove you to pick the
12 University that you're working with?

13 And what are they doing differently
14 than what the other services are providing now,
15 to where what we see in PTSD, and we know that
16 it's a difficult injury to diagnose and to deal
17 with.

18 But there's constantly changing
19 ways of diagnosing, constant changes. And
20 we're not ever going to get to the end of this
21 if we keep changing ways that we're doing this,
22 if that makes sense.

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1 COL POINDEXTER: I think I
2 understand your question. And I guess what I
3 would answer back is, that the University is
4 really assisting more with the data collection.

5 We're using what would be considered
6 current standard practice for a diagnosis, using
7 the DSM-IV, and so forth and so on. So we're not
8 changing. The University is not assisting us in
9 making changes to what we already know is the
10 effective way to appropriately diagnose PTSD.

11 What we are using is our civilian
12 colleagues who may have data repository and data
13 extraction expertise, to let them help us. We
14 can get the data. They will help us then be able
15 to do the appropriate analysis of that data. If
16 that clarifies the point.

17 MEMBER DEJONG: Yes, sir. Thank
18 you. My fault.

19 CO-CHAIR CROCKETT-JONES: I also
20 want to say, when the Task Force discussed this
21 recommendation, one of the things that had been
22 coming up as a concern from providers that we saw

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1 throughout the installation visits for last
2 year.

3 That they get folks into a treatment
4 program, they don't complete it. And that their
5 sense was, from a provider standpoint, that they
6 had no, they were not having a way to know what
7 happened to those people once they left their
8 treatment.

9 That as providers they'd see, you
10 know, have them in a treatment program that was
11 going to require, say eight visits. They'd have
12 them for four, and then those folks would drop
13 off their sight lines completely, either
14 because, you know, they were --

15 If they were not in a WTU they could
16 drop off. And then they had no way of
17 recapturing those people, or knowing if they
18 were symptomatically actually improved, or if
19 that, you know, they went off sort of information
20 cliff. That they suddenly lost complete sight
21 of them.

22 And that effective, sticking to

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1 evidence based treatment is only half the
2 equation to predicting outcomes. The other
3 thing is completing the treatment, especially
4 for some of these that are very specific
5 protocols.

6 And is that, are you saying that this
7 information, this new data collection system
8 will give, will help people, will help providers
9 not lose sight of those folks? Or is this just
10 -- I'm trying to see how the thinking behind our
11 recommendation is matched up by this answer.

12 COL POINDEXTER: Okay. Well first
13 I think it's to the comment, and I would also have
14 Major Fuller chime in of her experience. The
15 Air Force really, hopefully was not one of those
16 areas where providers were saying that they lost
17 their patients to follow up. Because we are in
18 individual bases.

19 And so once they go into that clinic,
20 they have that patient through the entire course
21 of treatment. And the patient stays with them.

22 So the only time that someone from

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1 the Air Force would be potentially lost to
2 treatment is if they were sent somewhere else for
3 the entire treatment, and the patient elected
4 not to finish it.

5 But at that point they would then
6 come back to the base. We would know where they
7 were in their course of treatment, and then we
8 would continue treatment from there.

9 What this study is designed to do,
10 is to basically look at the ways that evidence
11 based treatment is currently being used, the way
12 we're diagnosing it. Making sure that the
13 current clinic flow, the clinic processes, the
14 treatments that are being offered, the frequency
15 they're offered, and the way it's offered, that
16 this clinic has been optimized, and it is
17 actually doing the best that it can to take care
18 of PTSD. All their patients are receiving
19 evidence based treatment. Everyone is actually
20 being followed up to the complete course of
21 treatment. And that there are no potential
22 better ways to do things.

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1 So the goal was, it's not, they were
2 working on this I think before this
3 recommendation came out. It just kind of
4 parallels with the issues of auditing. Looking
5 to ensure that evidence based treatment is being
6 done. Does that answer your questions, sort of,
7 kind of?

8 CO-CHAIR NATHAN: Let me ask a
9 little bit akin to that. If we had a map of the
10 world, or of CONUS up here, including Alaska,
11 including Minot.

12 If we saw, put a dot where the Air
13 Force wounded warriors, or Air Force or Guard
14 patients with PTSD were being treated, would it
15 cluster? Or would it be fairly disseminated?

16 COL POINDEXTER: It would in some
17 respects --

18 CO-CHAIR NATHAN: It would --

19 COL POINDEXTER: -- cluster.

20 CO-CHAIR NATHAN: -- cluster.

21 COL POINDEXTER: Only in the sense
22 that, just like you would expect, there would be

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1 a diffuse spray. But you would see clusters at
2 our larger bases, because of just sheer
3 population. For instance, the San Antonio
4 area, the NCR, you would see more patients there
5 just because of the size of population.

6 If you look at the Air Force when you
7 look at PTSD the vast majority of our PTSD is not
8 combat related. So this is PTSD that is
9 occurring for reasons other than combat.

10 So it's not maybe the same as what
11 some of the other services are experiencing. So
12 therefore, you're looking at wherever the Air
13 Force is, that's where potentially you could see
14 PTSD.

15 We do have pockets of our wounded,
16 obviously our recovering warriors who also have
17 PTSD. And but those, we deploy individuals from
18 the entire spectrum of where we're stationed.

19 CO-CHAIR NATHAN: And I only bring
20 it up because it's somewhat numbers driven. But
21 for example, because of the numbers in the Marine
22 Corps and the Army the NICoE has been established

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1 at Walter Reed-Bethesda, which is Air Force
2 personnel who have moderate to severe TBI and/or
3 PTS are cared for there.

4 Then you're going to have the six
5 satellite NICOEs deployed, two to Marine Corps
6 bases and the remaining to Army bases. Even
7 then, places that don't have Army and Marine
8 Corps and Navy facilities, that don't have
9 NICOEs, have a separate sort of TBI/PTS clinic,
10 because of the numbers involved.

11 In other words, other than say San
12 Antonio and Walter Reed, I would think most of
13 your PTSD patients are sort of assimilated into
14 the natural fold, or natural rotation of the
15 mental health clinic.

16 COL POINDEXTER: Absolutely.

17 CO-CHAIR NATHAN: And so again, I
18 think the good news is access is pretty good. I
19 worry a little bit about the fact that you're a
20 little more at risk of having the independent
21 provider, with their independent experience,
22 who doesn't have the collective latest TBI or PTS

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1 skill sets treating. That's all. And so I
2 didn't know how you were approaching that as you
3 look at the dissemination of your patients.

4 COL POINDEXTER: And, sir, and I
5 would concur. And what I would say is, the same
6 that we would do, even for myself from a primary
7 care perspective.

8 If I were at the favorite base of the
9 day, Minot, and I'm taking care of someone, and
10 they're exceeding my capabilities, I do need to
11 realize that I need to tap into a larger
12 resource.

13 And one of the things that we stress,
14 not only in primary care, but obviously in mental
15 health as well, when you're scattered like this
16 and you have someone, if they're exceeding your
17 capabilities, you need to make sure that you're
18 referring them to a center of excellence.

19 And we can benefit from the
20 satellite NICOE clinics, even if they are at an
21 Army or a Marine base. And I think they were put
22 in the right places. But we can still send our

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1 patients there if need be.

2 CO-CHAIR NATHAN: Thank you.
3 Anything further on this recommendation?
4 Number 17.

5 COL POINDEXTER: So number 17 said
6 that the services should ensure that the PEBLOs
7 brief family members enrolled in the Exceptional
8 Family Member Program about potential loss of
9 TRICARE benefits if they were separated.

10 And we definitely agree that the
11 PEBLOs are vital communication link. And that
12 the ability to them to provide benefit change
13 information to the recovering warrior is
14 certainly advisable.

15 What we would say is, we need to be
16 careful that the PEBLO should not be considered
17 the expert in TRICARE benefits. And we
18 definitely would plan on them providing basic
19 information, and a vital, quick link to our
20 TRICARE benefits experts that we do have at each
21 MTF.

22 But we don't want to leave the

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1 impression that we're going to have the PEBLO be
2 the sole source talking about ECHO, for
3 instance. Because it is a complex program.

4 We want to make sure that that family
5 gets the absolute critical information they need
6 to make the best decision for that family.

7 CO-CHAIR NATHAN: Good answer.
8 Okay, number 33.

9 COL POINDEXTER: Number 33.
10 Number 33 stated that the current PEBLO staffing
11 formula was inaccurate. And also that we should
12 work on a new one and make sure that the services
13 have minimum manning.

14 We actually have cooperated with DoD
15 in providing data, in order to make sure that
16 this new staffing model is developed, and has
17 clear Air Force input into what the model will
18 look like. We are waiting on the final product.

19 In addition, we already have
20 alternate PEBLOs at each of our Air Force MTFs.
21 So that there is no place that there is not at
22 least two, a primary and an alternate. That is

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1 not currently, though, codified in an Air Force
2 instruction.

3 And we are updating 41210 to make
4 sure that not only is it happening now, but it
5 will happen in the future. Because it is
6 actually an Air Force instruction. And it's a
7 requirement. And so pending any other
8 questions, this would conclude our briefing.

9 CO-CHAIR NATHAN: I would just say
10 again, kudos. The Air Force, I think, has
11 always been, trying to be centric to the needs
12 and welfare of families and of their personnel.

13 You couple that with my predecessor
14 in this job, Lieutenant General Green, who was
15 very aggressive and passionate about leveraging
16 IM IT, and trying to do things.

17 I mean, if they can give you an iPad
18 when you buy a new car these days, that has the
19 instruction manual on it, we should be able to
20 give a wounded warrior family an iPad that has
21 everything they need for resources. And how to
22 find them on it as well. So again, I credit his

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1 passion with a lot of that stuff.

2 CO-CHAIR CROCKETT-JONES: Thank
3 you very much.

4 COL POINDEXTER: Thank you.

5 CO-CHAIR CROCKETT-JONES: Can we
6 take a five minute bio break while we switch over
7 to Dr. Sims.

8 MS. DAILEY: Five minutes, please,
9 ladies and gentlemen.

10 (Whereupon, the above-entitled
11 matter went off the record at 3:16 p.m. and
12 resumed at 3:22 p.m.)

13 CO-CHAIR NATHAN: Okay, we'll go
14 ahead and get started. I'd like to welcome Dr.
15 Carra Sims who is a behavioral scientist with the
16 RAND Corporation. And Dr. Sims will be
17 presenting information regarding the Air
18 Force's most recent Warrior Survivor Care Survey
19 and any plans as a result of the current
20 findings.

21 You can find this presentation under
22 Tab G. Dr. Sims, thank you for being here.

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1 DR. SIMS: Thank you. So as my
2 introduction said, I am with the RAND
3 Corporation working within Project Air Force,
4 which is the Air Force's federally funded
5 research and development center dealing with
6 studies and analysis.

7 So our mission is objective
8 research. And that is why the Air Force asked
9 us to undertake this investigation. Of course
10 it's a strategic issue, recovering warriors.
11 And that is what we deal with.

12 In addition to my co-author
13 Christine Vaughan who is not here today, I would
14 like to acknowledge briefly the other team
15 members who made and continued to make the study
16 possible, Bobby Theologis, Ashley Bull, Kayla
17 Williams who is here with me, Terri Tanielian,
18 Carl Rhodes, and many other RAND colleagues who
19 gave me feedback along the way.

20 Okay. So this survey, I'll give you
21 a brief background in method and then I'll talk
22 about the outcomes. We'll move to the

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1 recommendations and then next steps, the follow
2 up warrior survey. You'll see this outline
3 slide again.

4 So we fielded in fall 2011 the survey
5 had been in development before this period of
6 course. So in terms of time lines keep that in
7 mind. Our study sponsors were Air Force
8 Directorate of Services; they were our primary
9 sponsor for the beginning of the survey. Also
10 included Secretary of the Air Force SAF/MR and
11 Surgeon General.

12 What we were doing with our study was
13 assessing a base line for a longitudinal study.
14 So this is the first step in something that is
15 considered ongoing and a general pulse for
16 wellness. I'll talk about the content in a bit.

17 We sampled all 872 wounded warriors
18 enrolled in the AFW2 program and receiving
19 benefits. So this did not include separatees
20 who were not currently receiving benefits.

21 I'll probably skip over this a
22 little bit quickly. Some of our responding

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1 groups were relatively small. It did reflect
2 the population. But that does lead to less
3 stable estimates. Nothing that I talk to you
4 about today is not significant. But I want you
5 to keep that in mind.

6 So who was our population? I said
7 we went out to 872 AFW2 enrollees. At the time
8 the survey was fielded, these were the
9 eligibility requirements. So it is any Airman
10 who has a combat or hostile-related injury or
11 illness that may require long-term care.

12 Even though these eligibility
13 requirements are shifting as the Air Force
14 itself is shifting its care, we will be able to
15 track those who are combat injured. So we've
16 made allowances for that. The Air Force then
17 and now had multiple referral strings to the AFW2
18 program. They include the casualty list,
19 self-referral, and the disability evaluation
20 system. So that's how people are coming in.

21 When we were first designing the
22 survey, the Air Force asked us to focus on the

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1 following issues: Utilization of and
2 satisfaction with Air Force support services,
3 the prevalence of psychological wounds, the
4 extent to which wounded Airmen were receiving
5 social support and other issues of concern.

6 So this reflects the web of
7 relationships that we were expecting and that we
8 were planning for. You can see that this is more
9 of a holistic perspective than just satisfaction
10 with services. This deals with multiple issues
11 that Airmen may encounter during reintegration.

12 Right now what I'm reporting to you
13 is data from one point in time. So we can't
14 speak to causal issues. Also one issue to
15 consider is that we covered a lot of ground with
16 this survey. So it was a timely, time consuming
17 survey and we did enable participants to skip out
18 when something wasn't relevant for them.

19 So we did ask about employment. If
20 Airmen weren't employed we didn't ask them about
21 their job satisfaction, for example. So keep
22 that in mind. So we went out to 872 Airmen, as

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1 I said before, this is the census. Of that 872,
2 493 started the survey and 459 were considered
3 to have completed the survey. When I say they
4 completed the survey, they completed at least 50
5 percent of the items that everybody saw.

6 So I mentioned the skip patterns
7 earlier. Not everybody saw every item. So
8 it's not as relevant. In terms of missing data,
9 generally if people started the survey they did
10 complete it. There were people who slowed down
11 early on and stopped. But most people completed
12 most of the items and there were no outstanding
13 patterns in terms of missing data.

14 Airmen could complete the survey
15 either by web or by phone. And most did complete
16 by phone. The survey was open for about two
17 months. I don't know what the Halloween closing
18 date says about the survey, but it did close on
19 October 31.

20 And given the population I want you
21 to consider that we had both Airmen who were
22 current and Airmen who were retired. So we had

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1 a mix. And because hostile-related injuries or
2 injuries related to deployment could lead to
3 enrollment in the AFW2 Program, not all of our
4 Airmen had been deployed.

5 MEMBER STONE: I wonder if you would
6 just pause a minute. I'm not sure, so those that
7 are retired were included. But in a previous
8 slide you said separatees were not included.
9 Now are you saying that those that separated
10 without benefits were not included?

11 DR. SIMS: Correct, exactly.

12 MEMBER STONE: So one of the
13 requirements was benefits?

14 DR. SIMS: Yes.

15 MEMBER STONE: Okay.

16 DR. SIMS: Okay. So a lot of your
17 questions about the survey dealt with who were
18 our participants. We have a lot of information
19 on that. In terms of reducing burden not only
20 did we engage with skip patterns when we could
21 in the survey itself, we also leveraged Air Force
22 personnel data. So we had information both on

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1 the sample and on our population. And we did do
2 the comparison between the two.

3 Our respondents were slightly more
4 educated, had slightly more years on active duty
5 and were slightly older than the Airmen who did
6 not participate. These differences, while
7 significant, in this case were not substantively
8 meaningful. So when I say a difference, I mean
9 about a year. The Airmen who participated in
10 the survey were about a year older.

11 You can see the information on
12 gender in the information on the component of
13 respondents. These were both representative of
14 the population. In terms of the proportion
15 enlisted versus officer, that's up there.

16 But to break that out for you E1 to
17 E4 we had 16 percent. E5 to E6, 48 percent. E7
18 to E9, 21 percent. O1 to O3 was about 10
19 percent. And O4 to O6 was about four percent.
20 And I'm rounding there so they don't add up
21 perfectly, but --

22 You can also see here that a high

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1 proportion of Airmen were in the system for PTSD.
2 So that drove some of our mental health focus.
3 Did I hear a question?

4 CO-CHAIR NATHAN: So how would you
5 summarize this slide?

6 DR. SIMS: The title, our sample of
7 survey participants was fairly representative
8 of our population. We looked like the Air Force
9 enrollees in the AFW2 Program.

10 Okay. Here's the 20,000 view.
11 I'll get into the nitty-gritty.

12 So I did mention about smaller group
13 sizes leading to less stable estimates. Here's
14 a quick illustration of what that might look
15 like. You can see here that we have 127 who were
16 active duty, active component Airmen. We had 48
17 who were Guard and Reserve. And 284 who were
18 retirees answering this question. This is the
19 break up by duty status that I'll continue with
20 throughout. And we broke it out like this to
21 help illustrate differences in overlapping but
22 somewhat different systems of care.

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1 So for the Guard and Reserve group
2 we have the point estimate. But we also have the
3 uncertainty around that point estimate. The
4 confidence interval which is larger than for the
5 Retiree group. Basically the more people who
6 are answering a given question, the more
7 information we have and the more we can narrow
8 that down.

9 So program usage and satisfaction.
10 I'll start off with a general question we asked
11 everyone. We asked Airmen if they could have a
12 support service, whether or not they used it,
13 would they be interested. So as you can imagine
14 universally endorsement rates were pretty high
15 for the ten options that we provided for them.

16 Even if you don't need a service
17 right now your tendency is to say, yes, I would
18 like to have that. For the desired social
19 support services, Airmen were asking for general
20 information, an advocate, a helping hand, help
21 connecting. Some of these services the Air
22 Force helps to provide.

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1 In general, Active Duty, Reserve and
2 Guard and Retired Airmen were similar in what
3 they thought would be helpful. The only
4 difference here was for housing assistance or
5 loans.

6 CO-CHAIR NATHAN: Are you able to
7 make any generalization about the folks who did
8 not want any help, shape, way, or form?

9 DR. SIMS: There were very few of
10 them. I think --

11 CO-CHAIR NATHAN: Those are the
12 ones that worry me. I mean, in other words your
13 question was fairly liberal, right which was,
14 hey, you may not need something right now but
15 would you ever be interested in support services
16 either from advocacy or loans or help? And 90
17 plus percent said yes, right?

18 DR. SIMS: Right.

19 CO-CHAIR NATHAN: So I'm just
20 curious about the percent that said no. You
21 know are these on their way out, these are, you
22 know, it almost seems like a little bit of a

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1 yellow blinking light to me.

2 DR. SIMS: The percent who said no
3 for a given service were for the item overall
4 because they had ten options. I haven't done
5 this analysis, but I would suspect that everyone
6 endorsed at least one.

7 CO-CHAIR NATHAN: Got you.

8 DR. SIMS: I mean we asked about a
9 variety of different things. I'm just
10 presenting a subset here. So I'll go quickly
11 over this one since you're familiar with the AFW2
12 Program and the Recovery Care Coordinator
13 Program. Program personnel have been helpful
14 and actually helped provide input into our
15 survey items.

16 So we asked about usage and
17 satisfaction. So given that we went out to Air
18 Force Wounded Warrior enrollees it's not
19 surprising that we had pretty good coverage.

20 When asked what specific services
21 they had received, we asked about several
22 different options, regular supportive calls,

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1 help for paperwork, advice for dealing with red
2 tape, other types of services all were used.
3 Most report using at least one support service.

4 Those who received services were
5 asked about their satisfaction with those
6 services. And satisfaction was very high. You
7 can see that overall satisfaction was very high
8 and specific item satisfaction was high as well.

9 So I'm pausing here because I know
10 this is of interest to you guys. Are there any
11 questions on this one?

12 CO-CHAIR NATHAN: No, Stone and I
13 were just saying we joined the wrong service,
14 that's all.

15 DR. SIMS: Well RAND does Army too.

16 MS. DAILEY: Well according to the
17 Army survey we saw this morning their
18 satisfaction levels were along the same area.

19 CO-CHAIR NATHAN: Right did you
20 break up the cohort from Minot in this group?

21 DR. SIMS: No, we didn't. That
22 might be a different story entirely. But that

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1 wouldn't necessarily be with the AFW2 services,
2 that might just be with Minot.

3 So we also went out and asked about
4 the recovery care coordinator services. So
5 consider that the eligibility for this one is a
6 little bit different. And it had a more recent
7 roll out. So roughly 20 percent of all Airmen
8 surveyed had received services from this
9 particular program. The program is newer,
10 differently targeted. That's expected.

11 When asked about what services
12 they'd received, program users said referral to
13 other programs and services, advice for life
14 matters, red tape, help adjusting or coping with
15 service-related physical or mental health
16 conditions and follow up after the development
17 of the Comprehensive Recovery Plan. That's the
18 lowest endorsement rate. But I'll actually
19 show you on the next slide why we think that might
20 be more of a branding thing than anything else.

21 So program users received questions
22 about satisfaction. Endorsement here was also

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1 very high. People were very satisfied. And
2 you can see that also high is endorsement for the
3 item recovery care coordinators can help me
4 achieve personal goals. And that's what a
5 Comprehensive Recovery Plan is all about. So
6 they may not have been calling it that at the time
7 that we fielded the survey, but they're getting
8 help with that issue.

9 We did split this out by duty status.
10 And the different duty status groups did not
11 differ. They were very satisfied universally
12 with AFW2 services. Further the three groups
13 endorsed a similar number of positive statements
14 about the AFW2 Program. Given the small numbers
15 of respondents for the Recovery Care Coordinator
16 Program, we didn't break it out this way because
17 that would have led to small cell size and less
18 stable estimates.

19 (Off microphone comment)

20 DR. SIMS: This particular one is
21 yes/no. Satisfaction, were you satisfied
22 overall yes/no. Yes, as a psychologist I would

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1 have liked to have gone out with Likert scales
2 but we wanted to make it shorter too. And we
3 were covering a lot of ground.

4 So psychological injuries and their
5 measurement and perceived treatment barriers.
6 So we knew, as you saw in the slide describing
7 the sample, that mental health issues were an
8 issue for our population. So we screened for
9 them. For PTSD we used the PCL, which is
10 actually used by the DoD and the VA as a screener.
11 It consists of 17 items that were keyed to DSM-IV
12 diagnostic criteria.

13 So how well does this work you might
14 say. It works pretty well. It has a
15 sensitivity of a 100 percent and a specificity
16 of 92 percent in past research. And what that
17 means is that in a study using a gold standard
18 diagnostic clinical interview for people who
19 were classified as having PTSD, the PCL
20 identifies 100 percent of them.

21 For people who are classified as not
22 having PTSD, the PCL correctly classifies 92

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1 percent of them. So it's not a diagnosis. But
2 it's pretty darn close. We also screened for
3 major depressive disorder because we know that
4 this tends to be co-morbid with PTSD.

5 So we thought it was a good thing to
6 check into. For this we use the PHQ also keyed
7 to DSM-IV criteria, also with good sensitivity
8 and specificity.

9 MEMBER STONE: You said you used the
10 gold standard of a face to face interview.

11 DR. SIMS: No, we did not. We used
12 the screeners because --

13 MEMBER STONE: I got that, but when
14 you said when compared to --

15 DR. SIMS: Yes.

16 MEMBER STONE: -- the gold
17 standard. And what is the sensitivity and
18 specificity of a face to face interview?

19 DR. SIMS: That's an interesting
20 question because that's considered the gold
21 standard.

22 MEMBER STONE: Okay. Who decided?

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1 DR. SIMS: The medical doctors, the
2 researchers, the research community. So for
3 PTSD that would have been the CAHPS interview
4 that is considered --

5 MEMBER STONE: So it's hard to
6 exceed a 100 percent sensitivity --

7 DR. SIMS: Yes.

8 MEMBER STONE: -- specificity or
9 accuracy in diagnosis. It would be hard to
10 believe that a face to face interview that would
11 be more accurate than the numbers that you're
12 coming up with?

13 DR. SIMS: Well we do a very close
14 match, let's put it that way, to a face to face
15 interview.

16 MEMBER STONE: I would submit to
17 you, you may even be higher. Sobering thought
18 for us as clinicians. But I would submit to you
19 that this may be a better tool than a face to face
20 interview based on the fact that it's pretty
21 non-threatening.

22 DR. SIMS: Right, right. It's

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1 somebody at a distance. And we did emphasize to
2 participants that we were not the Air Force and
3 the Air Force would never see their individual
4 level data. So we did have those advantages.
5 But it's not the same as clinical treatment.

6 MEMBER TURNER: But again didn't
7 you just, you based it against the gold standard.
8 So the sensitivity and specificity were based
9 against clinical diagnosis to get those numbers.
10 So it's a circle.

11 DR. SIMS: I'm not sure I have to
12 brief this slide. Why did we collect our own
13 mental health data? Consider that this is the
14 start of a longitudinal survey and we wanted to
15 be able to track change over time.

16 To be able to do that we wanted
17 consistency of measurement with our own
18 standardized items and to have a current and
19 consistent time frame with the rest of the
20 information we were collecting on the study. So
21 I do speak a little bit about mental health data
22 collected as part of on the record assessments.

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1 This can go either way. There are
2 controversies either way. But we used well
3 validated, widely used measures. As
4 anticipated based on what we knew about the
5 population, we had pretty high rates of both PTSD
6 and also of depression.

7 CO-CHAIR NATHAN: So let me ask a,
8 and I apologize if you covered this and I sort
9 of missed the concept, basic question. So yes,
10 you are germane to your previous slide why did
11 we do this in addition or, you know, outside of
12 Air Force's own values. One advantage is you
13 don't represent the company. People may be less
14 threatened so therefore may be more prone to give
15 you realistic answers and more accurate
16 diagnosis.

17 But I thought I saw a slide earlier
18 where you showed, and this may be apples and
19 oranges, where you showed you're fairly
20 representative, your group, you're fairly, that
21 you sampled is fairly representative of the
22 group at large. And the group at large is based

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1 on what the Air Force thinks.

2 DR. SIMS: Correct.

3 CO-CHAIR NATHAN: So what you think
4 is what the Air Force thinks. So if I'm the Air
5 Force right now I'd say thank you, you're done,
6 right? I mean we've got it right.

7 DR. SIMS: To some extent, yes.
8 But if you consider that, so that's an issue
9 about their clinical diagnosis, right and
10 whether or not their clinical diagnosis is
11 matching an outside observation. But the
12 survey wasn't just about mental health. It was
13 about more issues involved with reintegration.
14 Mental health is of course a big issue. So we
15 couldn't ignore it.

16 CO-CHAIR NATHAN: So you widen the
17 aperture beyond what the Air Force itself
18 samples and you're adding additional
19 information to that.

20 DR. SIMS: Right. So I mentioned
21 earlier that this was sort of a pulse and we
22 covered a lot of ground. We did look at

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1 satisfaction with Air Force services. But we
2 also looked at other issues including social
3 support a little bit, employment and housing, so
4 other issues where people might experience
5 challenges. And this is sort of a demand signal
6 for planning down the road.

7 So we did break this out by duty
8 status. You can see that Reserve and Guard
9 tended to screen positive more frequently than
10 did current Active Duty. Also Retirees tended
11 to screen positive more often for both than
12 Active Duty.

13 We did look at an analysis just among
14 retired Airmen looking at the odds of screening
15 positive for these two disorders based on time
16 of separation. We found that for PTSD the odds
17 of screening positive were higher among more
18 recent retirees. For major depressive disorder
19 there was no such relationship.

20 MEMBER STONE: So because all of
21 these service members or retired were receiving
22 benefits how did this match to their reason they

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1 received benefits?

2 DR. SIMS: We didn't actually do a
3 one to one correspondence of that.

4 MEMBER STONE: So we don't know if
5 the, because you were so heavy into the retired
6 group, we're not sure whether this was major
7 depression arising post retirement or whether it
8 was why they retired?

9 DR. SIMS: Right, correct. Now in
10 terms of the overall cohort information based on
11 the disability evaluation system, so matching
12 our 872 as closely as possible, which the perfect
13 match wasn't possible, depression was less
14 frequent among that cohort.

15 MEMBER STONE: So, Surgeon
16 General's rep, what do you guys think?

17 COL. POINDEXTER: Initially that
18 data analysis was not included. And we were the
19 ones that actually asked for it because we did
20 want to know what is going on when we saw the
21 original numbers based on RAND. This is what
22 they're saying point in time, but what did they

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1 leave the service with?

2 In the area of the PTSD it was
3 relatively similar. We still can't say for sure
4 because we can't do a one to one to know. But
5 it was reasonably close, both were in the 70's.
6 It is very interesting to see that the level of
7 depression that screened positive in this group
8 was markedly higher than what was listed as
9 depression in the entire cohort when they
10 actually left, what their rating was.

11 And we've actually, I mean and
12 clearly there are multiple potential reasons for
13 that. Obviously this is a point in time. We
14 can't go back to find out was the individual
15 having spousal issues, had they just lost their
16 job? Were there issues related to their injury
17 that was driving issues of depression? Because
18 of the criteria for depression it requires two
19 weeks.

20 There may have been, but given the
21 large number it clearly appears to be some
22 relationship between this group and an increased

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1 incidence of depression. And we do think it
2 warrants further study. And we plan on doing
3 that as you will find out in a couple slides.

4 DR. SIMS: Well more than a couple,
5 perhaps unfortunately. But so are those facing
6 these challenges getting treatment? And the
7 answer is that a lot of them are. So for people
8 with PTSD and/or depression over 90 percent had
9 received mental health services in the past
10 year, which is very high.

11 For those who are getting mental
12 health treatment, the majority are getting both
13 meds and therapy. And for those who had a need
14 and got treatment over the past year there was
15 a large proportion who indicated that they
16 wanted mental health services, but did not
17 obtain them.

18 So we dive into that a little bit
19 more. But if you consider they had at least one
20 appointment in the past year and in the same time
21 frame, in the past year there was a time when they
22 wanted an appointment and didn't have one or

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1 wanted treatment of some sort and didn't have it.

2 Past year mental health services
3 were more commonly received by Reserve and Guard
4 and Retirees then Active Duty Airmen. And
5 Reserve and Guard and Retirees were also more
6 likely to indicate, sorry Reserve and Guard were
7 more likely to indicate that they'd received
8 both meds and therapy.

9 Our participants were seen in a
10 variety of treatment locations. More than half
11 were seen in more than one setting. So since we
12 asked about the barriers that they encountered
13 in mental health services, in a general sense
14 this makes it hard to pinpoint where the problem
15 is and where work needs to be done. That's for
16 the next survey as we'll talk about.

17 MS. DAILEY: So real quick on your
18 slide past the one right before this. I believe
19 if I could get you to go back one.

20 DR. SIMS: This one?

21 MS. DAILEY: Past year mental
22 health services were more commonly received by

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1 Reserve component and Retirees than Active Duty.

2 DR. SIMS: This one.

3 MS. DAILEY: That one.

4 DR. SIMS: Okay.

5 MS. DAILEY: Does that mean, I hate
6 to interpret, does that mean that the Reserve
7 component and Retirees had more access to mental
8 health services than Active Duty?

9 DR. SIMS: Not necessarily. It
10 might mean that they had more need, which we did
11 also show higher rates. So there are multiple
12 explanations.

13 For those who said there was a point
14 in the past year where they needed mental health
15 services and didn't get it we asked why. We
16 provided a variety of potential barriers
17 including logistical ones, ones that dealt more
18 with issues of cultural and institutional
19 barriers and ones that dealt more with treatment
20 beliefs of participants as well as having
21 another option.

22 MEMBER EUDY: Ma'am, a quick

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1 question here. I'd asked this earlier
2 regarding the Airman Family Readiness Centers
3 and access to care as a priority for the
4 recovering warrior population.

5 Specifically addressed in priority
6 of services I noticed back in the
7 recommendations, I'm actually going through the
8 slides and just to reference this, it stated here
9 that case managers might be able to address
10 scheduling difficulties and future research
11 that identify causes of scheduling difficulties
12 or potential solutions. I'm wondering what
13 separate of these points is being done then to
14 meet that need of that 49 percent.

15 As we say we would give the priority
16 for the Airman and Family Readiness Centers.
17 What is being done then to facilitate it in both
18 the mental health but then the, you know,
19 orthopedics any other care department
20 separately of that? So that may be just you,
21 ma'am. But it's also to the Members that are
22 here.

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1 DR. SIMS: So to a certain extent
2 this gets at the challenge that I just mentioned.
3 We asked about barriers in a general sense and
4 we didn't pinpoint the location. That is
5 something that we have worked with the surgeon
6 general's office to pinpoint for the next
7 survey. We'll ask about the top three barriers
8 experienced and where exactly those happened.

9 But for this, we did recommend that
10 potentially non medical case managers could also
11 help with scheduling an appointment. But the
12 next bullet there also says, you know, find out
13 why this is an issue. For some this might just
14 be an issue of the number of providers. That's
15 a big rock that everybody's working on. So --

16 COL. POINDEXTER: I'll just stand
17 up and add in. We're actually drifting into the
18 third hour, which is great because then we all
19 end early. But one of our three areas that the
20 agenda asked to cover was exactly some of the
21 concerns from this study that we felt needed
22 further survey and inquiry.

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1 And this is clearly one of them.
2 And you've actually hit on it. And the
3 challenge that we face is this was a great base
4 line study and opened a lot of areas of inquiry,
5 which is one of the problems of the study is that
6 it's opened the inquiry area but it didn't really
7 give us a vector to know is this in the lane of
8 the VA where they're experiencing trouble? Is
9 this in the lane of the Active Duty direct care
10 system? Is this is the civilian sector?

11 We certainly are continuously
12 looking internally at ourselves and saying fine,
13 we'll just assume potentially this could be
14 within the direct care system. And let's look
15 at our systems and see what are potential
16 barriers to care. And what would be reasons why
17 someone could not access mental health care?

18 We make sure that we actually are
19 making as few of, barriers between the time they
20 pick up the phone and actually someone answers
21 and they can actually make an appointment. We,
22 as stated, certainly we have additional

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1 individuals who can assist them. If they feel
2 like they want care we'll point them towards
3 mental health care. The hard thing we have
4 right now is we don't know exactly what triggered
5 that to be able to then pinpoint what would
6 answer their concern.

7 MEMBER STONE: And as you move into
8 the center portion of the chart on
9 confidentiality, stigma, and career harm you
10 can't tell whether one is linked to the other.
11 I had trouble scheduling an appointment because
12 I didn't want to give my name and rank because
13 I thought it might harm my career.

14 COL. POINDEXTER: Absolutely and
15 you will see that is also part of the third hour.
16 That was one of the other areas that was
17 highlighted as a concern. And it is a
18 recommendation, issues of confidentiality.

19 MEMBER STONE: In your population
20 because of flight status you have unique
21 challenges that some of us don't share in large
22 percentage of our population.

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1 COL. POINDEXTER: Absolutely, yes,
2 sir.

3 DR. SIMS: Well and it's a concern
4 generally if you think about the stigma in
5 general society. It's not just a military
6 issue. It's an issue that happens frequently.

7 MEMBER STONE: Are those numbers
8 similar to civilian, I'm sorry. Are those
9 numbers similar to civilian?

10 DR. SIMS: I don't know that these
11 items have been given to civilian numbers. But
12 certainly in terms of the general research
13 literature, yes. People with mental
14 disabilities have trouble getting jobs and
15 keeping jobs.

16 And it's a stigma issue that
17 everyone confronts. And to some extent if they
18 can keep in confidential within themselves they
19 are inclined to do so because it's stigmatized
20 generally.

21 MEMBER STONE: But you don't have
22 any hard data?

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1 DR. SIMS: Not off the top of my
2 head. I can send you some journal articles
3 later. But I don't have any that match this.

4 CO-CHAIR NATHAN: All we're saying
5 is intuitively in our services if you lose your
6 reactor qualification, if you lose your ability
7 to be in the cockpit of an aircraft, if you lose
8 your ability to transfer weapons because your
9 command is required to report you as part of a
10 PRP program, intuitively we believe that stigma
11 plays a larger role in our service than it does
12 in the outside.

13 But there's no question that
14 somebody who has to fill out a job application
15 that says have you ever been hospitalized or seen
16 for any physical or emotional illness, there's
17 stigma there to.

18 DR. SIMS: Correct. I just didn't
19 want it overlooked on the other side either
20 because it is one. So we broke this down by duty
21 status. These are the only differences that
22 were significant among duty status groups. So

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1 you can see Reserve and Guard were more likely
2 to indicate that they had trouble in terms of not
3 knowing where to get help.

4 They were significantly more likely
5 then Retirees as were Active Duty to say that
6 they were concerned that others would respect
7 them less. And Reserve and Guard and Active
8 Duty were together in terms of being concerned
9 about professional harm to career. And we don't
10 know if this is the Air Force career or their
11 civilian career for Reservists and Guardsmen.

12 So we also asked them what kind of
13 a provider would they prefer if money were not
14 an issue at all. Out of the 459, so going back
15 out of the skip pattern, 51 percent said that
16 they'd like a civilian provider. Active Duty
17 Airmen were significantly more likely to say
18 this.

19 We tried to dig a little bit deeper
20 into this. Again looking at the 459, so for the
21 barriers items if people experienced a barrier
22 we asked them about the barriers that they

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1 experienced. But we also did ask people if they
2 thought they might encounter a barrier, what
3 barrier would that be? That's how those people
4 were able to be included in this analysis.

5 Airmen who were Active Duty,
6 unmarried and concerned about confidentiality
7 had higher odds of preferring civilian
8 providers. When we narrowed that down to the
9 199 who actually received, who actually
10 experienced some challenges, the issues about
11 confidentiality were still significant and
12 large.

13 So other pertinent areas. We asked
14 Airmen who served as someone from whom they got
15 help when they faced challenges. The specific
16 language was who most often helps you deal with
17 problems that come up? And we gave them several
18 options of which they had to pick one.

19 So for most this person was their
20 spouse or partner. However, about 25 percent
21 did indicate that the question was not
22 applicable to them because they did share their

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1 problems with anyone.

2 MEMBER TURNER: Can I ask you to
3 talk about spouses and did not share their
4 problems with anyone, could you simply comment
5 upon single people, or did you have very many
6 unmarried people in this?

7 DR. SIMS: Most people were
8 married. I can go back --

9 MS. DAILEY: We'll get to that
10 information, okay.

11 DR. SIMS: Okay, yes, there were
12 single people. They were not as frequent as
13 married. But I would have to go back to give you
14 the specific statistic.

15 So in terms of people who don't share
16 their problems, we didn't delve down into why
17 they didn't share their problems. This might be
18 because they didn't have anyone to fill that
19 function. It might be because they didn't want
20 to. All right. So some of the discussion
21 earlier was about people who didn't want help.

22 MEMBER STONE: So just anecdotally

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1 I will bet you that if you ask their spouses they
2 were sharing their problems. They may not have
3 felt they were sharing their problems. This
4 goes back to the discussion we had earlier on
5 engaging the family and why if you hide behind
6 HIPAA and say well I can't talk to the family you
7 deprive yourself from the knowledge that the
8 spouse or family can bring to you about how the
9 service member is doing.

10 DR. SIMS: Right, right.

11 MS. DAILEY: Were the non medical
12 case managers or the RCC's or case managers,
13 medical case managers, nurse case managers
14 included in this list of who was most commonly
15 identified as someone to help them with
16 problems?

17 DR. SIMS: They were actually not.

18 MS. DAILEY: They were not, okay.

19 DR. SIMS: Yes. That was actually
20 something that we had originally had in the first
21 version of the survey. And our institutional
22 review board pushed back on that I think. Well

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1 because we had I think medical practitioners.
2 This was two years ago so I know you're
3 transcribing. But don't quote me on that.

4 So in terms of employment, about 35
5 percent of the non Active Duty respondents were
6 working full-time. In terms of the headline
7 numbers that you hear on the news, that's usually
8 the Bureau of Labor Statistics' U3 measure. And
9 for our survey working that formula out leads to
10 about 14 percent of Airmen who are unemployed.

11 Now to some extent you expect
12 unemployment after you've left the service. We
13 don't have the timing for that. We asked those
14 who were disabled and not working and unemployed
15 and looking for work what barriers they
16 perceived and what challenges they encountered
17 in getting a job.

18 For this one they could choose as
19 many as applied. And less than 10 percent chose
20 one. Most chose many. Though many worried
21 about their injuries and their disabilities,
22 many also listed concerns about qualifications

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1 and skills and finding information about
2 available jobs. So these are things that the
3 Air Force can do something about potentially and
4 also the VA.

5 MEMBER EUDY: Question, ma'am, in
6 regarding that. And forgive me because I think
7 I'm looking at this correlating the colors of the
8 previous charts with the Active Duty,
9 Guard/Reserve and Retirees that are listed here.

10 But that makes me wonder about the
11 involvement of the transition coordinators or
12 the employment initiatives that exist on these
13 bases for getting numbers that are so high. So
14 do you have break down? Is that, of that 69 and
15 59 that are listed at the top is that, from which
16 component? Guard and Reserve, the Active Duty
17 component or the Retirees?

18 DR. SIMS: So for that we're getting
19 into the small cell sizes. And we looked at
20 splitting it out and it was too small to do so.

21 MEMBER EUDY: Because my concern is
22 then just from the response of the population,

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1 I don't want to say something is ineffective as
2 in we're not, you know, getting the transition
3 options out. But that, you know, it sets off
4 something for me to see those numbers that high
5 considering the services that offered, so.

6 DR. SIMS: Well consider who got
7 this portion. And this is part of why the
8 numbers who answered the questions were smaller.
9 These were people who said that they were
10 disabled and not working or unemployed and
11 looking.

12 In the next survey we're actually
13 going out to a more general group. So we can do
14 more parsing. In some cases the options don't
15 match up because they aren't as relevant. But
16 we are going out to everyone in that sense. So
17 no one study is perfect. We are still working
18 on this one too.

19 So this is a very busy slide. And
20 I wanted to give you some context here because
21 it is about housing and stability which is a very
22 sensitive issue. So we started the section with

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1 a screener item for lifetime history of
2 homelessness.

3 We asked have you ever spent the
4 night, so one night, in any of the following
5 places during your life time because you had no
6 regular place to stay? And we gave them seven
7 different options. If they said yes, we asked
8 them how recently and compared that to their
9 deployment return date.

10 So then because people who were
11 living in unstable housing conditions more
12 recently are logically a subset, we asked those
13 people more detailed questions. We asked about
14 the past six months and asked where they were
15 staying.

16 When I talk about people who were
17 homeless, the people that we're classifying as
18 homeless in that sense are this last group.
19 These people who said they were staying in a
20 transitional shelter, a voucher paid hotel or
21 motel room, a boarding, transition or halfway
22 house, a mission or shelter, a church or chapel

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1 but not in a bed, an all night theater or similar
2 public place that's not usually used for
3 sleeping, an abandoned building, a vehicle or
4 the street.

5 So I'll refresh on these as I go
6 through. But I wanted to set the stage. About
7 20 percent have spent the night homeless at some
8 point in their lives. For nearly half of these
9 Airmen the first time was after returning from
10 deployment. So recall that this is people who
11 reported spending the night, one night, in one
12 of the following due to no regular place to stay.

13 This may not be the prototype of
14 homelessness, but it's an indicator of risk. So
15 among the 99 who had experienced a life time
16 history, a third reported being homeless in the
17 past six months. So this is only seven percent
18 of the 459.

19 And this third are saying that they
20 were staying in a transitional shelter, voucher
21 paid hotel, boarding or halfway house, mission
22 or other shelter, church or chapel, public

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1 theater, other all night location, abandoned
2 building, vehicle, or the street.

3 We also asked them if they
4 considered themselves to have been homeless.
5 And of the 99 only 18 percent said yes.

6 MEMBER MALEBRANCHE: Was this,
7 excuse me, was this a subset of the original
8 group that had case managers when the wounded
9 warrior or this was a different group, this 99?

10 DR. SIMS: When you say, so it was
11 definite --

12 MEMBER MALEBRANCHE: Was it all
13 part of the same survey?

14 DR. SIMS: It's all part of the same
15 survey. But this is part of the skip patterns.
16 So because it wasn't, these questions in the past
17 six months weren't relevant for anybody who
18 hadn't experienced it in their life time, they
19 didn't get these questions.

20 MEMBER MALEBRANCHE: Okay. I was
21 trying to figure out about the case managers
22 though because the earlier folks had them. And

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1 I was wondering if this group would have been of
2 that same group that 90 percent or 85 percent had
3 the case managers if they wanted them. This
4 group did have that.

5 DR. SIMS: Yes, they potentially
6 could draw upon that resource.

7 MEMBER MALEBRANCHE: Okay. That's
8 all. Thank you.

9 DR. SIMS: And maybe in some cases
10 they chose not to. We didn't dig down in there.
11 So just to sum up Air Force Wounded Warrior
12 enrollees are facing a variety of reintegration
13 challenges. This should come as a surprise to
14 no one.

15 Mental health is a concern for the
16 majority. There may be some issues with social
17 support with roughly 25 percent of Airmen who
18 were surveyed reporting not having a primary
19 supporter. This is their self-report.
20 Whether or not their spouses would agree with
21 that, that's another issue. This does not vary
22 by duty status.

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1 In terms of housing and stability,
2 roughly ten percent of Airmen surveyed reported
3 having spent the night homeless since returning
4 home from their last deployment. This does not
5 vary by duty status. In terms of unemployment
6 nearly 14 percent of Airmen surveyed were
7 unemployed per that U3 measure. This does vary
8 by duty status with Active Duty more likely to
9 say that they were employed.

10 So in terms of recommendations,
11 nearly half of Airmen with unmet treatment needs
12 sometime in the past year perceive that mental
13 health treatments available to them are not very
14 good. So some of our recommendations deal with
15 branding and public perception because a lot of
16 people, this is based on the general literature,
17 a lot of people tend to think civilian care might
18 be very good.

19 But the available evidence suggests
20 that it's not so good. So inform Airmen about
21 the quality of care available to them. Collect
22 and publicize data on the quality of care

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1 implemented in the MTF's. Tell them where high
2 quality treatment can be obtained and what it
3 looks like because people might not know
4 automatically.

5 Let them know that medication is not
6 the sole therapy mode. This will help alleviate
7 concerns about negative side effects. If you
8 think about going to the doctor, you never got
9 a class on that. You don't know that you're
10 supposed to have a discussion with your doctor
11 about how you're being treated and whether
12 you're having side effects and things like that.
13 So they may not think about that.

14 CO-CHAIR NATHAN: You know it's
15 interesting we've done a great deal reducing
16 stigma with the Marine Core. If you talk to the
17 Marine Core leaders more Marines than ever are
18 now raising their hand saying I need help, I'm
19 not doing well.

20 The problem, and this gets to the
21 education of the patient, the problem is that
22 those same Marines are going to the doctor or to

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1 the psychologist or psychiatrist and saying give
2 me the pill or hit me with the ray gun or whatever
3 you do so I can get back to work. And they're
4 told this is going to be an evolution of anywhere
5 between three to six to 12 to 20 weeks.

6 And they don't return because their
7 expectation is that they can get a quick fix. So
8 this is something else I think that we need to
9 do for those people. We're doing a great job
10 lowering the bar for people to come in and see
11 us. But we're not doing a good job of getting
12 them psyched, if I can use that term, up for the
13 long road ahead.

14 MEMBER STONE: So we've taken just
15 a bit of a different approach to this. And that
16 is we've embedded the behavior health in the
17 brigade combat team. We've put 13 behavioral
18 health providers in a team of 3,000. And they
19 actually embed so therefore there's not any
20 coming in.

21 It's the provider going to the
22 service member and then the therapy is

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1 integrated into PT. It's integrated into all
2 those other things that go on. And we've found
3 dramatic changes in the ability to complete
4 care.

5 CO-CHAIR NATHAN: Yes, and that's
6 true, Rich. And we have the OSCAR teams that
7 we've put in with the Marines. But I'm speaking
8 more of I think the folks who are not, who are
9 more in the garrison and have come back from
10 deployment and are doing their thing who finally
11 sort of get the nerve up to go in and see the doc.

12 And so again, I think we're making
13 headway. But this resonates with me where we
14 don't cultivate a culture of service personnel
15 and/or their families on how to best utilize the
16 services and what's available to them.

17 DR. SIMS: Well in some cases just
18 getting the pill would be contraindicated
19 actually.

20 MR. LARRY: So may I just piggyback
21 on your comment? You make a very good point
22 because I can tell you in 2010, for the Air Force

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1 we had what we call Year of the Air Force Family.

2 And one aspect of that was medical care.

3 And Dr. Green and his team put a lot
4 of emphasis on working to make sure that the
5 availability of care, they could get access.
6 And also this element of mental health and
7 looking at some of the barriers and what else
8 that we could do as an Air Force to help to
9 educate the team on the care is there. We'll
10 give it our best. But you need to give us an
11 opportunity.

12 And your point you just made
13 regarding the Marines was spot on because even
14 though we could get some of the members in it was
15 always if it's not a quick fix I'm concerned
16 because it's going to impact my career and I'm
17 not coming back.

18 And the second thing I would like to
19 say about a year and half ago under Admiral
20 Mullen and some of you may recall he had some
21 family initiatives where we had to come to him
22 on an IPT construct and say what are you doing

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1 about these particular issues. One of them was
2 medical care and it focused on pain management,
3 yes, sir.

4 And the other part we looked at was
5 the military health aspect. How do we make sure
6 people have access? How do they get the care?
7 So we would walk through these many times. And
8 there's some good points revealed here.

9 Some of it is follow on to validate
10 lessons learned and things that we are working.
11 But it's a constant battle. We know that and as
12 a collective bunch of service pro we keep working
13 it. So thank you.

14 MEMBER EUDY: Although it is a
15 fairly new program recently we had been told and
16 we talked about it at San Antonio, the resiliency
17 enhancement visits that have now been started
18 where the service member can go and receive four
19 off the record visits. Has there been any
20 response yet from the installation levels
21 regarding these?

22 Although this is a fairly new

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1 initiative Air Force wide. Sir, is there
2 anything back yet from any of these?

3 MAJOR FULLER: Major Fuller, thank
4 you. That was an AMC initiative. And a great
5 program that they initiated. That program has
6 been transferred to the BHOP program in primary
7 care, which I think was a great move because it's
8 that liaison, that step to get them into
9 behavioral health, but in the primary care
10 setting.

11 So the program is still moving and
12 may have a change of name. But that's going to
13 be across the Air Force, not just AMC specific.

14 CO-CHAIR NATHAN: The services
15 wrestle with this. This is a tremendous source
16 of tension between the anonymity of the patient
17 and the awareness of the command of a problem.
18 I learned this mainly from the comprehensive
19 soldier fitness program where the Army has this
20 great GAT test that you can take that can
21 identify that you may have real, real problems.
22 You're in danger.

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1 And then some of the line leaders say
2 well great, have a little bell go off in my office
3 and we'll all swarm the guy and take care of him.
4 And the Army says no, that will defeat the
5 purpose. You'll never get anybody to actually
6 be candid and give you those assessments.

7 I'm wrestling with some of my
8 nuclear community right now because I'm saying
9 you really need to waive those people who are on
10 antidepressants, who are stable, who I've seen
11 and let them on your nuclear platforms. And the
12 line response is why would I want somebody who's
13 on antidepressants around my reactor?

14 And my answer is I'm not worried
15 about the one I know about. I'm worried about
16 the one I don't. And so anything we can do I
17 think to reduce the barriers to get folks in and
18 then show that the consequences are no harm, no
19 foul.

20 I have a lot of respect for the CSF
21 that you guys have done in the way that you're
22 protecting the anonymity of the soldier and

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1 giving them various outlets to go to, to get help
2 if they need it. Sorry we digress.

3 DR. SIMS: Well actually we kind of
4 go to the next slide where we recommend and I
5 think you spoke to this earlier, that we
6 emphasize there for some and enhance
7 confidential treatment options. And this goes
8 for all of the services.

9 Future research for us should
10 identify the settings in which there was an
11 experienced barrier. We mentioned that. We
12 need to drill down on that to help get some
13 specificity around that.

14 Nearly one half of Airmen with unmet
15 treatment needs some time in the past year
16 reported difficulty scheduling an appointment.
17 So one option is to engage everybody in the team
18 to help make that happen. In some cases though
19 this is just a challenge that everybody's
20 dealing with.

21 But doing what we can to address them
22 is important. Perceived employment barriers

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1 include a lack of knowledge regarding jobs and
2 skills transition. For some areas there is a
3 substantive evidence base including medical
4 care.

5 There is less of one, I'm an
6 industrial, organizational psychologist. And
7 I say that as an industrial, organizational
8 psychologist. There's a less robust evidence
9 base regarding employment and getting people
10 back to work.

11 But what is there suggests that
12 employment assistance should focus on
13 individual skill sets and their translation to
14 new contexts. And it sounds like the Air Force
15 is actually working in that direction.

16 Ongoing program evaluation is
17 needed for the services for the recovering
18 warriors. It's a long-term approach. There
19 are no quick fixes. A long-term assessment
20 approach is needed not just for more work for
21 RAND. But I think it's important to collect
22 multiple types of data to triangulate because

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1 you want to make sure that everything is coming
2 together.

3 MEMBER DRACH: Excuse me, over
4 here. Can I ask a question about your perceived
5 employment barriers and maybe even go back to
6 your slide on the employment issue?

7 DR. SIMS: Okay.

8 MEMBER DRACH: Your recommendation
9 is to include, all right, let's go back to the
10 first.

11 DR. SIMS: Did you really want me to
12 go back?

13 MEMBER DRACH: The most prominent
14 perceived employment barrier is not physically
15 capable, that's 69 percent. Telling them about
16 available jobs is not going to overcome that
17 barrier.

18 DR. SIMS: Correct.

19 MEMBER DRACH: My question about
20 this slide is was this an open ended question or
21 was it a multiple choice? Well how did these ten
22 or 12 categories come up?

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1 DR. SIMS: So you're asking about
2 the specifics of this item, not the item
3 development?

4 MEMBER DRACH: Right.

5 DR. SIMS: Okay. They were given a
6 number of different options and they could
7 endorse as many as applied. So it's yes/no for
8 not physically capable, yes/no for no one will
9 hire me, yes/no, yes/no, yes/no. They could
10 endorse each one if they wanted to.

11 MEMBER DRACH: One of my concerns on
12 the not physically capable is purely subjective
13 on my part. I don't know what the status is or
14 how long the wounded, ill and injured in the Air
15 Force are kept on active duty. But we've seen
16 and we've talked to some service members that
17 have been on active duty post injury for up to
18 three years.

19 So if you have somebody that's on,
20 that's physically injured, wounded, ill or
21 injured and they're not working and they're not
22 doing anything during the course of their

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1 recovery and you leave that alone long enough,
2 they're going to begin to believe that they're
3 too disabled to work. Thus the first response,
4 not physically capable.

5 Because I've sitting around for a
6 year, 18 months, whatever number of months not
7 doing anything. So I start thinking, gee, I
8 can't do anything. Why should I even try to go
9 to work? I'm physically unable because we're
10 starting to, I think inculcate in their mind set
11 that they're too physically incapable of doing
12 anything. And it just perpetuates itself.

13 So I guess my other question is on
14 your recommendation you picked, I think you
15 recommended don't know about available jobs as
16 24, military skills as 26. But neither one of
17 those come anywhere near the 69 percent.

18 So what do you suggest or could you
19 go back and think about what you could be doing
20 to try to get into their mind set that yes, you
21 have a life altering injury, disability,
22 whatever. But here are some employment options

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1 as you go forward. Does that make any sense to
2 you?

3 DR. SIMS: Well so one of the
4 changes that we did incorporate was to ask more
5 than people who said that they were disabled and
6 not working or unemployed and looking. So
7 people who actually currently have jobs and ask
8 them what barriers they are perceiving and
9 things like that. I'm not sure that actually
10 answers your question necessarily.

11 (Off microphone comments)

12 MR. GONZALES: I'm Edmundo
13 Gonzales. I'm an SES with oversight for the
14 Wounded Warrior Program for the Air Force. I
15 think that's a great question because what we
16 have just adopted is the Adaptive Sports
17 Program. And in talking to the wounded warriors
18 it's pretty clear to me that a lot of them had
19 pretty much given up on a lot of particularly
20 competitive activities.

21 And most of them are pretty
22 competitive before they got injured. And what

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1 the Adaptive Sports Program does is it really
2 provides them the opportunity to compete again.
3 So it's a whole mind set kind of thing that you're
4 approaching. I think we should start asking
5 some questions to see if we can ferret out how
6 effective our Adaptive Sports Program is as far
7 as getting people to consider maybe they could
8 do a lot more than they thought.

9 MEMBER PHILLIPS: I'd like to make
10 a comment somewhat connected to this. I used to
11 do cardiac surgery. And there seemed to be a
12 time period when patients would return to work,
13 and this is in the civilian sector. If you were
14 able to repair them within a year of the onset
15 of their injury, more than 75 percent returned
16 to work if they were in the working age group.

17 If it was a year or more, they just
18 didn't return to work. I'm not sure what the
19 factors were. I never really, you know, looked
20 at that. But this is an old statistic and that
21 may be something that might be applicable and you
22 may want to look at that beyond your study just

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1 to review the literature and it might be
2 informative.

3 DR. SIMS: Yes, so I definitely
4 follow up and review the literature. I think,
5 so getting toward next steps. The current plan
6 is to survey, for RAND to survey every two years.
7 What you're actually asking about though is
8 something that's more process data. But that
9 gets at the recommendation to collect multiple
10 points and triangulate, right.

11 So that's an important piece of the
12 puzzle as well in terms of reintegration. For
13 our specific, RAND's specific follow up plans I
14 will be contacting about 1,000 Airmen, both from
15 the base line wave cohort follow up and new
16 enrollees. We'll track those AFW2 and Recovery
17 Care Coordinator Program usage and satisfaction
18 items.

19 We do have some new items planned to
20 get at gaps that we've seen thus far and to get
21 at changes that have been planned and
22 implemented by the Air Force. So we wanted to

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1 track some of that.

2 We're careful to focus on programs
3 that have been in existence long enough for them
4 to actually have an impact in the field because
5 as a researcher it's not necessarily fair to ask
6 questions about programs that haven't had time
7 to hit the field yet.

8 Here in the National Capital Region
9 we know everything that's going on, but it's not
10 as frequent out there. We will look
11 specifically at the top three experienced mental
12 health barriers and how they relate to various
13 health care providers and locations.

14 Other content that has proven less
15 useful will be trimmed to make room. And we will
16 continue to assess mental health because it's
17 clearly a pressing need for many.

18 CO-CHAIR NATHAN: Thank you. Any
19 more comments or questions? Well thank you for
20 the survey results. It obviously generates as
21 many, if not more, questions than answers. The,
22 where we sort of dropped anchor for a little

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1 while was on homelessness and on joblessness.

2 Pretty heady stuff because we're
3 very concerned that we're going to create a new
4 generation of homeless and jobless veterans on
5 our city streets. And so what can we be doing
6 to change that. The Adaptive Sports Program is
7 an amazing program. And if you're in San Diego
8 or San Antonio or Bethesda you can't help but
9 almost be pulled into it.

10 If you're out there in the more
11 peripheral areas, not so easy. So there's a lot
12 of good stuff going on. But I think that chance
13 favors the prepared mind. And so the more that
14 we can understand why people either turn inward
15 or turn outward will help us a great deal.

16 It's a very complex, I think you'd
17 agree, General Stone and Members of the Board,
18 it's a very complex Rubik's cube that these
19 people face. And just as we get all things lined
20 up physically we look on the back on the cube and
21 everything's a hodgepodge now emotionally. And
22 we get the emotional things all fixed up and we

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1 look on the back of the cube and now the family's
2 gone a different direction.

3 So it's trying to coordinate all
4 these things at once on these precious warriors
5 and their families to try to make a difference.
6 Thank you again.

7 MS. DAILEY: Did we miss a set of
8 slides? Did you have anything that you wanted
9 to add to about how you're incorporating these
10 results into improving your programs?

11 COL. POINDEXTER: Ms. Dailey, we
12 were actually going to speak to those questions.
13 But there were not slides. And it would be up
14 to the Committee at what time, whether they
15 wanted to take a break or whether they wanted to
16 immediately go into the rest of the agenda items.

17 MS. DAILEY: We do, no break.

18 CO-CHAIR NATHAN: I'm sorry. I
19 didn't hear. Yes, no I think we're past the
20 point of no return.

21 What time is it?

22 COL. DEMARCO: There's about six

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1 questions that we're going to go over for our
2 survey.

3 CO-CHAIR NATHAN: I think we'll
4 probably power through here because if you
5 release the hounds now you'll never see them
6 again.

7 COL. DEMARCO: Absolutely and I'm
8 one of the hounds here. Okay the, I'm going to
9 go into a tag team here with me and Colonel
10 Poindexter. There were six questions for us
11 regarding the survey. The first asked for some
12 encouraging results.

13 And from my briefing earlier today
14 the Air Force Wounded Warrior Program and also
15 the Recovery Care Program both got high marks
16 when we looked at the survey. Still some work
17 to be done for sure. But we identified a few
18 things, the high satisfaction on information
19 available and resources provided by the RCC's
20 and that they're easily accessible, the RCC is
21 easily accessible.

22 And again high marks for the Air

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1 Force Wounded Warrior Program in general,
2 availability to help, providing general
3 information. So I know it's the smaller
4 footprint for a survey. But still the
5 encouraging news for us is that there was high
6 marks for us as well as the Guard and Reserve also
7 thought they were doing well so far.

8 I am encouraged to know that the next
9 survey we're going to be able to ask specific
10 questions. I know, General, you asked to kind
11 of remember that early on in the brief about some
12 sort of questions in the future. But so far for
13 Air Force Wounded Warrior and Recovery Care,
14 great marks and we're encouraged with what we
15 see.

16 Colonel Poindexter has a couple more
17 he's going to bring out. You want to come up
18 here, Todd, or are you going to stay over there?

19 COL. POINDEXTER: Do you want to go
20 ahead and do those now? Basically I think in
21 reality we have actually addressed the three
22 items were the first three that she talked about.

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1 The first one of course is that
2 mental health treatments may not be very good.
3 We clearly think that we need to investigate more
4 information in that. We had some discussion
5 already in relation to it. We firmly believe
6 that we do have good treatment options.

7 The problem is being able to
8 communicate that to our patients and making sure
9 that they not only hear it but believe it and will
10 continue through those treatments. We
11 continually though reassess to make sure that we
12 are practicing state of the art, quality
13 medicine.

14 Another one of course was
15 confidentiality. Clearly we all know that even
16 if we do more research I can almost guarantee you
17 that we're going to find that a certain component
18 of it was in the Active Duty section.

19 We have already and will continue to
20 work on reducing stigma and making sure that
21 people understand that they do have a limited
22 confidentiality, that they are briefed that at

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1 every single first encounter so that they know
2 going in that if they're starting care there is
3 a level of confidentiality they have. We also
4 talk to commanders so that they are all very
5 aware of the bound --

6 MEMBER STONE: I'm not sure that's
7 terribly effective. And I think it's borne out
8 in your numbers. People seem to feel little
9 barrier to care once they're retired. And my
10 bet is the major barrier to care is my flight
11 status.

12 Now if you look at Army formations
13 we have x number in our combat brigades of people
14 seeking behavioral health care. In our combat
15 service support, medical people, it's way
16 higher. Combat aviation brigades it's very
17 low. It's not because they're healthier. It's
18 because they won't report it. And you've got
19 exactly the same kind of numbers.

20 COL. POINDEXTER: Right.

21 MEMBER STONE: So for you and I as
22 providers to stand in front of a service member

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1 and say well you know there's not going to be any
2 stigma and we'll protect your privacy, forget
3 it. You know, you're not giving me that
4 medicine because I'm losing my flight status.

5 And if I come see you I might be
6 forced to take that medicine or something might
7 happen that you're going to compromise my flight
8 status.

9 COL. POINDEXTER: And I think one of
10 the words that I used in front of it was limited.
11 And I do think that we need to be very honest with
12 our patients --

13 MEMBER STONE: All right. I missed
14 the limited part. So that changes all my
15 comments completely. Never --

16 COL. POINDEXTER: But it is true it
17 is a limited confidentiality and we have to be
18 honest brokers. The other thing that we can do
19 is that there comes a time that even if your
20 career is on the line you need to do the right
21 thing for the sake of yourself and for others.

22 What we need to do is make that an

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1 easy decision rather than a career catastrophic
2 decision. And it's not easy. And as we all
3 have known and anyone, everyone in this room has
4 had some level of participation in making this
5 a better system, we're not there yet. And we
6 know we're not. And we need to keep working at
7 it.

8 And then of course the last one was
9 difficulty in scheduling appointments.
10 Clearly when it comes to mental health and this
11 was specifically for mental health, we do
12 actually have in all of our mental health clinics
13 where they actually make the appointment there
14 in the mental health clinics. They don't have
15 to go through a long phone tree and then get into
16 a central appointment line.

17 If they pick up the phone they'll get
18 to the mental health clinic and they will then
19 make the appointment. The challenge is
20 sometimes, as we said, the difficulty in making
21 the appointment is possibly the difficulty in
22 the sense not that they can get in, but they're

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1 not so sure they want to get in.

2 Sometimes it could be access as
3 well. One of our highest stressed deployment
4 career fields is mental health. We have
5 actually had, they are on one of the highest
6 rotations, especially within the medics, is our
7 mental health providers. And that does create
8 challenges as well.

9 But we actually have 100 percent
10 success in seeing people same day. So if
11 someone truly needs to be seen, they will be
12 seen. But this is only talking about the Active
13 Duty MTFs. What we don't know is that some of
14 these people may be having difficulties not only
15 in the civilian sector or in the VA and we can't
16 respond to that.

17 And hopefully the survey will give
18 us a better idea of where they are experiencing
19 difficulty so that we can apply the correct
20 interventions to try to improve that. Those
21 were our three areas that we felt needed
22 attention and some of the plans that we have in

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1 order to address them. Were there any concerns
2 with those three areas? Thank you.

3 MS. DAILEY: In the non medical
4 area, what about the transition, employment,
5 anything about this survey has shifted your
6 resources into that area?

7 COL. DEMARCO: That was my next
8 input before you. We saw the slide that said it
9 was perceived employment barriers. It's going
10 to be interesting though now we have the VOW VEI
11 coming up this year.

12 And also we started with it at the
13 Airmen and Family Readiness Centers doing the
14 ITAP program, the individual care which I
15 briefed earlier today where the wounded warrior
16 has the five days one on one briefings with their
17 caregivers and his spouse to go through what's
18 available.

19 So it will be interesting to see the
20 next survey how that will then come up because
21 I don't know if that was addressed too deep here.
22 But now with the new programs coming I think you

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1 should see a change in the education of the
2 recovering warrior for the new programs.

3 MS. NEWTON: The big change is that
4 it's now mandatory. Before transition
5 assistance was optional for all our members.
6 Now it's mandatory as of 21 November '12.

7 MS. DAILEY: Yes, but come on, Tam,
8 you know, that your AFW2 and your RCCs was
9 putting everyone through TAP before they left
10 the Air Force.

11 MS. NEWTON: Right and there's been
12 a rewrite of the program. We weren't addressing
13 how your AFSC, your skill codes, transitioned to
14 civilian sector. We weren't addressing that.
15 Now we've got that beefed up. We actually deal
16 with that.

17 We actually have a whole half day
18 where we talk to them about resiliency and how
19 they make that transition, what it's going to
20 mean to them to leave a military culture probably
21 a lot earlier than they wanted to and go into a
22 civilian sector. So I mean we, the programs

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1 gone through a total rewrite.

2 VA is still channeling through their
3 pieces. But we're going to get there I hope.
4 And you're right, our wounded warriors have been
5 the ones that have gotten the most attention.
6 So we really had to look at the program itself.

7 COL. DEMARCO: We could add
8 specific questions about transition for the
9 survey that we're doing next year. Anything
10 else? So I think that concludes our, we had one
11 more comment or question regarding the influence
12 on our AFI that came out. But the AFI came out
13 before the RAND survey.

14 So we're kind of behind a little bit.
15 But I think we have an opportunity to add
16 questions for the next survey. We have a lot of
17 questions, especially about education and other
18 services. But, sir, that's all we have today
19 from the Air Force from our briefings and from
20 the follow up for the RAND study. Any
21 additional comments from you, sir?

22 CO-CHAIR NATHAN: No, thank you.

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1 It's a comprehensive follow up. And again look
2 forward to what this generates and sprouts in the
3 next survey as you drill down on the various
4 areas that you find that are significant in
5 dealing with this population.

6 Around the table, any comments? Dan,
7 any comments? I'd like to thank the Air Force
8 constituency for coming here very professional
9 and tight presentation.

10 And obviously you take what you do
11 very seriously and you're very passionate about
12 the welfare and the well being of those charged
13 to your care. So thank you. Anything else
14 besides, any housekeeping?

15 MS. DAILEY: No, sir. I'll see
16 everyone tomorrow morning at 8 o'clock. That
17 would be great. Thank you.

18 (Whereupon, the above-entitled
19 matter was concluded at 4:39 p.m.)
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