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

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BUSINESS MEETING

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WEDNESDAY
FEBRUARY 27, 2013

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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
RUSSELL A. TURNER, M.D., Member

ALSO PRESENT

DENISE F. DAILEY, PMP, Executive Director, Designated Federal Officer
ANNE E. SOBOTA, Alternate Designated Federal Officer
KAREN DALHEIM
MICHAEL PARKER
CAPT STEPHEN HALL, USN
MERISSA LARSON
ROBERT POWERS
CAPT JOHN RALPH, USN
CDR DAVID WEBSTER, USN
GEOFFREY PATRISSI (by telephone)
COL WILLARD A. BUHL, USMC
PAUL WILLIAMSON
ERICA FLORES

T-A-B-L-E O-F C-O-N-T-E-N-T-S

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

(7:59 a.m.)

MS. DAILEY: Good morning, everyone. We have 45 minutes. We are going to finish up talking about San Antonio this morning. We also want to take a photo, so I think we're missing two individuals, which is good. As soon as I get those two individuals in here, we're going to head over to the left corner and we're going to get a photo taken.

And then we'll return to our seats, but I need everyone in one place at one time, we'll get the photo taken, and then we'll get back to business. I've got Stephen here and he's got a camera ready.

And I know, due to traffic and someone is trying to squeeze some more furloughs out of Major General Stone, so he's probably trying to run over here and there's probably someone who's got his pant leg back in the Pentagon, but get some coffee.

We do want to talk about San Antonio.

It was a very good trip. So this next hour is going to be busy and we have the ethics lawyer coming in at 8:45. She'll want to spend just a little bit of time in our annual requirement to review ethics.

At nine o'clock, we have public forum; 9:15, we'll be starting with our next service, which will be the Department of the Navy. No, that's filler. We need to do San Antonio. If I had to do something with this time, we'd go over the agendas and we'd go over the rest of the visit, but San Antonio is our first priority.

CO-CHAIR CROCKETT-JONES: Or do you want us to get -- are we going to do the photo and get it done? I mean, which way do you want to --

MS. DAILEY: I'm missing two people. When they walk in the door --

CO-CHAIR CROCKETT-JONES: So we'll start with San Antonio, then a discussion --

MS. DAILEY: Correct.

CO-CHAIR CROCKETT-JONES: Colonel Keane, do you want to start off?

MEMBER KEANE: I went to San Antonio last year too, so it was good to go back and see the strides that the Air Force had made; significant strides. Kind of like a 180 from what they had been doing the year previous. Several different initiatives, but one that came to mind was the creative human resource manning initiatives; active duty, reserve, and civilian.

They have a former Air Force personnelist who's now back with the Air Force as a GS-15 capacity and using some creative ways to getting unused billets sight-lined back to his organization.

A lot of success in scanning records, I forget the amount of number of records that they had scanned, but they've gotten rid of a lot of file cabinets, and most notable was their ability to go through the backlog of PEB packages, and that's, certainly, through their

human resource initiatives of getting more people to review those packages, and it was 70 degrees there.

CO-CHAIR CROCKETT-JONES: They also, one of the things they spoke to was in this transition to scanning in medical records in the IDES process, that there was a warm-up time, that folks were processing things slower for a very brief amount of time before they got the hang of doing their IDES reviews electronically, but that, once they, sort of, got it, they felt they were picking up the pace and eliminating mailing times, so they were going to get quicker and quicker.

So I think that it was good to hear that there was an increasing tolerance of, sort of, the training time to go electronic.

MEMBER TURNER: I think also, you might want to comment on it as well, but in addition to the wonderful resourcing turnaround that they had made, they also had -- we had a very successful presentation on their review in lieu

of board program, where they actually pre-screen all of their packages before they go to MEB to determine who's going to stay on service.

And that actually cut their workload in the MEB by about 60 percent, because most of the people were returned, so they had this pre-screening board before they entered the process, and it really was very, very efficient, and was very well done.

CO-CHAIR CROCKETT-JONES: They had had, I forget what their return-to-duty rate had been, but it was high, it was over 40-something percent from their MEB process, so they have it down to less than -- hovering around 4 percent winding up being return-to-duty through their MEB process.

And so that they're much heavier reliance on that review in lieu of the RILO. And it also spoke to the idea of, because all of their work is centralized, it means that they were processing people in very different ways if they were going to return to duty, which is something

that we have, sort of, talked about, several of us have talked about, as a group, that early tracking with a very specific mission of return to duty versus separation was probably helpful.

And I'd also like to say that we saw, culturally, a very different set of methods and results when it comes to family contact. They are much, much more successful at actually talking to families.

In some other installation visits we've had, we ask about contacting families and we'll hear that they have a 100 percent contact, and what they mean is, they send emails to 100 percent of the email addresses that they get.

But their 100 percent contact is actual, either face-to-face or voice over the phone. They actually were successful, but my impression is, it's not a particular policy internal to their recovery system processes, that it may be a, sort of, cultural predisposition to be comfortable with contact.

MEMBER EUDY: To follow up, a couple

of key things. You know, with their massive increase in population, especially last year in November, assuming the ill and injured that added in almost an additional 1000 persons to their roll, they briefed the medical home concept and what they're doing, pushing that out as an initiative.

Again, it's in its very basic stages, as they have onesies and twosies that are spread out throughout the United States. But again, they reiterated that FLO training will become more robust beyond what's currently listed in the 34-1101 and in talking with the RCCs and non-medical case managers, we identified that HIPAA training would be ideal for the RCCs in all situations.

Basic premise being, to not rely on 2874s and the good faith and relationships with these facilities, especially because the Air Force RCCs are at, you know, facilities like Minot or places that deal with such small populations that have to serve directly to the

civilian community for their local healthcare, so other than that, definitely, big amounts of progress in the past year.

MEMBER TURNER: Just to give the board a -- to quantify their resourcing turnaround, last year, when we went, they were about 60, 65 percent manned and were looking at an increase in more patients coming onboard, and they were also looking at funding cuts and personnel cuts, and this was verified by the leadership when we were there last year.

So they were, certainly, on a bad vector. If you can use active sonar, I'll use vector. So this year, again, with this wonderful new leadership they have, they've actually added 12 positions and they are totally manned, except for two places, which they were about to fill, and they had got full exemption from the sequestration, so remarkable.

I like the word stunning. It was just a stunning turnaround, so kudos to the leadership there.

CO-CHAIR NATHAN: Any other comments? When you were in San Antonio, Ms. Dailey is going to provide a little outline of what you did, for those of us who didn't go on that trip, but you had a chance to -- you spent most of your time, the center of gravity, at what facility?

CO-CHAIR CROCKETT-JONES: Randolph.

CO-CHAIR NATHAN: At Randolph? Okay. Because, now, we're starting to see -- you know, we started out, early on in the war, with just about everybody coming to Reed and most of the burn patients going to Brooke, and then as more and more Air Force patients accumulated during the war, and more Navy, we started equilibrating the patients throughout a system where, if the Marine had family in San Antonio, or the greater Texas area, we would regulate to that area, so I've been impressed.

When I go to San Antonio, not to Randolph, but when I go to San Antonio to SAMMC,

and to Brooke, Wilford Hall environs, the milieu of all services that are there now, and the Navy, interestingly, you know, has a huge footprint in San Antonio now.

I'm proud to say, we've never lost a naval battle in Texas and I think that'll be true in the future as we've now moved thousands of troops down there for our integrated training of our Corpsmen; from Great Lakes down to San Antonio.

One of the problems we had, about a year ago, was, the Vice Chief of Naval Operations was going through San Antonio and was talking to the wounded warriors in the Navy who were there, and they were, sort of, lost orphans.

We had some Marine liaison personnel down there in San Antonio, and they were trying to do a great job, but they were, sort of, in the confines of the Army and the Air Force, who wanted to help, but weren't really savvy with Marine Corps, Navy wounded warrior personnel in the San Antonio area.

We changed that and we created the liaison to Corpus Christi as well as rewickered some of the command and control algorithms of the SAMMC wounded warrior outfit, and the last I checked, the Marine Corps wounded warriors down there, and ill and injured, felt much more engaged and much more embraced by the system, and felt like they were getting their advocacy.

They were having trouble getting to a lawyer who could speak Navy and Marine Corps disability issues, not too surprising, given the fact that it had been, sort of, a small focus, or a small group, of Marine Corps, Navy down there at the time.

Grown, fairly robust now, and so I think, you know, if there's a future trip down there, we probably need to include that in it because that's one of the things that I think can fall through the cracks is the Marine Corps and the Navy element down there. And it was not as a result of Army or Air Force negligence, not at all, it was more of a result of not having the

resident subject matter experts to be able to help advocate for those folks when needed.

And I think we're fixing that now, but I think that's something we need to follow-up on in that area, but overall, from what it sounds like, Suzanne, it sounds like significant improvements at Randolph over the last year; staffing up to speed, people getting what they need, advocacies there, and tucked in.

CO-CHAIR CROCKETT-JONES: I just want to temper it that we did not speak to patients. We did not speak to anybody in the process, so it was good to see improvement from the leadership and from the service providers, but tempered. You know, tempered with, we didn't have a comparison to see if intentions were being met with outcomes.

MEMBER EUDY: One thing to follow-up, sir, on what you just said in regards to the Air Force, I had mentioned it while we were at San Antonio, currently, at Walter Reed, the hospital liaison positions of all the services

are filled in periods of two to four-year billets, on average, between all the services.

However, the Air Force is filling those billets, you know, out of hide from Andrews, and those NCOs are there, at a minimum, you know, running around 12 months right now, so you're losing that continuity that they mentioned at San Antonio that they strive for, whether it was their non-medical case managers, PEB personnel, that they're holding.

So I had asked the leadership to look towards placing one billet full-time at Walter Reed to have that continuity, due to the FLO program relying so heavily on the RCCs to be that go-to individual at certain locations and treatment facilities, but to have that permanent hospital liaison position, even if it's one deep, due to the small caseload of the Air Force, to provide that long-term continuity in regards to, you know, changing policies, personnel, having those one-on-one relationships at what is the most common Air Force stop for medical care.

MEMBER TURNER: I would also just, what the Admiral said, on a cultural note, many people in San Antonio have noticed that there are a lot more sailors on the Riverwalk now.

CO-CHAIR NATHAN: Right.

MS. DAILEY: Sir, I do have the San Antonio agenda up here. We covered a lot of ground. We wanted the Air Force to talk to us about some initiatives they took last year. We also went to see their PEB and their IPEB facility. And the common themes coming out of the IPEB and PEB touches that we do, they've done a remarkable amount of work reducing their backload.

They've embraced the electronic case transfer pilot aggressively and they've truly embraced it. However, even with the increased manning and their ability to reduce their backlog, they reduced their backlog by, like, 600 cases, they still aren't meeting the DoD standards that are published in the DTM and what DoD and VA are shooting for at each stage,

and that was frustrating.

We really tried to nug down with them and say, use it manning. Are they realistic goals? And, you know, Air Force, a little bit like the Navy, something of a Petri dish, you guys are smaller, smaller numbers, it is easier to look at your processes and if it's not working with you, it's certainly not going to work with the Army putting 26,000 people through it, and it was a little frustrating.

They really couldn't tell us, you know, why they still weren't meeting, you know, the DoD standards and DoD guidelines. We know they're sincere, they're looking at it, however, we still couldn't get visibility of what the issues are in the IPEB and the PEB.

CO-CHAIR NATHAN: So are they an outlier, then, for the rest of the Air Force?

MS. DAILEY: This was Air Force-wide. We were at their PEB, their formal PEB, and we were at where they do --

CO-CHAIR NATHAN: Because the last

time I checked, didn't the Air Force, on their 100-day MEB and the 295-day requirement, weren't they hitting their wickets?

MS. DAILEY: As of the meeting we had with them last week, they were not.

CO-CHAIR NATHAN: They were not, okay. All right. Interesting and I think that's going to bear further scrutiny, but it sounds like they're on the right vector, so I think it's something we need to keep a close eye on.

MS. DAILEY: Yes, sir. We wanted to see their operation, and as noted earlier, their reduction in the paperwork, the stacks and stacks of paper, has been remarkable. So there's a lot of progress being made, but it's also the same case we heard out at Colorado, they reduced backlog by 700 cases, it still doesn't impact their ability to hit the numbers that the Department of Defense has established as goals.

And so we kind of start getting into the camp of, well, are these the right goals? Is

this the right amount of time? Is it realistic?

CO-CHAIR NATHAN: Yes, you know, we find the IDES, one size doesn't necessarily fit all, as was alluded to yesterday when the Army was briefing by General Stone. You know, the Army has a different way of approaching their retirement physicals, and they're very comprehensive, and they, in my opinion, sort of plow the same ground that the VA is going to plow anyway when you go for your disability physical with the VA.

And to what General Stone was alluding to, he's not sure why they continue to do that. It clutters up their process; their disability process. The Army has different people who dictate the narrative summary than the actual provider who's working up the patient. Works for them because of the large numbers.

So that was the question about process as to, you know, what is the best process. And then you look at, there's our

piece of it, then there's the VA piece of it, and then there's the Recovering Warrior piece of it, which is the, I'm going to take 90 days of terminal leave in-between the time I start IDES and the time I finish, and we're trying to figure out how to account for that too, when we extract that from the model.

So we made these, as we do in the military, draconian edicts and we said, okay, once you start the IDES process, you may not take leave, and everybody wrote their Congressman. And so then we said, okay, now you can take leave, but then it pushed us over 295, and everybody wrote their Congressman.

So again, one size doesn't fit all and as you know, members of the board, if you go to an area where there's wounded warriors that went through the IDES process and you grab several of them and you say, how are things going? A common lament is, I don't have good situational awareness on where things are. I'm not sure. Nobody's telling me, you know, where

my package is and what I need to be doing.

And we've heard that being addressed, but the other problem you hear is, you'll get one group that will say, the process is too slow, it's not agile enough, it doesn't meet my needs to separate from the service at a time that I want that I think should be expedient so I can move on with my life, get my disability rating, and then go on with plan B.

And then another group you talk to said, I don't like the speed this is moving at. This is going too fast, I'm not getting my day in court, I don't have a chance to rebut, I wish they would slow it up, and so again, the one size fits all is difficult, and I think there's goodness in the way that the studies are occurring now; looking at the PEBLOs, looking at the right number of PEBLOs.

I worry, as we're going to hear from the Navy today, we're going to hear that the Navy has hit all its marks. We're within spec, but, the question I asked, are we doing that on the

backs of our PEBLOs? Are we breaking them? Are we turning them into sawdust in this effort to move people through? And what is the quality of life of that?

And so that's part of the aspects that I asked for in our study is, what is the work quality, professional satisfaction, of our PEBLOs? I'm a firm believer that anybody, military uniformed or civilian alike, who works for the Federal Government, the right answer should always be, it's very frustrating, but it's working. I think that's fine.

If everybody says, it's great, then, probably, we're not working hard enough. If everybody says, I'm about ready to quit, we're probably working too hard. So I always look for that, yes, I don't mind my job, but boy, I could use some -- you know, it could be better. That's about the right tempo.

And I'm being a little glib, but I think that that's my concern. In some of these, there's been so much emotional pressure, what

are we doing on the backs of the administrators who are caught in the gears of these, both at the VA side and at the DoD side, who are worried that, any minute, there's going to be a camera crew that comes in the door and takes pictures of these records that are on their desks, stacked, and the poor civil servant is there pedaling as fast as they can, and we're breaking their backs.

So I think that's something that we have to keep an eye on. All right, barring any other questions, concerns about the Randolph visit?

MEMBER MUSTION: Can I ask a question? Question number 5 up there. Did you all discuss that when you were down there?

CO-CHAIR CROCKETT-JONES: Yes, we did. They opposed the concept of a joint board, but I have to say, and they gave us two reasons, we have it recorded somewhere, they were not topical to the recommendation. So it was a little bit of a disconnect, in my opinion; although they said they opposed it, their

reasons did not actually apply to what had been suggested.

So I felt it was a complete disconnect in communication on that.

MS. DAILEY: I did get to talk with Mr. Tierney in the van in the surrey ride over to Lackland Air Force Base to the FPEB, and he said, what did that question mean? So we then went over what its intent was and how it would function at a joint level. And he goes, okay, well, I'd have to think about that, but we are asking that question at our FPEB locations.

We asked it out at the Navy and they were not in favor of it and if you just kind of take a first impression out at the Air Force, and their first cut on it, it was no. And so, I mean, that's good. We like to hear why not. Many times, the harder the no, the more hard they're thinking about it.

CO-CHAIR CROCKETT-JONES: I also want to say one thing about -- you're talking about how much we're stressing PEBLOs, and I have

to say, I believe that the folks in the offices, with mountains of files, have a much greater sense of pressure just from the physical presence.

And I'm not sure it's productive pressure, because the folks at the Air Force PEB location had, you know, just as much work and they were, you know, pushing pretty hard with their work, but they all felt the relief of space.

And I actually think that that was more significant than just the logistics of moving mountains of paper. I actually think that there was this different atmosphere because of the lack of columns and hallways filled with, you know, eye-level height medical record boxes and papers.

And just their sense that, if you need to find a record, that instead of facing this hallway where you were going to have to rifle, you were pressing buttons. This actually made a significant difference, I think,

in the work atmosphere.

You know, it didn't change their workload, but it definitely changed their -- just the optics in the atmosphere, so just a comment.

CO-CHAIR NATHAN: Okay.

MS. DAILEY: I do have, and we are in Tab N, I believe, the next agenda. Tab H, I'm sorry. Tab H. The next agenda for the April meeting. I have sent it out. I just want to briefly talk with you and get a touch on it. I don't want to spend a lot of time on it. I've contacted briefers already. They're lining up.

It's a very personnel and readiness health affairs-centric agenda, and I just want to remind everyone, this is the last information briefing; April 2 and 3. This is the last time we'll be taking briefings. So I need you all to keep that in mind. If something trips your trigger and you go, we got to have this before we start work on the report, I got to get it into this last meeting, if I can, I'll cram it in

there, but this is my last two-day window for informational briefings.

In June, we will sit down and take two days to build your recommendations, it'll be a month, and the research staff will pull together the findings and recommendations on those, and on the work you did in June, and then about six weeks later, five weeks later, you'll have a two-day voting session. That's all you'll do in those two days is vote on the recommendations.

We'll get a report out to you, it has findings, has your recommendations, you'll review it, you'll come into the July meeting, and that's a two-day voting session. So the April agenda, very quickly, we want to try and pull in the Health Affairs Oversight Board; sir, your question yesterday about how to tie all the centers of excellence together and synchronize their efforts.

I've got health affairs onboard. I don't think they know who's going to brief it.

I'm going to have to talk with them a little bit more before they can come to the table about exactly what we want to hear and what they would have to offer in this hour.

The next one would be, you all asked about medical home, we'll get a briefing on medical home. I only have 45 minutes for this. We got a touch of it out at Randolph. We did. Ma'am, you asked about urogenital injuries, we've touched base with health affairs on that one.

This, you all asked about information on transition to the Defense Health Agency. There's an Office of Transition, which is orchestrating that. They'll be in to talk to us. Sir, I found these guys rooting around in your organization, didn't mean to ruffle anybody's feathers, but this goes to your issues about, you know, systematic evaluation of the IDES processes. N81 has done some work on it. I invited them in to talk to the task force about it.

And the next one, IC3, we have them in the afternoon of the first day. And then, quickly, on the next day, we'll bring in Dr. Kelly. This is the DoD/VA Employment Task Force, the VOW Act; implementation of the VOW Act. Our touch on this so far has been, it's a lot of transition out there. A lot of angst.

The training packages aren't online yet. There's a backup on trying to get people through the class, so they, generally, like to do a very strategic overview. If future, you want a more tactical touch on the VOW Act, we're going to have to bring in each one of the services and ask them how they're implementing. You're really just going to get an overview on this one.

The Warrior Care Policy is going to come in and talk to us about the recommendations that were more to DoD level. And then, they'll talk to us about E2I and Operation Warfighter, which they still need to publish their DoDI on, and we'll move into lunch, and then into -- I have a non-profit panel coming in, it's a panel, and

they'll talk to us about these three questions and then you can talk to them about what they're seeing in their work with Wounded Warriors.

Center for Deployment Psychology will be coming in and then our last event of the day is Returning Warrior Workshops, Yellow Ribbon Reintegration Program. It'll be an overview and I think we are talking here with the director and with the Navy liaison in that office.

That's our two days. If anything else comes to mind, I need to know. I'm going to publish this in the Federal Register here pretty quickly. And then again, no more briefings. We will have a session, we're developing recommendations, and the session in July will be the vote. Moving quickly.

It's hard to believe this meeting is already over; almost. Two more services. So the next thing touched briefly on is the remainder of our schedule this year. That should be the next slide in there. Yes.

Remainder of our schedule. Several of us are heading out to Joint Forces Headquarters North Carolina tonight and we'll be back Saturday.

We will leave Monday for Iowa. I got these pretty well manned. I had to rejigger Arkansas into this date here and my staff didn't fill-in the names, but I've got Tech Sergeant Eudy and Mr. Rehbein are going, but that's kind of a short crew. That's just two individuals.

It is, I do have the researchers from the VA. There's a big PTSD study going on out there. Okay. Anyone else's schedule freed up for Arkansas, that would be great, otherwise it's, right now, Mr. Rehbein and Tech Sergeant Eudy.

Okay. With the 19th and 20th, we start the West Coast swing, I call it. We will be on the West Coast for two weeks. So 19th and 20th will be at Pendleton. Can we go to the next page? The morning of the 21st, we're in transit up to San Diego, and then starting on the afternoon of the 24th, of the 21st, is the NOSC,

Naval Reserve Station at San Diego.

So we'll spend a half a day on the 21st with the NOSC and a full day on the 22nd with the West Coast Medical Hold, the Naval Reserve Medical Hold West Coast. We'll spend all day with those individuals. We'll do focus groups. We'll do briefings by the command.

That is a Friday. It closes us out on a Friday afternoon. Either Saturday or Sunday, we haven't determined yet, we will transit up to Fort Lewis. At Fort Lewis Monday and Tuesday. We will do our, what I call our, normal agenda for a WTU. We will also include their formal PEB that is there and a visit to the formal PEB while we are there.

So Monday and Tuesday we're at Fort Lewis, Wednesday is a transit day, Thursday and Friday we are at Elmendorf, Richardson. Richardson, Elmendorf. We will return that weekend and then Tuesday and Wednesday are the business meeting; 2nd and 3rd of April.

So any changes you will be needing

to make, if you can't make a trip, let me know. We'll cancel you out. I'm fairly confident we'll be able to execute this schedule as-is as of right now. I've not had anyone pull funding or question the completion of this aggressive schedule before we start writing the report.

Okay. Other questions, concerns?

CO-CHAIR CROCKETT-JONES: I would like to ask, I don't know that it's something for the business meeting, but I would like some information. When we were at Bragg, we were briefed by the legal regarding, in the IDES process, a disparity that legal attempts to rectify between, sort of, medical treatment providers and, necessarily, the hallmarks used to determine if, you know, a condition's existence and fitness; testing that is required but not always done.

Required by the reviewers and the MEB and PEB, but not necessarily, routinely done during treatment. There were several of these kinds of things and I would just be interested

to see how the document that they used, they use -- I forget what it is called now. Can you remember?

MS. DAILEY: Yes, I know what you're talking about, ma'am. I'll see what I can do.

CO-CHAIR CROCKETT-JONES: Thank you.

MS. DAILEY: I mean, I have the picture in my head. I'll see what I can do. It's not necessarily in our lane. I mean, that has a lot to do with VA claims adjudication and marrying that up on the massive 900,000 that they do a year with our board process is a big task.

CO-CHAIR CROCKETT-JONES: Okay. Then I guess what I really want is what is the information, sort of, she said she had a structured information that she discusses with the folks who go through. So maybe what I want is something from her office.

MS. DAILEY: Okay. So we do have that 50-page briefing, but she also said she hands out a sheet of paper that has some sort of

information on it. Is that --

CO-CHAIR CROCKETT-JONES: Yes, that's what I'm talking about.

MS. DAILEY: Okay. All right. We'll get in touch with Ms. Quist down there and see what -- we do have her 50-pager.

CO-CHAIR CROCKETT-JONES: I'd like both of those, sort of, make sure I get eyes on those.

MS. DAILEY: Okay. All right. Good, good. We have some time here. Is Ms. Dalheim here? Is our lawyer here? She is here. I can turn it over to her right now and get the ethics briefing. Any other questions? Okay. I'm going to turn it over to Ms. Dalheim. Thank you, ma'am, for being here.

MS. DALHEIM: Hi. So my name is Karen Dalheim and some of you -- I'm with the General Counsel's Office and we provide the ethics counsel to folks, but, you know, I know this is a mixed group, that we have regular government employees and outside folks here, so

I'm really only talking to the outside folks, which I think are just four, right? Is it four? Okay.

Because you folks who are regular employees, you're covered by the rules every day, so there's nothing extra for you. And so the folks who are private citizens, you've gotten advice from our office and primarily what we're interested in is the specific conflict with your outside world and the role you play here with this federal advisory committee.

I don't think it will be problematic for you based on what I understand the committee is doing, because as I was looking at the charter, the charter was saying that, assess the effectiveness of the policies and programs developed and implemented by the Department of Defense and the military departments.

So to me, that doesn't look like you will be involved in making decisions that could affect, maybe, your employers or organizations that you are involved in. And of course, this

would apply to folks who are federal employees already, is that, if you are a board member, an officer, maybe, in an outside organization that might be somehow related to the topic here, obviously, you shouldn't suggest that that organization would be a good organization to, maybe, implement some kind of, or work with this organization, but I don't think that's the kind of thing that you folks get involved in anyway.

So I don't really anticipate that you'd have any problems, but for the private sector folks, it's really about keeping your world separate. When you're here, you are giving advice to the Department, and so we want to make sure that there's a bright line between your two worlds, okay? That's the conflict of interest.

We also want to make sure that you don't represent the Department. So if you were approached by, maybe, an outside news organization, you don't have the authority to speak for the Department, so you should contact

Denise or somebody on the FACA, and they would speak for, or they would get someone to speak for, the committee, because you, as special government employees, you don't have the authority to speak for the Department, so we want to make sure that that's clear for folks.

And then, little things like, you shouldn't trade on, or use your influence, of being on this FACA in your outside world, so let's say you're speaking some place and it's not related to the FACA, you can use this bio. You can use the fact that you are a member of this federal advisory committee as part of your bio, as one of several parts of your bio, as opposed to, I am a member of this FACA so you need to give me preferential treatment, or something like that, so we want to make sure that you don't trade on the fact that you're on this committee.

So does anybody have any specific questions? I really don't think that ethics will be a problem, just based on what the advisory committee is going to be doing. Okay.

And if there are questions, you know, you can contact me, contact Denise, and we answer the question and we deal with it. Usually not an issue. Okay? It's as simple as that.

MS. DAILEY: Thank you, ma'am. Every year, Ms. Dalheim reviews your OG-450, so very important. That's why I have you -- thank you, ma'am. All right. We've got one more coming, but we will move on with our day and if I get all 14 members here at one time, we're all going to stand up and head for our picture, all right?

So we have a little bit of time. I don't want to start till nine o'clock. Are there other issues that we can use with this 15 minutes, ladies and gentlemen?

CO-CHAIR NATHAN: I don't want to take up the whole 15 minutes, because everybody's thinking, wow, a little bit of a break here, but I would like to give the board a little bit of background about, probably, the most significant change in the military health

system in the last 60 to 70 years, and that is going to be the reorganization to a Defense Health Agency.

I only bring it up because I think it's a collateral interest of the task force. It, at the present time, won't have a dramatic effect on Wounded Warrior or Recovering Care, other than to say that, as we speak right now, in spirit, and by law this October, Walter Reed National Military Medical Center will no longer be a military command.

It will be a field activity no longer commanded by a commander, but run by a director who works for an agency; the Defense Health Agency. It will no longer be under the auspices of the Army or the Navy. It will be under the auspices of the Defense Health Agency, which is being stood up.

The DHA is an answer to what has been a problem, or a significant issue, for the military health system for years, and that is the following; healthcare in America is very

expensive and the President is trying to attack that, and whether you agree or disagree with the President's methods, you can't help but agree with his concern that healthcare in America is eroding, the cost of it is eroding into our other gross domestic products.

Same is true in Department of Defense. We are on a non-sustainable trajectory of cost in the military health system. In the year 2001, the DHP, that's the Defense Health Program, that's the money that Congress gives us, fences and gives to the military health system, we do not get our money from the line.

I don't get my money to run my hospitals from big Navy and the Army doesn't get them. We get them from the Defense Health Program, which is run through the TRICARE management authority, headed by Dr. Woodson, who also is the Assistant Secretary of Defense for Health Affairs.

So anyway, in 2001, we spent $19

billion on military healthcare; hospitals, care, buying care in the networks. Last year, we spent $55 billion. We're on a trajectory that, if we don't stop, we're going to be at $65 to $70 billion in several years, and at that point, we'll basically eat up all the discretionary income that the Department of Defense has for other things.

So people got really serious about this and they said, what can we do? Can we remove redundancies among the services? Can we remove duplicate services and create efficiencies? Reduce personnel to some extent and get our costs in control?

So each service has a pharmacy organization, each service has a privileging organization, each service has an acquisition logistics, each service has an education and training, each service has a research and development, and somebody said, you know, why do all three of you have three of your own cottage industries?

Why don't you just combine them all and put them under the auspices of an agency and then let that agency give that capability, or that product, back to you as you need it as a service, akin to the Defense Logistics Agency, which supports, from a logistics standpoint, the rest of the services?

So the problem with that was that the services then said, we're willing to do that, but we don't want to partition out our readiness availability. In other words, how do I, as an Army General, or a Navy Admiral, if I need troops in a hurry, or I need readiness capability in a hurry, how do I get to that if I don't own these things?

And so the devil is in the details, but the bottom-line is that a task force was comprised, about two years ago, to look at all of this and they came up with the solution that said, the best consensus that was reached -- it was not unanimous, no shock there, but the consensus that was reached was, let's create a

Defense Health Agency and pick ten shared services and move those out from the services to the agency to be in charge of education and training, research, development, pharmacy, acquisition, logistics, a variety of others.

And let's make this a three-star position, this DHA, a three-star position, a new three-star, uniformed position, let's take health affairs and TMA, and let's enforce upon them that they are a policy organization, not an execution organization, and make them review how many people they have in TMA and health affairs, and make them streamline.

Remove some of the bureaucracy out of that organization. Let's remove some of the personnel that are redundant in the services so that we don't have three people in the services doing pharmacy, but maybe one person doing pharmacy for all three services. And that's where we are right now. We're in the midst of forming that.

They've picked a person to be the

three-star for the Defense Health Agency, which will, sort of, kick up in October in its initial planning phases. The only audible that was called that the task force didn't suggest, but was called by the Deputy Secretary of Defense was, I also want to take Fort Belvoir and Walter Reed-Bethesda, and put them, tactically, underneath the Defense Health Agency.

All other hospitals will be run by the services. The Army will still run Madigan, the Navy will still run San Diego, the Air Force will still run David Grant, but Bethesda and Belvoir will come underneath this DHA. It will no longer be under the purview of the services.

And of course, you know, victory has a thousand fathers and defeat's always an orphan, and so, when those hospitals are doing well and getting good press, everybody wants to own them. If there's ever a problem with them, everybody says, well, it's not my hospital anymore, but I think that that's a big change, and you might ask why.

And I bring that up because that is our largest footprint of wounded warrior care in this country and it is our marquee wounded warrior facility, and not at all slighting San Diego or SAMMC, but Walter Reed-Bethesda has captured the national attention of the wounded warrior, the gravitas of wounded warrior care.

And so why would the Department, then, pull those out from the services and put them underneath an agency? And the reason is twofold. Reason number one is that, as you know, in combining Walter Reed and Bethesda to a joint facility, it's difficult for one service to say the other service owns it.

The Army is not very prone, or excited, about saying, well, the name Walter Reed belongs to the Navy as a Navy hospital. The Navy, on the other hand, is saying, well, you know, it's at Bethesda, it's always been Navy, how do we turn this place over to the Army?

It was all very civil, but the Department and Secretary of Defense, you know,

basically said, okay, don't make me stop this car and turned around and said, here, I've got a better idea, to capitalize on the jointness that's already occurring at that facility and to leave it under a joint organization, let's move it under the Defense Health Agency, which, in pure essence, is joint.

And then because it's an agency and an agency cannot command a military facility, the hospitals now must become field activities, and no longer with commanders, but in October, when they formally switch, they'll be directors.

So those are some of the changes and I think we're going to take it slow but sure. I don't think we're going to see anything dramatic in the way we do business differently. One other change in the military health system that's fairly significant, and that is, the installation of EMSMMOs, Enhanced Multi-Service Market Management Systems, in the various areas.

Predominantly, in the Pacific Northwest with Madigan, in the Tidewater area

with Portsmouth, in the Colorado Springs area, in the San Antonio area, and in the Hawaii area, with Tripler. EMSMMOs, there will be a lead agent brought into those areas who will, and this is being debated, argued, defined, wrestled with, whatever you want to call it right now, we're not sure how it's all going to settle out, but the lead agent will be given much more authority in that local area to move and manage the business operations of all the services in that area to make sense.

Why? Because you know how I just told you that we spent that $55 billion last year on the Defense Health Program? Over half that money went to the network. Over 50 cents of every dollar we spend in military healthcare is going to the private sector. That's how much care we've pushed out to the private sector over the last ten years.

Partly because of war, deployments, and other reasons. So the EMSMMOs are designed to pull that care back in, to try to start getting

the care back in the direct healthcare system. And you can only do that if you have smart business processes in a business region, and so we're engaged in looking at that.

So an Enhanced Market Management System means that they'll have the authority to move some of the service's personnel around within the region. Tactical example, maybe. You're the EMSMMO lead in the Pacific Northwest, you look over at Bremerton Hospital and you say, you know what, you have a dermatologist there, but I don't see the bang for the buck there.

Whereas, if the dermatologist were stationed at Madigan, they would be seeing more patients, and more severe patients, and better business case. Before today, the Navy would say, well no, keep your cotton-picking hands off my dermatologist, Army, you can't take them to Madigan. I have some need for them at Bremerton.

With EMSMMO rules, the Army, or the lead agent from Madigan, should be allowed to go

to Bremerton and move some people around. There are courts of appeal and there will be, as you can imagine, some bickering and, you know, somebody got the bigger half of the candy bar, but we're working that out.

Same thing in Tidewater, the lead agent at Portsmouth Navy Medical Center will be able to go to Langley and go to Eustis and rearrange some of the chairs in their living rooms for a better business practice for the whole region.

As you can imagine, this is fairly unsettling for the services. They're not used to losing this degree of autonomy. That said, the three of us who run the healthcare in our services, Patty Horoho, myself, and Tom Travis, recognize we can't live without this.

We cannot sustain the current business practices without capitulating some of our autonomy, some of our control, and nowhere is that more prominent than transfer of Walter Reed-Bethesda, Walter Reed National Military

Medical Center, out of the services to an agency.

So the chain of command for Walter Reed, which previously, was Secretary of the Army, Chief of Staff of the Army, Surgeon General of the Army, Commander Walter Reed, and conversely with Bethesda, same pair down, will now be, Deputy Secretary of Defense, Undersecretary of Defense for P&R, Assistant Secretary of Defense for Health Affairs, Defense Health Agency, three-star, Medical Director, two-star, and then Director, one-star, Director of Walter Reed.

So the Secretary of the Navy, Secretary of the Army, Surgeons Generals, Chiefs of Staff, CNOs, will no longer be in the chain of command of those hospitals. We're watching that very closely because, obviously, with the repository of wounded warrior care there and everything else that's going on.

So I didn't want to bore you with details, but this is pretty dramatic stuff and it represents a big change, and so I just thought

I'd bring it to the board's attention, kind of, update you so you'd know what I know now about the latest in the military health system reorganization.

MS. DAILEY: Thank you, sir. I'd like to give the members a five-minute break. I need everyone back here at nine o'clock. We will do our public forum at nine o'clock.

(Whereupon, the foregoing matter went off the record at 8:58 a.m. and went back on the record at 9:06 a.m.)

CO-CHAIR CROCKETT-JONES: With us this morning to provide an oral statement for the public forum, we have Mr. Michael Parker, a retired Lieutenant Colonel and Wounded Warrior advocate. We have the information under Tab I for Mr. Parker's presentation to us. Good to see you again.

MR. PARKER: Well, good morning. The easiest way for the military to avoid paying disability benefits is simply to ignore disability laws and regulations. There's a

serious lack of accountability and oversight in the process, and this allows the military to systematically cheat our Wounded Warriors out of disability benefits.

One of the first soldiers I represented was Captain James Wollman. In 2006, he was discharged from the Army without any disability benefits because the PEB claimed his unfitting condition pre-existed service without aggravation. The errors made and the regulations ignored in Captain Wollman's case are numerous.

I have delineated them in a brief I have attached to this statement, which you can find in your binders. I presented this brief to Captain Wollman’s disability review board in February of 2007. The Army Disability Review Board responded with a one-page letter that upheld the PEB's determination, but failed to provide any rationale to back their decision or to address the points raised at his board.

I've attached this decision letter

along with this statement as well. I made numerous attempts to get the Army to provide rationale to back their decision and they refused to do so at every turn. Jason Perry, at PEB Forum, took the case to federal court. In a recent decision, the judge remanded the case back to the Army Disability Review Board and ordered them to provide the rationale to back their decision.

I've attached the judge's decision to this statement and it is must-read for you. A Wounded Warrior should not have to wait several years and have to get a federal court order to get the decision rationale used to deny their disability benefits, but that's the MO, avoid the decision rationale and you can avoid paying the disability benefits.

Last month, I presented the case of Sergeant Lynn Jarvis to the task force. He was diagnosed of brain cancer that the VA, his treating oncologist, his medical evaluation board, and his line of duty investigation have

stated is due to the burn pit exposure in Iraq and that the condition began when he was on active duty.

The Human Resources Command recently notified Sergeant Jarvis that they intend to overturn his favorable LOD, thus making his cancer ineligible for DoD disability benefits. In doing so, the HRC refused to provide rationale for overturning the LOD as required in AR-600-8-4 for line of duty investigations.

I've sent multiple emails the Human Resources Command, and to other Army entities, trying to get the rationale used to overturn Sergeant Jarvis' favorable LOD, and all have refused to do so. I've included the emails and other documentations on this matter with this statement, and I ask that you please read them.

What was true in Captain Wollman's case back in 2006 remains true today. The military can avoid paying disability benefits by simply ignoring laws and regulations and by

avoiding decision rationale. The system is out of control, and our Wounded Warriors, and their families, are paying the price.

I'll be glad to address any questions or comments you have on this issue.

MEMBER KEANE: Sir, you mentioned this case, Captain Wollman, from 2006, have you noticed any difference in numbers of dissatisfied service members in your years of being an advocate? Are the numbers steady state; increasing, decreasing?

MR. PARKER: I think the biggest swinger so far has been the fact that the military no longer rates disabilities. Captain Wollman, before Walter Reed broke and there was these changes in the 2008 NDAA, the military was systematically ignoring the VASRD, resulting in rates lower than 30 percent resulting in separation versus retirement.

So from that aspect, it has been a good thing. There are pockets of resistance, like this EPTS issue. I know for a fact that,

you know, in 2009, Congress changed the law and said, DoD, you will follow the same presumptions as the VA, and that was worked in the X USC 1201 and 1203, which is the military's version for Chapter 61 disability.

It was also put in a very good DoD policy, but it hasn't been enforced, it hasn't had any oversight, and if it was, I mean, the DoD policy is spot on and it echoes the VA policy almost word for word, but nobody's making sure that it's being followed.

And that's why you have these EPTS-type cases where there's no rationale provided as to why it was overturned. In my recommendation to General Mustion last month, and to Mr. Powers, just recently in a conversation was, is that, there ought to be a specific chic to the determinations for an EPTS case that says, you know, so that a person can find it, it says, the clear and unmistakable evidence to overcome the presumption of a service connection is this and the clear and

unmistakable evidence to overcome service aggravation is that.

If you can get that at the informal board process, then you've got something to go to the formal board and dispute instead of going there blind and not knowing why in the world they did what they did.

MEMBER KEANE: So are you advocating for the same numbers of service members? Have the numbers increased, or decreased, or a steady state?

MR. PARKER: Well, you know, again, General Stone said there's 24,000 people in the IDES, so I am constantly busy. So there's always somebody out there, whether or not there is more or less that are satisfied, I don't know, because the door is always knocking on my end, but how long the line is outside the door, I couldn't tell you, so I really couldn't answer that honestly.

I think there has been some positive stuff with some of the changes, but again,

there's pockets of resistance that are not doing what the law requires and not doing what the regulations require, and there's really no accountability on that. And when DoD comes here at the next meeting, that'd be the first question I'd ask them, what are you doing to make sure that all these policies and regulations that have come out since Walter Reed are being properly enforced and implemented by the services?

And I've asked that several times of them and I get a blank stare and a door slammed in my face most of the time.

MEMBER KEANE: Thank you, sir.

MR. PARKER: All right.

MEMBER REHBEIN: Sir, Sergeant Jarvis' case, and not specifically his case, but the burn pit issues. We've been hearing more and more about that over the past years. Are you finding more people that, because of exposure to the burn pits, deserve more than they're getting?

MR. PARKER: Well, burn pits are

not. They deserve that their case be adjudicated according to law and regulation, and that's where I'm seeing the issue. Certainly, Congress has passed legislation for a burn pit registry which might illuminate how this is an issue. I know General Stone told me that he had concerns himself coming back out of Iraq with scarring in his lungs.

So in terms of the burn pits, I don't know. I will tell you that, anecdotally, after Sergeant Jarvis' case came out, about two weeks ago I got a pinging from another soldier's wife. He's on active duty and she was actually referred to me by somebody inside the wire of the DES process because of the frustrations they were having.

He's going to be taken care of, well, I think the Army is doing the right thing for him. He's active duty, though. So because his condition, he basically had to camp out on JP8, jet fuel, for months, I guess, on end and he had burn pit exposures, and now he has a terminal

neurological condition, about a ten-year window to survive.

What struck me is that, I said, well, you know, how did they treat the burn pit issue when you brought it up, and they said, don't do it. Do not talk about burn pit. It will complicate your case. You know, if you know what's good for you, don't talk about burn pit.

So it leads me to the conclusion that, you know, the VA has already rogered up, as Sergeant Jarvis' case has shown. Yes, there are these issues with burn pits, we don't know exactly, benefit of the doubt, you know, just as likely as not that the burn pit, you know, when the stuff they're burning, it is carcinogenic, they know that, so they grant him the service connection.

I think there's a reluctance on the military to do so because of the obvious cost issues, and such, with that. So, you know, it was somewhat perplexing and troublesome that they shut this lady down the first time she

mentioned burn pits. Don't talk about it. You know, you will rue the day you do, and so it makes me wonder.

MEMBER REHBEIN: That's a sufficient answer to my question, for me to get the understanding that I was looking for. Thank you.

MR. PARKER: You're welcome.

MEMBER PHILLIPS: Mr. Parker, you have been speaking at most of our business meetings and you've been giving us some very valuable information and I, you know, thank you for your efforts. In listening to your reports, there have been a number of common themes that you have presented, you know, the usual roadblocks.

And it might be helpful to this committee, and when we compose our recommendations, if perhaps, you could identify one, two, or three bullet points that you would like us to consider. I mean, we're hearing all these issues, and the delays, and the

bureaucracy, and not following the rules, but at least for me, it would be helpful just to have a sentence, or two, or three that could be concise.

MR. PARKER: I can give you a bumper sticker right now, is that, if you haven't read the Dole-Shalala Report, read the Dole-Shalala Report, because one recommendation out there is that anybody found unfit should get disability retirement, just like they do in the civil service. And that would uncomplicate a lot of things.

You no longer have, you know, the issue of what's fitting, what's unfitting, what the ratings should be, basically, you would get a retirement based on your length of service, and then you would get VA compensation for the impact to your earnings capacity, separate and distinct without offset from the VA, and to me, I think that's the gold standard.

I don't think it'll eliminate all the problems, but it sure, hopefully, would take

the lion's share of it. We probably spend more money saying no than we would pay in benefits, you know, with the $200 million that somebody quoted yesterday in terms of the whole IDES process, and I think the bureaucracy tail is wagging the dog.

MS. DAILEY: And we'll circle back around, Dr. Phillips, to Mr. Parker before we do our recommendations set, and he's given us a lot of information over the years. We'll go through that again and we'll make sure we get it out in front of you for the June and July meetings.

MR. PARKER: All right. Thank you. And my last bumper sticker was, you want to shorten the IDES timeline, do it right the first time. That's really the key.

MS. DAILEY: Thank you.

CO-CHAIR CROCKETT-JONES: Denise, is there any -- do we have a timeline for when General Stone will be joining us now?

MS. DAILEY: No, I'll get my staff to shoot out an email to him.

CO-CHAIR CROCKETT-JONES: And are the Navy Safe Harbor folks here?

CO-CHAIR NATHAN: All right. We'll go ahead and get started. So this morning, we welcome the group from the Department of the Navy who's going to speak to us on the recommendations issue. Captain Stephen Hall, who is the Commander of Naval Installations Command, Code N95, which is Navy Safe Harbor, and other members from the Navy staff. And the Navy session will begin with a briefing on their response and status, and the specific FY '12 recommendations that applied to the Navy.

As additional briefers address the task force during the session, we ask that introductions be made, especially the young lady second from the right there. I don't believe the committee knows who you are and I question your credentials. If you would introduce yourself at the appropriate time.

Please find the biographies and the

presentation under Tab J of our binders. Thank you. Steve, go ahead.

CAPT HALL: Thank you, sir. Next slide. So the first recommendation that Safe Harbor is going to address is the, provide more access to the CRP for Recovering Warriors and their families. Our non-medical care managers work on the comprehensive needs assessment, they get input from the family members and the Recovering Warriors, it's maintained in our database right now, the non-medical case management system, which the family members do not have access to, but we're required by the DoDI to give them copies of the plan as its updated, and the initial plan.

So we're getting input back and forth from the family members. Of course, the future state, there's, you know, the fix it eventually will be the bigger IT system where the families would have access to it. So in the current state, they don't have immediate access to the plan of record that's in the system, but

we do provide hard copies of that.

And I think, probably, really, after watching the discussions yesterday, the underlying issue is, how do we document that the family members are having their input and that it's getting collected into the CRP? And with our current system that we have, we don't have a great way to collect those metrics.

I went back and looked at some of the records this morning, not a comprehensive look, but went through some of them to see, are we documenting the interface with the families in our system? And for most cases, in the couple of records that I looked at, they did document that, I called the mother and talked to her, I called the wife and talked to her, or they came to our office and met with them.

So we have that information available in our system and we can go back and look at it, but I really don't have a good way to roll that up at this point to show you, you know, the metrics on that interface happening.

MEMBER TURNER: Captain, what metrics do you have; are you using?

CAPT HALL: Well, we did a survey last year, and you're going to get briefed on that later today, the response rate from the families was not great. It was only 7 percent and so we'll have some more information on that. And that was the first time we surveyed the family members and their satisfaction rate was 65 percent; about, so not great.

We definitely have some room for improvement. I'm not going to say, you know, we're hitting the mark totally on that, but it's definitely an emphasis point.

CO-CHAIR NATHAN: Captain Hall, can you give the task force membership here a little bit of an idea of how Navy Safe Harbor, the chain of command, for lack of a better term, or the relationships to a Recovering Warrior in your system versus the Army's system with the triad of care --

CAPT HALL: Sure.

CO-CHAIR NATHAN: -- and so that I think everybody understands what we do and can either celebrate or critique it based on what we hear.

CAPT HALL: Yes, sir. So in our system, we have 23 non-medical care managers in the field. The record way that we would find out about an injury or an illness would be a casualty report. So we get the casualty report, if it looks like the person is going to be a CAT 2 or 3, then we'll have the care manager and immediately start collecting data, contact the family, and then we'll make an enrollment decision.

Probably the biggest difference in our system is, the Safe Harbor is a directorate under CNIC and is not a command. So we never actually own the recovering service members. They're not attached or assigned to us. They stay assigned to their command, or sometimes transferred to the hospital, so we're working in a support role to the recovering service

members.

CO-CHAIR NATHAN: So how does, you know, I'm trying to be a little provocative today, because my good friend General Stone isn't here, so I have to do it for him, you know, in the Army, whether it's the right way or the wrong way, the Recovering Warrior is owned by the chain of command that exists at the facility and they always know who their squad leader is, they always know who their senior officer is, how do you avoid de-confliction in your system when you just said you're a supporting agency, but the individual belongs to another command?

So how do you make sure that you can get to them and they can get to you without their radio signal being lost to their command somehow?

CAPT HALL: I think, in a lot of cases, sir, they're getting treated, a lot of times, at a remote location from where their command is. So we're kind of the de facto, their command representative, sometimes, but there

are definitely issues with this setup sometimes because we have the responsibility for doing certain things and don't always have the authority to make it happen because we don't have the command relationship.

So we rely on, just, a lot of communication back and forth with the command and bumping it up the chain of command, if we have to, to get the issues resolved.

MEMBER DEJONG: Sir, if you would, how does that relationship between the commands and -- what we see in the Army quite a few times, and other services, is that, the service members are telling us that they're kind of lost from their original chain of command. How do you see that relationship with the chain of command being so integrated with the care of your service members? Does that benefit them or is it a hindrance?

CAPT HALL: Does it benefit them not to be assigned to the Wounded Warrior program?

MEMBER DEJONG: Do you think that

communication and that relationship with having them not assigned directly under the command of the Wounded Warrior, do you think that that is a benefit to the service member or do you think that it makes it harder on them?

CO-CHAIR NATHAN: The fact that they remain attached to their original command, do you see that as adding or subtracting to the ability to manage their care?

CAPT HALL: I think it goes, kind of, both ways. It kind of depends on the community. For example, the EOD community, they are very adamant that their sailors are going to stay assigned to their command and they want control of their EOD guys. So if they're at Bethesda and there's nobody up there, they'll drive up from Portsmouth and they'll see him. And that interface works very well.

In other areas, I can't say that not having your command co-located with you can't be beneficial, so I think it kind of goes both ways.

MS. LARSON: Captain, may I add to

that? Good morning. Merissa Larson here with Navy Safe Harbor and I'm the strategic support officer for the program. Good morning. One thing that I would like to add and just to follow-on with what Captain Hall was speaking about. We have heard a lot of concerns from the non-medical care managers in regards to the relationship that we currently have with the Wounded Warriors.

And so with our recent realignment from OPNAV to Commander Navy Installations Command, there's a potential opportunity that we're looking into for CNIC to directly have command and control over the Wounded Warriors. So this is something that we're currently investigating with the command and we're hoping to see if this might be a possibility in the future for us to own them at the regional level. Thank you.

CO-CHAIR CROCKETT-JONES: Do you all see a difference in how this particular aspect plays out between reserve and active duty

folks? Is there an even greater gulf that, sort of, has to be overcome in command issues for the reserve?

CAPT HALL: Yes, ma'am. The reservists are a special case in every way. Just the ability to get things done, you know, especially if they have transitioned and made it back to the civilian status before the medical issues get addressed, and it takes high-level interface to get those things addressed. And we work with N95, the reserve program, to try to get those out.

Our doctor, Commander Shapiro, is very sensitive to reserve issues and been a great advocate for, you know, going back to N95 to try to get them back on active duty, or in LOD status, you know, things need to get done, but just finding them is an issue too.

CO-CHAIR NATHAN: And I'll just add that, you know, in the Navy, the majority of the Wounded Warriors, Recovering Warriors, from non-illness standpoint, but from combat

injuries, you know, come from three communities; special forces, the EOD, and medical.

Over half of all Navy forces in Iraq and Afghanistan over the last 10 to 11 years, of all Navy forces that have been wounded in action, have been from Navy medicine, and over 1/3 of those killed in action, from hostile enemy action over the last ten years have been from Navy medicine.

And then the remainder are made up, primarily, of Special Forces, and as you were saying about CNIC, sort of, owning them, we'll see. The special forces, you know, the SEALs, and that group, really take care of their own, and when they end up in our hospitals, the nurses will come to us and say, how did they know they were here, they swooped in, they're doing all this stuff, what are you going to do about it?

And I said, that's what they get paid for, is to figure out where their people are and how to, you know, get into places they're not supposed to get into. So it's an interesting

system. So it's a little different just because various communities, we're represented by only a few communities that have the majority of them.

I worry much more about the ones that are out there in the hinterlands. The bottom-line on this is, basically, you know, are we satisfied that, as we asked the groups yesterday, are we satisfied that families and the Recovering Warriors understand the algorithm of their care, understand what's expected of them, understand what they should be entitled to, and what they should expect, and understand the end state?

And we've migrated between lead coordinators to provide continuity of care, RCCs, but that's really the genesis of this recommendation. And the question on metrics is a good one. I mean, I think everybody's kind of saying, the dog ate my homework on that one, that we've talked to, which is, you know, how do you know that the families get it; understand where they're supposed to be?

Because I can tell you that when the group goes to site visits, one of the general laments is, we don't really know where we are in the thing and we're still waiting to hear what's happening next. And medically, they get good gouge, as a rule, medically, they'll say, oh, my doctor was in and says, my leg has to do this first, and then they're going to call in this person and that person, but non-medically, they often don't know where they're supposed to be.

So again, you know, we're going to continue to look at this as a way to put more effort into situational awareness on the parts of the warriors and their families. Any other questions on --

MS. DAILEY: Yes, sir. We had a great visit with Navy Safe Harbor in December, two full days where we had our arms wrapped around them, and it was a great visit. We had no doubt when we left that these very senior non-medical case managers, which is a unique set of non-medical care management team, unlike the

RCCs in the other services, or their non-medical case managers in the Air Force, very senior system, very satisfied team of patients.

What we did ask and notice was that, we had no doubt that the CRP was being used and non-medical case managers were in it every day, so was everyone else, adding all the appropriate information, but when we asked what a CRP is, the family members didn't know. I mean, it's still an invisible document to them.

They don't know there's a plan. They know everyone is doing everything right and what's going on, but they can't say they've got a plan. So we did ask you to market your CRPs a little better, and the Army gave us a little, you know, handout here, which I was going, hmm, I wonder if the Navy is moving into something like this for your CRP? Have you marketed your CRP to your customers or are you thinking about that?

MR. POWERS: Robert Powers, Department of the Navy, Marine Corps Physical

Evaluation Board, we have a quick serious pamphlet that goes to each Marine and sailor once they're entered into the IDES. Is that what you're talking about?

MS. DAILEY: No. I'm talking about the CRP, the comprehensive recovery plan. We made a recommendation on our outbrief that the comprehensive recovery plan get better marketed to your service members and your family so that they know, even though it's being done behind the scenes, that they would know they had a comprehensive transition plan.

CAPT HALL: No progress on that, ma'am. I think what we need to do is print it out, show it to them, explain to them what it is, and then ask for their feedback.

MS. LARSON: Denise, if we could get a copy of the Army's, that would be fantastic.

MS. DAILEY: I don't need it. I've got dozens of them.

CO-CHAIR NATHAN: Anything else on Recommendation 11?

MEMBER EUDY: To follow-up from the special operations community perspective, regarding all of our services and the Wounded Warrior Programs, because, you know, as we do have our own, we do lean heavily on our parent services for everything, and that supports our -- because that's where we come from.

Regardless of the Wounded Warrior Program, and, you know, our commanders will never give up their command and control of their personnel, but attachment versus assignment, so, you know, you can have some ADCON purposes, but for separate of that, so I was actually going to ask you, ma'am, about that earlier, if there needs to be some sort of waiver process put in place.

You know, in the case of U.S. Army Special Operations Command and MEDCOM, we have an agreement, or a memorandum of understanding, for how that process works. I'm just trying to head off those barriers if that exists, or would exist in the future, so I'll talk with you then,

ma'am, afterwards if necessary.

CAPT HALL: I think for the Navy Special Forces, typically, SOCOM is the lead and then we enroll them separately and provide a supporting role to the care coalition.

MEMBER REHBEIN: Captain, to circle back to the family itself for just a moment, because we're dealing with human beings, periodically, conflicts and disconnects develop between people, it appears to me that the families' primary contact into the RCP is through that non-medical care case manager.

If you see that kind of conflict between that person and the family developing, that means the family is going to have less input. They're going to be more reluctant to say what's really going on and we know how important it is for the family to say what's really going on with their service member.

Are they provided an alternate contact? You know, as we're dealing in chain of command, if a conflict develops between me and

my supervisor in the chain of command, I always have a way to move up the chain one step, to resolve that conflict. Is that being done here with the family so that if -- we understand that you have very high-quality people. I was very impressed with the folks we met that day, but because we're dealing with human beings, we don't always get along, regardless of what the quality is.

CAPT HALL: I know I've heard discussions among care managers about who would be the best person to deal with specific patients. So I think that's happening, but I can't lay out a formal process for that happening. You know, I would also have to say, in some places, we only have one person, so there's really no choice, other than to work with somebody remotely.

And if, you know, I got the word from a care manager that said I'm just not getting along with this person, we could do, you know, a remote relationship. So I think that's

something we could keep our eye on.

MEMBER EUDY: Mr. Rehbein, to follow-up, often, you know, the Ombudsman Program that the Navy uses with the group-size elements to send out, fulfills, in a lot of cases, that role to provide --

MEMBER REHBEIN: But is that family provided with that information periodically? You know, we quite often see information being provided early in the process and then 9, 10, 12 months later when it's needed, the family has lost awareness of that information, so that kind of regular information provision needs to be accomplished to keep it in front of them.

MEMBER EUDY: Understood. Speaking from personal experience with the Ombudsman Program, typically, that's during the series of acute care or immediate hospitalization, and then tailoring off as required.

CO-CHAIR NATHAN: Okay. Let's move to Recommendation 13.

CAPT HALL: So this one would send the non-medical care managers to RCC training and we're doing it, so we have been sending people. So I think we're good on that one.

CO-CHAIR NATHAN: Can you talk just a minute about the fact that you've been relocated, the program's been relocated, from underneath the Chief of Naval Personnel to the Chief of Naval Installations?

CAPT HALL: Yes, sir. So as of October 1st, our directorate is now under the Navy Installations Command. I'm under N9, which is kind of the family programs, so he owns the family housing, lodging, MWR, athletics, and fleet and family support, are the big ones, so those were a lot of the services that we were coordinating, providing for our enrollees, so it's a great place for us to be housed.

You know, we now have that direct interface on the staff with the directors of all those different programs. And then the other thing that we're pursuing is, we're realigning

our care managers under the Navy region staffs. So where our past alignment, we just had 23 people, kind of, on independent duty out in the field, they're going to be integrated under the Navy region staff so they'll have a better connection and a more direct working relationship with fleet and family support, and those other support roles that are out there in the field.

So it should magnify our outreach in what we can do.

MEMBER TURNER: As an example, could you tell us some of the places these 23 people sit? Where do they go to work every day?

CAPT HALL: Right. The big places are Portsmouth, Bethesda, San Diego, and then the rest of the places, we just have one person in Newport, Rhode Island, Tampa, Jacksonville, San Antonio, and then at two hospitals in the PAC Northwest. And we're looking to put a care manager in Hawaii soon.

CO-CHAIR NATHAN: In regard to this

recommendation, if I were to ask you to give me a spreadsheet on the Safe Harbor staff --

CAPT HALL: Yes, sir.

CO-CHAIR NATHAN: -- as well as inclusive of the non-medical care managers, would you be able to print one out that shows who's up to date in their training, who's had it within the last two years, how many people had it on the way in?

CAPT HALL: Yes, sir.

CO-CHAIR NATHAN: Any further questions on that?

MS. DAILEY: Can I clarify the last bullet? You say all staff, so your personnel officer, your adaptive sports officer, they're all going to be going through RCC also?

CAPT HALL: All the --

MS. DAILEY: Or does that all staff mean --

CAPT HALL: All of our care manager, I think the recommendation was that the care managers go.

MS. DAILEY: Okay. But your last bullet there, it says, all staff. You're talking about, for my staff, so that I don't interpret it incorrectly when I'm putting together our recommendations, that term, all staff, is just all 23 non-medical case managers in that last bullet or is that now all your staff?

CAPT HALL: No, what we were talking to was the non-medical care management staff.

MS. DAILEY: Okay. Current initiative is to cycle all non-medical care managers through RCC training every two years for a refresher training.

CAPT HALL: I think -- I'm sorry.

MS. DAILEY: Is that a correct statement? That term, on the third bullet under 13 says --

CAPT HALL: I think what we were trying to say was that, all the non-medical care managers have been to the training; is what I'm trying to say.

MS. DAILEY: Okay. And that they'd

get refresher training every two years.

CAPT HALL: Right.

MS. DAILEY: And that's only the non-medical case managers.

CAPT HALL: Plus a lot of the headquarters staff, but not the admin people necessarily, but, like, our family support would go to that, the adaptive athletics would go to that.

MS. DAILEY: Okay. So you are expanding it to include other staff.

CAPT HALL: Yes, ma'am.

MS. DAILEY: Okay. I just want to keep that clear for my --

CAPT HALL: But I could get a list, person-by-person.

CO-CHAIR NATHAN: Well, I mean, at the end of the day --

MS. DAILEY: I think it's a good initiative.

CO-CHAIR NATHAN: -- the spirit of the intent is that, anybody you have in Safe

Harbor who's talking to or touching the lives of Recovering Warriors and their family, receive this training, and that's all.

CAPT HALL: And that's our intent. Yes, sir.

CO-CHAIR NATHAN: That's the spirit of it. Okay.

MS. DAILEY: Good initiative. I just wanted to make sure we got it right; kind of the best practice. We would probably categorize it as a best practice.

MEMBER EUDY: A follow-up on that, sir. So those that are RCC-qualified, the RCC course, although it does change in basic principle every year with what information they're presenting, you'll be using it as a refresher training course? I'm just wondering if there was a, you know, more effective way it could be done for the size of that population; if it's through continuing medical education at those local facilities or through VTC capability, because, you know, roughly, if it's

every -- you know, I've seen the course every year. Only small things change.

CAPT HALL: Right.

MEMBER EUDY: So in the course of two years, I'm just wondering if it's the most effective, especially for, you know, the level that they're going to be active in those programs and knowing what's currently going on. Just thinking about the bottom-line, sir.

CAPT HALL: Okay.

CO-CHAIR NATHAN: All right. Recommendation 14.

CAPT HALL: 14, so when we wrote the answer to this, after listening to the discussion yesterday, I think I answered the wrong question, but we don't see a constraint in HIPAA in dealing with non-medical case management. Our non-medical care managers don't have access to the medical record anyways.

I mean, they have an understanding of what the injuries are and one of the first things we do with the service member is have them

fill-out this release form and that's primarily to give the non-medical care manager access to have the knowledge of what their injuries are.

So as I understand it, this is going back to, how do we know that the family members are getting the information?

CO-CHAIR CROCKETT-JONES: Yes, this was crafted because HIPAA was listed as a barrier to inclusion of family and the non-medical case management, and sort of benefits awareness, and it should not be. The benefits that are due to family members are due to them regardless of the medical, you know, details that would -- you know, HIPAA information.

So we're trying to eliminate that barrier.

CAPT HALL: Right. And I don't see that as a barrier.

CO-CHAIR NATHAN: So if you heard the conversations yesterday, it was mainly centered around, do we engage the families and

do we engage the families and try to do so in a way that is respectful of, but doesn't necessarily depend on, the permission of the Recovering Warrior, who may or not be interested in having their family involved in their care algorithm or in their non-medical care milestones? Your comments on that.

CAPT HALL: I think we can talk to the family members about their needs and I don't think that really compromises the rights of the sailor. I don't see a problem with doing that. And, you know, the metrics of this, of how we've documented that the family knows, we can document that we waved a paper under their face, or, you know, that they were in the vicinity of words, but the understanding of what I need in this particular case, I think we really have to rely on the care managers to understand the situation and present them with the benefits and the information that's going to help them in their particular situation.

I mean, we're not going to fix this

issue by informing all the family members of all the things that are available. It's just overwhelming.

CO-CHAIR CROCKETT-JONES: I think one area in which family member information is in contact, I think, that was brought to us, as sort of, a greater concern, was for your reserve members who wind up being brought into MEDHOLD. There are very limited opportunities for those folks to even have their families visit, let alone, they're not going to be there.

Some of those folks wind up being placed in MEDHOLD for extended periods of time, up to a year, with no real significant means for them to spend time with their families. The divorce rates were a little scary when we were talking to those folks and I think we have just concerns from our visits that, family member inclusion is more passively addressed than might be to benefit.

I don't think that, sort of, the underpinnings of why a recovery process for

someone over the course of the year is going to be made longer and more difficult if they are also experiencing a divorce, or a severe family strain, this is not going to enhance the recovery process and it can, often, prolong it, especially with some of the invisible wounds issues.

So I think that our recommendations we're all trying to get to, we'd like to hear an active voice in family contact, coordinating family needs, and connecting those dots. That's the driver behind a lot of the recommendations in this area.

CO-CHAIR NATHAN: You're not alone in this. All the services, I think, we need to see a sea change in the way that we're approaching the total care of the Recovering Warrior and their families. I think we're starting to see it, but I think there's still a lag. We're still in the days of, the active duty member is the end all, be all, and we participate, engage, aggressively intrude into

the family based on the druthers of the active duty member.

Yes, we've heard that, and again, I'm not lecturing you, I'm lecturing the general services' approach to this, but we've heard that everybody comes and says to the family, look, if you need help, we'll give it to you, here's what we can do, and makes the family aware of the services, and then says to us, you know, you can lead the horse to water, but you can't necessarily make them drink.

If the family doesn't want to take advantage of these services, there's not much we can do about it. I'm not so sure that's an acceptable answer as far as what we owe the families, because I still think we partition the families behind the active duty member to some extent.

And if the active duty member comes in hot and hard and says, to the family, you are not, I don't care what they tell you is available; you're not going to do that. This is

not a good thing for us. Trust me. This won't be good for us, or our family, or my career if you engage in that.

I think the services, from what I'm hearing, tend to sort of defer to that, and I'm not so sure we don't need to take a stronger tack now and recognize that, the recovery of these warriors is so much dependent upon the family dynamics and the health of the family, as you were alluding to, Suzanne.

And so it'd be one thing if we weren't seeing elevated divorce rates. It'd be one thing if we weren't seeing escalating domestic violence. It'd be one thing if weren't seeing some escalating -- and I'm not saying it's a crisis situation, but what I'm hearing, over the last two days is, maybe we need to take another turn on this in how much we inject into the family.

I'm the first one to admit, in a busy place, like a Walter Reed, or a San Antonio, or a San Diego, it's all hands to the pumps, you're

trying to put out the fires, from the medical issues, from the non-medical issues, and you just sort of give the family something, and you tell the family, here's a social worker, or here's a priest, here's a chaplain, here's a rabbi, if you need to talk to somebody, we'll make them available to you, and we do a good job of making them aware of that.

But I worry, from what I've heard in the last couple of days, that we're not doing a good enough job of being what I call intrusive leaders. And intrusive leaders can sometimes make people uncomfortable; the people you're trying to intrude on. So it's something that I think we need to talk about in our future meetings as to how we can do this.

I'm not trying to say that we kick open the doors of the families and say, RCC here, here to do a home inspection, here's our search warrant, I'm not advocating that. I'm just simply saying that, maybe we need to revise our approach when we first hit the ground and the

Wounded Warrior and their family intersect us, maybe, instead of saying to the active duty member, here's what we're going to be doing for you, and family, here's what's available for you.

We're going to tell the active duty member, here's what we're going to do for you and your family. You don't have a whole lot of choice about it. You're going to have to engage in these issues and active duty member, this is the way it is. It'll be up to your family to tell us they can't do it, not you, et cetera. So I think it's how we message it.

Any other questions for Recommendation 14?

MEMBER PHILLIPS: If I may just editorialize.

CO-CHAIR NATHAN: Sure.

MEMBER PHILLIPS: In my mind, we do have a model that seems to work, and that's the special ops community where they do a lot of things through social networking, they trust the

folks that land at their bedside because that's the way the community is, and I wonder if there's some way to look at that and convert some of those good practices into policies and procedures.

CO-CHAIR NATHAN: It's a great point. As a rule, special ops is pretty well funded. They often have a lot of benevolent organizations that they have worked with. They usually have a smaller number of folks, so they can provide a little bit more concierge care, but you're absolutely right. When a special ops warrior hits one of our facilities, all of a sudden a cadre descends on them.

As a rule, the families tend to be more involved in the beginning in the first place. As a rule, if you talk to a special ops family, even before the injury, they tended to be more engaged in the career, more engaged in what's going on, much more engaged in family activities, the support groups, the special ops families tend to really hold on to each other and cling together in a, sort of, cadre, a covenant

way, before an injury.

And so when one of their members is injured, boy, do they close ranks and support each other and take care of each other. So sometimes it's hard to replicate that in the larger more distributed military, but nonetheless, yes, the one thing you never have to do with the -- the problem with special ops when they come in your hospitals, is not trying to get enough care to them, it's trying to get care around the care they're already receiving from the special ops community.

You almost have to ask to be invited into the room. And so I think that they're a special case, but we can learn lessons from them, and their families certainly feel supported, but I think a lot of that is the culture that exists prior to even injury. Any comments?

MEMBER EUDY: That's a very good summation, sir. You know, to follow-up to that, currently, an issue put out by Admiral McRaven is the preservation of the force and family, or

the POTFF initiative, which addresses our needs as a force for the long term, due to the continuous deployment cycles after the large conventional side drawdown that will occur in the current theaters, and the sustainment of soft forces through the long haul.

Recently, even at Walter Reed, we had higher numbers of soft member injuries that were inpatient than some of our sister services did, and so we're trying to gear up and see what we need to do, and change ourselves, to meet that long-term need, but yes, if you need anything, doctor, we can talk offline.

CO-CHAIR NATHAN: Okay. How about Recommendation 16?

CAPT HALL: So this is another one where documenting that the family members have gotten the information is a challenge. We do have a federal recovery coordinator, VA federal recovery coordinator, that works in our headquarters, and she's been a huge asset. The ability for the care managers to reach back to

her, even though she's not on the benefits side, she has some really good connections, and that person, in particular, has been really beneficial to us.

And I have talked to her supervisor recently to make sure they're not interested in taking her away, but they are very happy with the relationship and that she's working from there.

Our non-medical care managers work with the VA resources at the MTFs where they're at. I think this is an area where you really do need the help from the VA because there are so many ins and outs to all of this. It is pretty confusing. So it's vital that we get them to the VA to help explain that and not try to become the experts and then put out bad gouge; essentially.

And then I would also point out, we have three non-medical care managers at VA facilities, Palo Alto, Tampa, and then Chicago, that actually work there, and then we do have a few patients, off and on, at Richmond, and we rely on the Marine non-medical care managers

for, kind of, the day-to-day keeping track of our patients there. That's been a really great relationship.

So when somebody shows up there, they'll look in on them and then we kind of manage those remotely with trips back and forth, but with the help of the Marines.

MS. DAILEY: We saw the non-medical case manager at the James A. Lovell Federal Health Care Center, and it was a very unique relationship; really well placed. He would get the individual while they were still active duty and then he was right there at the VA and able to transition them right into the VA. It is almost a model for how you would really like your transition to occur.

CO-CHAIR NATHAN: Denise, did the task force ever get to visit, onsite, one of the polytrauma VA centers?

MS. DAILEY: We have not been to the polytraumas.

CO-CHAIR NATHAN: I think that I've

gone to a few over the years to just follow-up because we send so many of our Wounded Warriors for long-term rehabilitative care down there. The ones that are really, really going to need long-term rehab; ventilator support, mostly those that are severely neurologically impaired from head trauma.

And I'm familiar with the two that are at the Palo Alto/Tampa area. They do amazing work. The one thing we always have to be concerned about is, does the Recovering Warrior and their family feel, sort of, lost when they leave the confines of the DoD and go to these VA systems? And as a rule, these VAs are amazing.

They truly embrace and take great care of the families and the warriors. I do think that sometimes we get so busy that we, sort of, partition them away after a year, or a year and a half, or nine months in our DoD facilities, and we send them down to the VA, and now they're away from their units but the services have put

unit liaisons down there to represent them.

So I think it seems to be working and I know that they're getting the liaison from your folks. I still contend that we probably don't do enough in the active realm to, sort of, go down and follow-up on them and see what they do, and I would advise, at some point in our travels, Denise, we probably hit one of the more robust VAs, like Tampa, which has a pretty high census --

MS. DAILEY: Good. Yes, sir.

CO-CHAIR NATHAN: -- to talk to the families down there and see how they feel they're doing.

MS. DAILEY: I'll definitely it on the calendar for next year because there is also the Reserve Component Processing Center there, is also there, so it's really a two-for-one in Tampa. So yes, sir, I'll put it on the schedule.

MEMBER MALEBRANCHE: And I might add, because I was thinking that too, as far as the Tampa center, but things we might think

about, and mind you, the VA is not complaining, but there are 11 different people from Department of Defense down there, from Wounded Warrior, AW2, Marine for Life, Navy Safe Harbor, onsite there, sometimes we don't even have that many patients.

But we need to talk to them too, I think, about the criteria of how they're placed, because in this day of shrinking resources, I think it'll be important that we have some of this cross ability, but also, that we do it wisely so that we don't, you know, mislook at some of the things. But Tampa is a close one and probably one of the better ones to do that.

CO-CHAIR NATHAN: Thank you. Anymore comments on 16? Okay. Captain Hall, Recommendation 20.

CAPT HALL: Okay. So I think this one is designated specific aspects for our Recovering Warriors. And I think our transition under CNIC, you know, I work, I appear with the Director for the Fleet and Family

Support Services, we're going to integrate our field staff under the Navy region staff who oversees the Fleet and Family Support, so I think the synergy there, kind of, addresses this issue and I think we're doing fine on this one.

CO-CHAIR CROCKETT-JONES: Is there any way for someone who is designated as being part of your, you know, AW2 program, or --

CAPT HALL: Right.

CO-CHAIR CROCKETT-JONES: If someone's enrolled in Navy Safe Harbor, when they go to Fleet and Family Services, do they have any way of getting priority? For instance if there is limited availability of a particular service, do they get to go to the front of the line? Things like that. I think that was some of the things that we were thinking about when we wrote this.

CAPT HALL: Right. Well, the answer was that there really isn't a capacity issue, but that's overall. And certainly, in a certain place, you could have a capacity issue.

So the care manager, and I know of one case where there was a capacity issue, brought it up to our family support person, who called his counterpart in the other parts of CNIC, and it got resolved. So we do have a way to address that.

MS. LARSON: Specifically, what we have been able to do with the realignment to CNIC is to develop enterprise-wide solutions. So for example, we've worked closely with the childcare director to revise their policy so that our Wounded Warriors can have those head-of-the-line privileges when they're going to the CDC. So that's where we find a lot of benefit with the realignment.

MEMBER TURNER: While I appreciate that synergy is very difficult to quantify, and I understand you're in, kind of, a flux since you're reorganizing under CNIC, could you speculate or come up with how you plan to measure how you are resourced, like, you know, how would you ensure that your resources are being met and,

you know, like, how much are you manned? I guess CNIC is going to own your resourcing dollar, is that accurate?

CAPT HALL: Yes, sir.

MEMBER TURNER: So, you know, will you have to compete with other, you know, processes, and again, getting away from synergy, but just, how would you quantify your support and track to ensure that the support is adequate?

CAPT HALL: So we transitioned to CNIC with, the entire workforce went over, 43 all together, and so there was a discussion at the high level, the CNIC, not to use those billets as a bill payer. So that's, you know, in the immediate area. Then going forward, Admiral French is very interested in making sure we're adequately resourced.

So we've shown them, you know, we have a metric where we have number of enrollees by place, so that you can see the caseload by region, and so we're tracking that. And then, another metric that I'm working on is, I want to

be able to kind of grade this ERP, and two grades it would get, one is, are all the needs on there? And then, are they getting met?

So I think that, are they getting met, would get more to, are we having capacity issues outside of the CRP? You know, we identified a need for our Fleet and Family Support, but it wasn't able to get addressed because they couldn't get in there. I think that's where we would be able to show, you know, how the overall system is doing.

MEMBER TURNER: Again, being a big fan of numbers, it would be really great if, when you all come back next year is, when, you know, you get asked these questions, and I know you can't now, and I understand that, if you would just, you know, plop a metric, bam, bam, bam, this is where we are, bam, bam, you know, with numbers, because the -- and I understand you're in transition, but numbers really talk.

CAPT HALL: Yes, I agree.

MEMBER TURNER: That would be

great. Thanks.

CO-CHAIR NATHAN: Suzanne, and also, to your point, there has been disparity, or, sort of, an error gap between some of our MTFs and the Fleet and Family Service Centers. We've been working hard at trying to figure out how to not create either redundant services or how to create better visualization between the two, these are at our bigger facilities, where somebody is going to the EFMP program at the hospital and the Fleet and Family Service Center doesn't understand it, or vice versa.

So we've been putting resources, sharing resources, between the two. And I think this is the other good reason for Safe Harbor to come under CNIC, because so much of what we do -- which begs the question, and it's not a real big one for the Navy, because we just don't have the numbers, but any comments on -- you know, one of the things that's happened, I have personal interest in this because my daughter, who is, you know, in high school, is trying to actively reach

out to some of the kids who are on the campus now who have come up with Wounded Warriors.

So Wounded Warrior comes up for one, two, sometimes two and a half years on the Bethesda campus, depending on the extent of their injuries, and the family relocates with them. And here's the good news, we have these beautiful, I won't even call them barracks, they're quarters, in Building 62, but something that was lost on me and was impressed upon me by my daughter was, what are you doing for the kids that are relocating and having to jump into high school, or middle school, or grade school in these communities?

And, you know, what are we doing to help them? And I said, well, they have the Family Services Center, and they have the social workers, and we'll give them head-of-the-line privileges with adolescent psychiatrists.

She goes, no, no, dad, you know, what are you doing to make them feel part of the community as kids who are coming to high school,

or grade school, whose dad is in the hospital, or whose mom is in the hospital, cut in half? And boy, I had an ah-ha moment there, and I said, you know, I don't know.

And, you know, I told her, I said, you help me figure it out. So any comments on that? And again, you don't have a large stack of these on your desk as the Marine Corps and the Army does, but we do have a population of kids in San Diego, and in San Antonio, and Bethesda, who are living now in, sort of, temporary quarters, going to school in a new school system, as though their family has PCS'd with a little bit of a difference, in that, every day, maybe, they're having to go visit their loved one on a hospital ward.

Any comments on that?

CAPT HALL: There's a case that jumps to my mind, MU1 Fennell, who had brain cancer, and he was in the Navy band, and he died Christmas Eve at Bethesda, and he was an inpatient there for a long time, and he had

teenage children. There was a lot of emphasis on them and they spent a lot of the time in the hospital with him.

I know they worked with a lot of recreational activities, you know, going to football games and giving them a break to get out, and there were some really good press about his son in particular, and the stuff that he was able to do helping his dad out, you know, during those last few months.

But I think, you know, each family is going to be different in setting that up, and with the small numbers, you know, how do you setup stuff that will address every age of -- you know, and then all these different places? It's definitely a challenge.

CO-CHAIR NATHAN: Yes, I bring it up only because it's the new paradigm now in what we have, because people are surviving the wounds that, previously, they would have succumbed to, because now, we've decided, and it makes sense, for somebody who's going to be hospitalized as

an inpatient for a year or more so, to figure out how to get their family up with them.

We're presented a whole new, sort of, predicament. And I don't look at it as a bad news story; I look at it as a good news story. I challenge any other healthcare system in the world, outside of the military, and in some places, the VA, to take this kind of care of families with chronic illness or injury, it's just not done.

And so I'm very proud of organization which wants to do this, but we create a new set of problems for ourselves. Every time we do something else, we now create a new set of problems. So again, I think that this is something we need to be cognizant of.

Anything else on Recommendation 20? Okay. Anymore questions for Captain Hall on this issue?

CAPT HALL: Will it roll right into BUMEDs? Go forward a couple of slides. Okay. So next up is Captain Evans from BUMED.

MEMBER EVANS: Not on your schedules is Dr. Ralph. He works with me in M9, so he's going to be presenting on two slides. Good morning. I'm Captain Constance Evans and I do reserve the right to phone a friend. My friend would be the Surgeon General of the Navy.

(Laughter.)

MEMBER EVANS: I'm the Director of Care Management, M9, in BUMED. Next slide. So I'm going to address Recommendation 6. In that Recommendation, your visit, I think you had two visits out at Twentynine Palms, we do have a BUMED instruction, clinical case management instruction, that addresses our caseload and how many, looking at our patients, to ratio of case management.

We are in the process of updating that instruction because we want all services to be standardized. As you can see, the instruction says 10 to 50 patients, depending on acuity. We do have an acuity model, and you've been presented that model, I think, last year.

At Twentynine Palms, specifically, they have eight case managers there.

They have a workload of about 20 with the Wounded Warrior Regiment, so they have 40 patients assigned to the Regiment and 20 per case manager. Those case managers' acuity there is not where they're overworked. And so they are supporting the other case managers in the command.

They are in the process of hiring an additional two case managers to get up to a workload of case manager number of ten. That's a hard area to hire. We are on the phone every month with them asking them about acuity. The workload there at Twentynine Palms is decreasing, so we are seeing a decrease in patient ratio to case manager, so I think we are okay at Twentynine Palms.

Again, we keep a constant contact with them each month to make sure, if they do need additional staff, then what's our other opportunities to support them?

CO-CHAIR CROCKETT-JONES: Do you know what the case management load is for those who are taking care of those not in the Wounded Warrior Regiment out there?

MEMBER EVANS: Right now, they have a case management load of about 40 per case manager. But again, they take care of non-combat injured warriors plus other beneficiaries, and so that's why you see that 40 ratio, and that's why they're looking to hire an additional two to bring that ratio down.

Our new instruction, we are going with a ratio of 30, and that's going to be across all services. With the regiment, we are looking at, and with Safe Harbor, a ratio of 20, just the complexity of the patients.

MEMBER PHILLIPS: Just as a short sidebar, are you getting any feedback related to the ability, or the ease, or difficulty of getting folks who are being managed in the line into the Wounded Warrior Regiment? That was an issue when we visited in the past.

MEMBER EVANS: We have had conversations with the case managers that they have requested a patient to enter into the program, the Regiment program, and we can only refer patients to there, and that decision is made by the Regiment. We have had some cases that come back and say they felt, based on -- and more behavior of health, because at Twentynine Palms, that's what the larger population we see there, and so they have made requests and a denial has been sent back, and that's been a Regiment decision.

CO-CHAIR NATHAN: Okay. Recommendation 8?

MEMBER EVANS: Captain Ralph will come up and present Recommendation 8.

CAPT RALPH: Good morning. I don't think my bio made it into your packet, but I'm John Ralph. I work with Captain Evans at BUMED and I'm the Chief of Staff for M9 at BUMED, which is wounded, ill, and injured programs. And I'm a psychologist. I'm the special to leader for

Navy psychology, and I'm going to talk about Recommendations 8 and 9, both of which deal with evidence-based care for PTSD in compliance with the DoD/VA Clinical Practice Guidelines.

And Recommendation 8 deals with the recommendation that the DoD ensures that a 100 percent of behavioral health providers are trained in evidence-based PTSD treatment and their primary care providers are trained in that as well. And we do have a variety of assets available to ensure that we meet this need, most notably is, the Defense Centers of Excellence has a variety of training opportunities, both in-person and online, that is pushed out to all of our MTFs.

One thing that's not mentioned on the slide that may be even more important is the Center for Deployment Psychology, which is actually a center that, its main mission is to provide training for providers in evidence-based care. We send all of our active duty providers through the CDP course, and the

CDP not only does this training, but they actually have contracted billets at several of our MTFs to provide ongoing supervision for providers who would like that in these evidence-based treatments.

So they're a huge partner with us in making sure we meet this need.

CO-CHAIR NATHAN: So, John, you know what's coming. You've just said that you send all active duty providers through this course and as President Reagan, during nuclear arms discussions said, you know, trust, but verify. If I asked you to produce a list of a roster of the people who are active duty mental health providers, could you do that and show me where they are at a checkmark on their training?

CAPT RALPH: Yes, sir. For active duty, I can say that they are all trained in evidence-based care because they go through our training programs, which includes the CDP in our residencies and our internships, and we all provide this training through our own training

program.

So I can say that, unequivocally, you know, a 100 percent, about active duty.

CO-CHAIR NATHAN: And that range of providers is what? What areas?

CAPT RALPH: Psychiatry, psychology, and psych nurse practitioners, and social workers.

CO-CHAIR NATHAN: Okay. What about enlisted psych techs?

CAPT RALPH: They don't have the same kind of training programs that we do in terms of providing evidence-based treatment for PTSD. They're not providers. They're not actually providing treatment, but all of our providers are getting this training.

I hesitate to give that same figure for non-active duty providers. The resources are there, the guidance is there that requires them to have this training, that guidance was formalized through a health affairs memorandum in August of 2012, but they're a bit of a moving

target in terms of, particularly, our contract providers who are coming and going, so it's difficult for me to say a 100 percent.

But I would say that if it's not a 100 percent, it's very close, that the resources that we have available and the emphasis that we placed on this, there's no reason that anyone should not have this training. Yes, ma'am.

CO-CHAIR CROCKETT-JONES: How much of PTSD treatment is done in civilian provider population?

CAPT RALPH: A great deal. I would say the majority. The majority of our providers and our MTFs are not active duty.

CO-CHAIR CROCKETT-JONES: No, I mean, how much goes out of the MTF? How much goes into a community for civilian provision?

CAPT RALPH: Well, active duty are treated within our MTF. There are exceptions to that at some places, but active duty are treated at MTFs, particularly, Wounded Warriors. They are treated at our MTFs. Where we send people

out to the network is through dependents, and families, and non-active duty; for the most part.

So if we're looking at Recovering Warriors, they are treated at our MTFs.

MEMBER MALEBRANCHE: But when you talk about the reserves, because they're active duty and then they're not, they would be treated, perhaps, in the network?

CAPT RALPH: Yes, ma'am.

MEMBER MALEBRANCHE: And then, I'm just wondering, as far as the training, is this tracked in CCQAS? Is that ability there, because I know we're looking at -- which I know privileging is different, but I mean, they were looking at different things with CCQAS with the VA as trying to go to one system, and I was just wondering, is that in there?

CAPT RALPH: I do not believe that this specific type of training is tracked in CCQAS. I mean, you don't need this training for privileging at our hospitals, so the licensure

issues, and the internships, and the required training for practice would be in there, but not this.

MEMBER MALEBRANCHE: Okay.

CAPT RALPH: Something to think about. I also want to mention our behavioral health integration program in our Medical Home Port Initiative, which places mental health providers in our primary care settings within our MTFs. Their mission is to provide care in the primary care clinic, mental health care, as well as train providers in recognizing, not only PTSD, but the mental health aspects of many of the conditions that people would come to primary care for.

So that program is rolling out as we speak. It's not online in every MTF yet, but it is online in a number of them, and that's a very structured treatment protocol with structure training, outcome measures, and the like, and so as far as ensuring that primary care providers are appropriately trained, that would address

that issue.

Questions about this recommendation?

MEMBER PHILLIPS: I just wonder, I know it's supply and demand, but for the non-active duty providers, can you mandate that they go through the training before they're contracted to do this job?

CAPT RALPH: We can, to the extent that that's been done in the past, I can't say right here, but you can write that into a contract that they have received training and are familiar with the clinical practice guidelines.

MEMBER PHILLIPS: I think it would help both sides.

CAPT RALPH: Yes, sir. For Recommendation 9, this is the recommendation that states that DoD should audit military treatment records for returning warriors with PTSD diagnosis to ensure that the treatment incorporates the CPGs. Let me start by saying

that this audit is happening. It's happening through our Psychological Health Advisory Board, which is an advisory board at BUMED made up of the clinical mental health specialty leaders.

I don't have the results of that yet and there was, just in total honesty, some pushback on this by our various specialty leaders for a couple of reasons. One, this requires a great deal of understanding of the records and the treatments to actually do an audit to ascertain the extent to which the care is evidence-based and of the type that is mentioned in the CPGs.

The type of therapy used is not coded in AHLTA, so you actually need to go through and read the record and understand what they're saying to give it an uptick or not. And there's a general concern with an audit that notes percent compliance since, even the health affairs guidance notes that, while providers should be informed of these CPGs, while they

should use them, document reasons why they may not use them, they're not always appropriate in every case.

There's the general sense among many of our providers that they should retain some flexibility in how they actually see their patient; for a variety of reasons. Many dual-diagnosis and other issues. Yes, ma'am.

CO-CHAIR CROCKETT-JONES: Some of the things that drove this recommendation were from providers talking at our installation visits about their frustration with having patients drop-off midstream in a treatment plan, that this was generated from a provider complaint saying, I can't fully know how successful -- it is impossible for me to assess a portion of the success of the treatments that I am performing because I lose patients midstream, that we have a plan for X number of weeks of treatment and they become non-compliant and don't finish those weeks of treatment.

And so quality control might be

looking at the effectiveness if they look at patients who are persistent and repeating, or going back in for further, or going into crisis, but if I have no method for pulling folks back in, or knowing where they went, or why they are non-compliant, this was what drove some of this recommendation.

CAPT RALPH: Right. So there, I think you're looking at a somewhat different question. You're looking at treatment outcome and was it effective? Did it work? Did the patient drop out? Did their symptoms get better? And was success measured and achieved? And that's the thing that we're also looking at and that our board was more inclined to look at. We're doing both.

But to what extent are outcome measures being employed in therapy, is success defined upfront, and are you tracking whether treatment is effective or not in meeting those outcome measures.

CO-CHAIR CROCKETT-JONES: And our

question, I think, is also, are you tracking the folks who don't complete?

CAPT RALPH: Right.

CO-CHAIR CROCKETT-JONES: Once they're in are they part of a tracking or are you assessing effectiveness? You know, this is going to give us two different sets of information. Does completion increase effectiveness? If we look at that population without discerning out those who completed versus those who enrolled, if we're only looking at completion, we get an effectiveness rate that doesn't reflect the problems and crisis issues.

And that's the differential that I think the membership of the task force, part of at least, what drove this recommendation was in saying, we think that those are two really different populations. And since a lot of the PTSD folks have, sort of, as part of their diagnosis and part of the hallmarks of their behavior is avoidance, especially when you add in TBI with that large crossover cohort, you've

got folks who have problems remembering to attend.

And this is a population that seems to be at higher risk to us, and if we're adding in that they don't get pushed back in to complete, for one reason or another, maybe because they reach a point in -- you know, they move, you know, we're trying to get a handle on what's happening with that population. That's really what drove this question.

CAPT RALPH: Right. No, I understand completely. So yes, any measure of efficacy has to include those who start treatment, not just those who finish treatment formally. Absolutely.

CO-CHAIR NATHAN: John, the task force is going to be going out to Camp Pendleton. Some of the members here will be going there in a few weeks. Can you speak to what they're doing out there with their --

CAPT RALPH: Yes, sir. I was going to mention that. At Pendleton, and on the West

Coast, we're piloting a system that they call Psychological Health Pathways, which, it is in the pilot stage and it does several things, but in line with our discussion here, it tracks improvement and outcome over time while therapy is going on.

So a provider will get periodic updates on the patient's condition regarding a variety of factors so that they can make some real-time adjustments based on whether a patient is getting better or not. So it's not just outcome-based, it's evidence informed while the treatment is going on.

And the providers out there do like that. It's been very effective and it's also something that allows the treatment history, and all these things I was just talking about, to be transferred from one provider to another as a patient transfers, because it's all stored in one database. So in many ways, it's a case management program as well.

CO-CHAIR CROCKETT-JONES: Right.

The bottom-line is that it's memorialized on a database, not just a particular patient's record with something else. This sends the information to a place where then, it allows milestones being measured. I only bring it up because, I think when you're out there, you may want to drill-down on it because this is, somewhat, impacting what you were talking about, Suzanne.

So I think it's an approach, and so far so good. We're thinking about exporting it to the rest of our organization, depending on how it's received out there.

CAPT RALPH: Yes, sir. One example of that is, if they looked at their patient outcomes, they would find that, while anxiety and depression, and some of the other focuses of treatment were improving. Things like sleep were not. You say, well, whatever we're doing is not targeting sleep problems, so what adjustments can we make to make sure that that's effective?

So that's been a useful thing to look at and that's what we're trying to look at more and more, not just these CPGs being used, but is therapy working and can we show that it's working? And again, not just for those who finish up and have a final outcome measure.

And then the last thing to mention, we do have our peer review process, so that is our quality assurance process. Peer reviews at all of our MTFs focus on evidence-based care, outcome measures, and the like, and so we do track that. We do have a QA process in place. It's governed at the local level, but they are required to have that to do that.

CO-CHAIR NATHAN: Okay. Let's go to 15.

MS. DAILEY: And just real quick. Sir, I hear an advisory board on psychological health. That's what you're part of? And is that something that would be worthwhile to come talk to the task force about? It sounds like it's very focused and is working down a very good

lane that would be --

CAPT RALPH: That particular task that we've been tasked with this year, I think, is exactly focused on evidence-based care for PTSD. And so as we get those results, I think that may be very appropriate.

MS. DAILEY: Okay. So there's an advisory board lead and --

CAPT RALPH: Yes, that's myself.

MS. DAILEY: That's you.

CAPT RALPH: That's right.

MS. DAILEY: Okay. Well, I know how to get in touch with you. Thank you.

MEMBER EVANS: Recommendation 15, designate a principal point of contact for family caregiver. In the current state, the primary contact is the Navy Safe Harbor Non-medical Care Manager. In the future state, we are going to the lead coordinator model. Walter Reed is one of our pilot states. Lead coordinator will be that central to bring the team members together, be the point of contact

for the families, and so we are actually in the pilot state with that. Any questions?

MEMBER REHBEIN: Captain, I'm a little bit confused as to exactly where that lead coordinator program is right now. Is it being rolled out in certain places? I heard the word DoD-wide yesterday. I'm just a little confused as to where we stand.

MEMBER EVANS: Well, we have a brief coming from the IC3 at our next meeting and that should help us.

CO-CHAIR NATHAN: Okay. Next.

MEMBER EVANS: Recommendation 18, Unify families/caregivers with their Recovering Warrior. This is actually stemmed from Portsmouth when we visit the reservists out there, and this is actually not a BUMED, more of a PERS/N95. Currently, we do follow the Department of the Navy DoD guidance and we try to get the families together, but I really don't want to address this one because it doesn't fall under BUMED. It falls under PERS.

CO-CHAIR NATHAN: You can take the 5th, I get that, but the genesis of this, Connie, was mainly to keep family integrity together --

MEMBER EVANS: Right.

CO-CHAIR NATHAN: -- as Recovering Warriors migrate through the process. So your comments on that, just from your previous life working as a casualty care coordinator at Walter Reed.

MEMBER EVANS: Right. Even in this life, sir, we work closely with PERS when we have families that we feel that the family need to move to one of our MTFs because of the longevity of the care, so we do work closely with them. We bring the families and our warriors, we work closely with Safe Harbor. As far as the medical, they rely closely on Safe Harbor to help us with the ITOs, bringing the families at the bedside.

Once they move to the outpatient, because of the JFTR, I think that's correct, we have to decrease that family down to one member

and if we need bring the entire family, we do work closely with Safe Harbor again to bring --

CO-CHAIR NATHAN: One member as a non-medical attendant.

MEMBER EVANS: One member as a non-medical attendant.

CO-CHAIR NATHAN: Right. Now, in your previous life, though, you did have to broker family issues across all the services.

MEMBER EVANS: Yes, sir.

CO-CHAIR NATHAN: And I'd be interested to know if there was an impediment from the Navy, were there any problems that you saw, service-specific, to the Naval services that hampered your ability compared to the Marine Corps, the Army, or the Air Force?

MEMBER EVANS: About two years ago we had to go to, and I don't want to say battle, but it was a battle with PERS-95 to prevent our families from paying out of pocket. So Navy families, when they arrived to the lodge, they were told, bring your credit card because you

will have to pay out of pocket until we get you on orders until we can get that pay.

So we had a conversation with a host of people at PERS to say, this needs to change or we're going to take this all the way up to, I think it did get to the CNO at the time. I think the current policy right now is that, we put them on orders and they are not paying out of pocket. When I left, we had, like, a credit card we could put that -- so that's not the current process. Okay.

CAPT HALL: So if they're on ITOs and they're combat wounded, the non-medical care managers have a purchase card and they can pay for their lodging, but only if they're combat wounded. And we got to go through PERS to get authorization to do it.

MEMBER EUDY: Is that, sir, until the orders then kick in to cover that?

CAPT HALL: Well, they could pay for it with their own credit card. It's the issue, if they don't have a credit card or they don't

have sufficient limit on it, and then we can pay with the purchase card, and then it gets reimbursed when the orders are liquidated.

MEMBER EVANS: So here's where we reach to our benevolent organizations to prevent families from paying out of pocket, and it's unfortunate that's the process we had to put into place. But our families, anyone that, when they would arrive and didn't have the money to pay, we would reach back to those organizations to assist us, because when you're talking about an E-4, E-5, even our officer community, you don't know the financial status.

So we did have support with the benevolent, but again, Navy, when you look at the other services, so if you take the Army, the families arrive, they automatically had a card to put the family on the orders to pay for the lodging. The lodging was paid up front, so the family never had to worry about coming out of pocket.

CO-CHAIR CROCKETT-JONES: What

about the specific situation at Portsmouth where we had MEDHOLD members who are part of the reserves, who were in housing, but had no room for any family visitors, who were extended, sometimes, to a full year at MEDHOLD, who were facing separation, unless they went out of pocket, for more than 12 months at a time from their families?

That particular situation, which was pretty dramatic, I mean, you know, it was a pretty dramatic situation, and has anything been put in place to give relief to that very specific situation?

MEMBER EVANS: We have been on the phone with N95 at PERS to talk about that specific situation that we encountered. Now, again, if you're a Marine, they uplift you and put you with the family or bring the family with you. PERS, the conversation has been, the expectation is not for them to be there very long, so they do not bring the families in.

And so we have gone back to say,

well, what if they're there for six months to a year, at what point in time do you bring that family? At Portsmouth, it's a little different because they will have to -- it's off-campus housing, not on-campus housing, and so we have been in conversation with PERS to see how we can bring those families to Portsmouth, and the lodge, and where could they stay?

And so, no, it has not been resolved.

CO-CHAIR NATHAN: The bottom-line was, there was a disparity between the services and if there was no room at the inn, and a family was forced to go to contract lodging off-base, the Army or Marine Corps family could walk in, and there was already a line of accounting with that facility, and the Navy was told, just give us your personal credit card, and then your Navy people will reimburse you, pretty soon, for whatever you spend on your credit card.

And some of our young enlisted and some of our young officers said, I don't have a limit on my credit card. I mean, it's not going

to cover what you want to take at the hotel right here. So we got that fixed --

MEMBER EVANS: Yes, sir.

CO-CHAIR NATHAN: -- using a purchase card system. Portsmouth is a problem because it's not designed to be -- it has some sort of an interior, I forget what they call it, inside the hospital, a little set of quarters for, sort of, a half-step quarters for Wounded Warriors who want to leave, they put them in this transition area quarters inside the hospital where they make their own beds, and do everything themselves, and makes sure they're ready to leave.

Transition housing, there's a name for it, but I can't remember what it is. But on the outside, the reservists who come in who happen to require repeat care or new issues are developed, and all of a sudden what was thought to be three months is now a one-year stay at the NMPS center for the reservists. And the reservist says, well, can I get my family here

since I'm going to be here this long?

And working through the reserve community, the answer is, well, if you need a non-medical attendant, we'll get you a non-medical, and they said, no, no, but I want my family as well, and the only people that broker that for the reservist is PERS; is Department of Personnel.

So we continue to work with them, and it sounds like, I wasn't aware of it, we had a family, or somebody in distress, down there and you're talking to the folks at PERS to see if there's policy relief.

MEMBER EVANS: Yes, sir.

CO-CHAIR NATHAN: Okay.

MEMBER EVANS: We had several that were in distress down there and that's why we came back to make this recommendation right here, but we also realized that, you know, the reservists, and we'll talk about them more in the next recommendation, you know, the comment to me was that, they don't have to be there. They can

go and get the care at home.

But the question, when they're there --

CO-CHAIR NATHAN: It's an emotional issue with the reserves, Connie, because there's no question, when I was down there five years ago as the commander, we had several reservists who had been there, I couldn't believe it, who had been there pushing two years. And so I would go to them and I'd say, oh, my God. I owe you an apology. You know, we're keeping you here for two years. I'm sorry we're not getting your care more expediently. And their answer was, "it's okay."

And I thought, you know, why don't you want to be back where you're home? I can get you care out of a reserve center at home, through an MTF at home, or through a private sector at home. And in some cases, the military had dropped the ball. In other cases, the reservists, sort of, liked being on active duty, and getting active duty pay, and may not have had

the similar soft landing to come home to when they got off-duty. So it's very complicated.

And there's sometimes the military is at fault and not being sensitive to these people and other times, there's secondary gain going on. And trying to sort through all those is very difficult. It's a very emotional issue, but one where I think the onus is on us as the military, as the DoD, to make sure that we provide the right safety net for these folks.

And as I would tell my doctors who would come to me and say, you know, we're doing everything we can for them, every time we try to get them off and get them moving, we have to pry their fingers off the doorjamb. My answer is, that's not the issue. You know, you take care of them medically and make sure all the medical wickets are hit.

And then let's let personnel policy decide where they best need to live. So again, I still think the onus is on us to fix those. So thank you, Suzanne, for bringing that up again

so we continue to look at that.

MS. DAILEY: And, sir, it's not just the Navy. I mean, when you put an Army soldier in a WTU and they are a reserve component or a National Guardsman from another state, their family is not moving to Fort Bragg or Fort Hood to be with them. And so this was in our findings, we captured both the Navy centralization on the East and West Coast, and the National Guard and reserve situation in the WTUs, so it impacts their families.

Right now, there's just no policy to move them close to the WTU for prolonged times or the two sides, the East and West Coast MEDHOLDs. And if there's going to be a -- our next one, we can transition to our next one, if there's going to be a centralized case management for reserve and National Guard, and you do end up pulling them into MTF to do some of that management for non-compliance, or whatever, you run back into the same family issues.

CO-CHAIR CROCKETT-JONES: Yes, and then we also have the complication of when folks have said they are ready for remote care and want to get back to their families, if their IDES process has started, they can sometimes have a very difficult time convincing whoever is in charge of that IDES process to let them go, so there's a lot of hurdles for these folks.

MEMBER EVANS: So I think this is a good news story for us right now. We're working to centralize the case management for Navy medicine. I didn't have a good feel on the number of reservists that we had out there that either would require PDHRA, LODs, any of the list the Captain Paver, over in Virginia, for Portsmouth, that he maintains the doctor. He's the fleet surgeon that maintains this list.

So finally, about a month ago, we receive about 490, I think I see the two case managers are back there, I think it's about 490, the list of all the reservists that he's currently tracking. So these are the ones that

are coming through the NOSC that require some type of medical assistance through the reserve fleet surgeon office.

We have that list. We are going through the list; combing through there. We are in the process of asking for a case manager to go to be with Dr. Paver to hire a contract to go and track. We've been making contact with the reserve populations, and it's a good news story because now they have a contact.

Although, at the policy level, it shouldn't be at BUMED, and so we are trying to push this back down to the fleet, but they do have a point of contact and we've received some positive feedback from the reserves saying thank you. Now I have someone to reach out to.

So we are going to put them into a database, track the reserve population. We're going to do the same for the Marine Corps. We've been working with Captain Adams at the Marine Corps to bring their reserve population to a case management level so that we can start tracking

that population, and reaching out, and making sure that we get them into the healthcare system.

So I think this is a start, was happy to get the list, happy to start jumping on those patients. That's been, kind of, one of our nagging population that we just didn't have a good hands on. As soon as we get moving to get onboard with the tracking system, FCMT, or whatever tracking system we go to, RCPSS, we're going to put those reserve patients in there so we can actually have them in a database and track them even a little closer.

So we are moving towards a centralized case management system for the reserve population.

MS. DAILEY: That is really good news.

MEMBER EVANS: Any questions?

CO-CHAIR NATHAN: I mean, we all recognize that, in many cases, the long pole in the tent is our reserve population. As they exist in that, sort of, limbo between reserve

status, active status, and now they're on active status, mainly because of healthcare issues, and again, one size doesn't fit all.

Some of the reservists are okay with staying and lingering is probably the wrong word, but perseverating at a certain area to get all their healthcare needs met, some of which become a debate as to whether their combat, or military, or active duty related, and others are just champing at the bit to get back to their lives, and their families, and get on with what they were doing as private citizens, and we sometimes hinder that.

And they get caught in the gears of IDES, and they're trying to leave, and here's IDES starting, we won't let them leave, and again, good people. Everybody involved, I think, wakes up in the morning wanting to do the right thing, but the system, the reservist gets caught in the gears.

And so I think it's very good for what this task force looks at to try to surface

that. But again, it's always more complicated and I thought when I was at Portsmouth and so this large cadre of reservists that I was going to go down there and save the day, and then I ended up just being tangled into one big fur ball.

And, you know, trying to sort it out and eventually assigning an action officer, like you, Connie, to sort it out for me. So I think this is good news. Any other comments on that? Otherwise, I think we're at a break point.

MS. DAILEY: I think our last one is Mr. Powers. We do need to try and push through a little bit more. We do have a briefer standing by on the survey population. And we've told him 11 o'clock. If we could just push through these remaining recommendations, I'll give you a break, and then we'll do the survey information.

MEMBER EVANS: Mr. Powers.

MS. DAILEY: Are we okay; physically?

CO-CHAIR NATHAN: I think we're okay. There are child labor laws, you know,

that govern how much you can push us. Okay. We're all ears, Mr. Powers.

MR. POWERS: Good morning. Robert Powers on behalf of the Department of Navy Physical Evaluation Board. It really is a great honor, personal privilege, to be back here as a witness before this body. I think, really, when we look at -- this board has been so much about actually just not managing change; leading change, next slide, please, which really goes into, on this recommendation, when we saw this recommendation, we already took it, instead of making it mandatory, we've already incorporated it at the Department of Navy Physical Evaluation Board.

And that is, giving them notice that they will lose this ECHO benefit. Actually, the next slide, also goes into the next question is, how do we, one, make sure we've notified them? And what we've done is make it a checklist requirement that each PEBLO tell them, hey, if you're under TRICARE and you're receiving these

ECHO benefits, you will lose that.

Secondly, if you could go to the next slide, which is still the Recommendation 17, it is also making sure we do a handoff to the ECHO benefit/TRICARE expert to remind them about those benefits. Now, of course, it does beg the question, we are notifying, but there's a loss of benefits.

And so I don't know if that's a recommendation the Board will eventually say is, the natural issue is, well, do we continue those benefits? And I'll leave that for the Board.

CO-CHAIR NATHAN: And that's not really in our purview. In other words, that's a TRICARE benefit discussion that should be held between the constituency, TMA, and health affairs as to whatever. Our job is to make \sure that Recovering Warrior families, with EFMP and/or ECHO, are not caught flat-footed when they leave the service and become either in the private sector or on the TRICARE benefits.

MR. POWERS: Yes, sir.

CO-CHAIR NATHAN: The loss of these. And you had us at hello when you said that the PEBLOs aggressively refer them to the health benefits advisors so they understand what they will and won't receive when they leave active duty.

MR. POWERS: Yes, sir.

CO-CHAIR NATHAN: Any other comments on Recommendation 17? Okay.

MR. POWERS: The other issue is, certainly on this, I think we have short-term wins on our staffing of our PEBLOs, and really, when we think about PEBLO, I think it's just not -- often times, it's not a person, it's really a multi-factoral role, as, certainly, the task force has seen.

It is the person building the case; it's the person actually making sure they're moving through the medical recovery, it's that role to make sure that, when the PEB findings come back they've been notified of it, and also, it's really, you would almost say, the IDES

attorney plays a part in this PEBLO role.

So the issue is, we're certainly welcoming a PEBLO staffing model. As you can see, this was directed by the House Armed Service Committee. OSD has taken the lead on that Wounded Warrior care and policy. And so we're supporting that to, one, hopefully, it's going to validate our current PEBLO staffing/MEBLO staffing. And of course, one of our concerns, certainly, is, we have short-term wins right now of temporary staffing.

What is the permanent staffing? What happens when the task force no longer is doing hearings? Do we have a document that's telling us, this is the number of medical evaluation board members, Recovering Warrior managers, and physical evaluation board liaison officers that we have? So we're looking forward to the study and fully supporting that.

CO-CHAIR NATHAN: One of the things we talked about earlier was, so the good news is that, in our service at least, in the Navy

service at least, we're hitting our wickets, our PEBLOs are getting the job done.

MR. POWERS: Yes, sir.

CO-CHAIR NATHAN: We've reached the milestone of the MEB and now the 295-day total disability review, but this also will help us to determine, I hope, if the PEBLOs are getting ground-up in the process.

MR. POWERS: Yes, sir. And I think, exactly is, the study is going to -- the issue is, everyone just thinks that -- it's easy to say, hey, they PEBLO can do this or the PEBLO can do that. The issue is, what is the role of the PEBLO, how many people really are serving the PEBLO role, and how many do we need as a permanent structure once we are at a steady state? Yes, sir.

CO-CHAIR NATHAN: Okay. Thank you. 34.

MR. POWERS: The Board brought this last year at the hearing, February of last year, they brought up the concern that they really did

not think that the service, the Marine or sailor, member was getting access to the attorney. So what we had done is, we have done a three-phase approach, three-prong approach, since then. First and foremost is, we actually make sure that the physical evaluation board liaison officer hands them a notification form explaining their right to an attorney.

And then we make that a mandatory notification requirement that the PEBLO does inform them their right to go to an attorney. Second approach is, we've also, and Karen Morrisroe, the program lead for OJAG, she wasn't able to brief this side, but as she's testified before the Board, we work very closely with her, we also give the, as part of the package and notification of rights, election of options form to the service member, we actually also give a one-page from the local IDES attorney talking about their rights and how to access that attorney there.

The third part is, instead of just

giving them the form, you know, these two forms and documenting it, we also do our best to have the PEBLO, if it's local, actually walk -- we do our best to co-locate the physical evaluation board and that IDES attorney to develop that relationship for a natural handoff.

So in many of the locations where we can, the member will sit down, meet with the physical evaluation board liaison officer, he or she will explain the case, once they're completed, they will then walk them to the IDES attorney, who will then do a handoff and explain to them, all their rights. So very important. We're trying to make it as robust as possible.

CO-CHAIR CROCKETT-JONES: In some places we've seen where when folks become enrolled in IDES, that same listing, that same data list of everyone who's been taken in, is given to the attorneys so the attorneys have a sense of how many they're actually seeing. You know, what the expectation is, what's going to be coming through their front door over the next,

you know, week or two as those folks in-process in, it gives a little preparation time to the attorneys to know what their workload might be, and it also gives them a sense of how many they're actually getting.

And I'm just throwing that out as a, do you know if any of your local, sort of, sites are doing that?

MR. POWERS: The answer is yes. And what we've done specifically, here in the last six months is, one, I meet regularly, probably at least once a month, and certainly, will do a biweekly phone call with all the IDES attorneys, but the answer is, how we're doing that? We've given them access to VTA.

And so now what happened is, each IDES attorney, basically, I don't want to say, ambulance chasing would be the way, but if you want to be a successful solo practitioner attorney, you find out where your clients are. Enroll in VTA, that's going to tell you where all the members are enrolled right from the

beginning.

So we've made sure we've provided training for the IDES attorneys so they can go in VTA, understand how to use it, and then, of course, have access. And then, of course, they also -- you know, we send them out the Excel charts, but to me, the answer is the VTA. So great point and we're following up on that.

CO-CHAIR NATHAN: Okay. Let's go to Recommendation 35.

MR. POWERS: From this perspective, certainly, I think we really have come a long way where we're starting to not just state seamless transition, but really make sure the service members understand all their VA benefits. Now, from our purview only, from the Department of Navy Physical Evaluation purview, we can only do so much on that level.

I can speak for ASN, they are taking a lead on this, is really, and this has become a major program for them, to look at the VA Vocational Rehabilitation and Education

Benefits. We're looking at that. They're doing a study about what the metrics are to make sure that we're doing this from a Department of Navy perspective.

From the Department of the Navy Physical Evaluation perspective, similar to what we do for the IDES attorneys, and the eBenefits, and the Turbo Tax transition and assistance program, excuse me, TurboTAP, is to make sure they're aware of these benefits. So we're doing that.

Finally, the other thing I think that is in coordination with Safe Harbor and the Board was talking about, is really, what we do is, the PEBLO, and it goes back, also, to the study, really is becoming a program manager. And so what we're bring in is what we do for the Department of the Navy is, we'll do an IDES seminar/consultation. We do our best to make it mandatory.

And I think that's where we see that trying to get the families to come in, trying to

coordinate their time, same thing, we have this exercise, you know, with the freewill of our reservists, and active duty, and family members, trying to do that, but what we do here is, we'll do an IDES seminar and we will bring in all the key players to come and brief their portions that they think are important to the service members.

So we fully understand that and doing our best to make sure, at our level, at our purview, that that is being notified.

MEMBER MALEBRANCHE: One thing, I was looking at this, I'm from the VA, and I think maybe, we should have been a little more clear, but I was thinking, not only from the VBA side, and I said this to the Air Force too, the VHA piece of this, unless you're considering that a benefit and/or a service, and in talking about marketing this with the DoD leadership, not just with the service members and those who teach the service members, but in areas such as the, in the Army, it would be the Sergeant Majors Academy, I'm not sure what it would be in the Navy, but,

you know, usually, it's the folks that actually touch service members.

But to get it at that level so at least they have the understanding, kind of a VA 101, because the health benefit and enrolling in the health system, and then eventually, registering it, as well as eBenefits, which are two separate portals, is an important thing to know.

So maybe in our writing this, we should be a little bit more clear, but I was thinking, it's not just the benefits piece. There's also the healthcare, which several of those folks will be --

MR. POWERS: Yes, ma'am. I think it's a great point because the issue here is, I think we all are looking at the nexus. It's easy to see the nexus between the Department of the Navy and the benefits. It is very hard, as the report talks about, is, who do you talk to for the health benefits? You go to a different hospital, the VA Web site does a great job about

providing a regional coordinator and how to find that, but that's for benefits.

So really, it would be helpful, I think for all of us, if the task force would be able to say, okay, well, what's the actual nexus, so that, when the members gets out, they go to this hospital and they enroll with this recovering health assistant; VHA part. We have the VBA part, I think, we're getting very good on that, not the VHA.

MEMBER MALEBRANCHE: Yes, and then the last year, there was a legislation to our vet centers, the Readjustment Counseling Centers, are now working on who they're able to avail themselves to active duty. So from the mental health aspect, which has been a significant issue with the warriors, that's a place that a lot of folks will access because of the confidentiality and the nature of those facilities.

So just, if you keep that in mind as you're going forward with your programs, that

that's a real significant, I think, support.

MR. POWERS: Yes, ma'am.

MEMBER CONSTANTINE: Mr. Powers, on the second bullet, are you talking about the TAP program there? So the individual Recovering Warriors are aware of the benefits and also, what's that, the bottom it talks about, informed consent. What does that mean?

MR. POWERS: Let me answer the first question first. Regarding the VRA, that is a major program that I know the Department of the Navy is looking at, in coordination with the Department of Defense, to really talk about, what are the, first, defining it, and secondly, what are the metrics to make sure they are accessing it, and third, getting them the continued benefits.

So that once they're separated, they know their various programs. So what we can do at our level, obviously, we don't run that program, but I can at least explain to them that that is an upcoming benefit and they should be

aware of it. And then what we also do, we give them a written, basically a page, notification where they can access more information on it.

And of course, then also, as we talked about, when we do the IDES seminar, we'll have a VA rep, two places, one, a VA rep that's supposed to come to the IDES seminar, but also, remember, we're handing them off to the military service coordinator, we're asking the MSCs to be fully informed of all their benefits besides just the rating activities side.

MEMBER CONSTANTINE: Yes, okay. I appreciate it. I was talking about in the second bullet where you're talking about the concept of seamless transition.

MR. POWERS: Oh, I apologize.

MEMBER CONSTANTINE: Are you talking about, is that the TAP program where, that's where they see the VA counselor or I haven't heard this expression.

MR. POWERS: I should have struck that. And I wasn't sure where the concept was

going, that is really just saying is, I think that is the intent, overall, is that we want our service members to fully understand all these benefits in a full concept, and so now, here are some specifics under that.

CO-CHAIR NATHAN: And, yes, for the normally transitioning individual who's not going through the IDES system, they would be through the TAP and the VA. And as we talked about, I don't know if you were yesterday to hear that, all the services are intensifying TAP now. They're adding more days to it, more time to it, more liaison to it.

And then we'll finish up with just one comment about the PEBLO training. Could you talk a little bit about how we've changed the training of PEBLOs now with Web-based training and the more consolidated approach than, sort of, the on-the-job training we had in the past?

MR. POWERS: Yes, sir. I mean, the PEBLO's place, that's your key role, so what we're doing is, instead of just relying on one

single method of training, obviously, we were doing our annual conferences, which was critical to the PEBLOs, but also, what we're doing is, making sure that we're, one, documenting the training, certification, making sure that we're certifying them, just because we say they're trained, and also, really, just putting an improved role in, you can't just throw somebody on-the-job training and expect them to be able to fully counsel the member. There's a very high learning curve, so we're doing that.

Probably the other thing to add to that is, I think, I know we were touching on Safe Harbor, is really looking at the role of the limited duty coordinator. That is still a role that I think is a force multiplier we have not really maximized. And I know we talk about the Special Forces and Wounded Warrior Regiment's going to come and brief, those service members who are taking care of it, they fall under that umbrella.

But there's so many different units

out there that, just like we've seen success with the substance abuse control officers, we've seen the success with the sexual assault awareness officers, we really don't have the same level of our limited duty coordinator.

There should be an expert in each unit, dependent on what level, at least I would say, at the battalion level, ship level, that can actually talk about the IDES. The reason we have a such a difficulty with that program is, in the military, they're changing every 18 months, they're changing every three years, and constantly rotating out.

But if we started that program where we got individuals trained on the IDES, eventually, you would start rotating over the years where people actually understood and can spell IDES. That still is left out there, and the problem is, they aren't getting trained.

There is no comprehensive training program for our limited duty coordinators. So hopefully, some day, we'll continue to maximize

that or develop that, but that, I think, would go a long way, because you put a lot of burden on Safe Harbor, you put a lot of burden on the PEBLOs, what would really help is, a unit expert at each, basically, battalion, regimental, ship level that can talk to that issue.

CDR WEBSTER: We're in the process of developing online training that can be certified, that can be standardized, and that can be tracked. The three phases that we're doing, first is, the PEBLO training, second is the limited duty coordinator training, and third is, also, provider training. So has not been rolled out as of yet, but we're in the development of that.

CO-CHAIR NATHAN: Yes, thank you. I mean, that's the point I was getting to, which is, we have some resident experts all around, but we're not convinced they're all learning the same thing because it has been somewhat apprenticeship done, reinforced by the yearly conference where they go through the

competencies, but online training means, everybody is getting the same training, go-bys, gouge, in these critical jobs. Anything to ask?

MEMBER EUDY: I just had one follow-up, sir, to the comment you made earlier, Dr. Phillips, something I should have said, and you had asked about the special operations community in taking the principles that are there to the services at large. You know, we discussed, based on the size of the services and such a diffuse population in regards to where the care centers are located, and I think everyone sitting on the task force would agree with me on this, we see that at the installation visits, a lot of the principles are being emulated, whether that's the embedded behavioral health teams.

You know, with some of the locations, the health adaptive PT programs are rehabilitation partnerships with local facilities. We see that at the community-based units. Now that more service members are back

at home station in regards to the large units that are deploying, those that do get injured now are getting a unit member with them at bedside.

And my final point was, we're seeing whether that's MOSs, rates, or AFSCs, specifically, that are getting either medical case managers, or non-medical case managers, in each of the services to meet the ones that have a higher usage. Again, those being, like, the Military Police or the EOD corps, the corpsman, as were mentioned, so just some of the ways that I think I see, personally, Dr. Phillips, that the principles are being emulated by the services.

CO-CHAIR NATHAN: Okay. With that, appreciate you and the rest of the gang for what you brought today and the information you shared. Thank you. I think we have time for a break.

MS. DAILEY: WE are doing to take a break. We're going to tee-up the next portion of the Navy presentation, which is the survey program that they have.

CO-CHAIR NATHAN: Right.

MS. DAILEY: Lunch is at 12:15, maybe a little later, surveys are extensive briefings, but break, break.

CO-CHAIR NATHAN: I'm confident the survey crew can deliver the salient points on time, on target, with few errant rounds.

MS. DAILEY: Thank you very much, gentlemen; Captain Hall. Thank you, Mr. Powers.

(Whereupon, the foregoing matter went off the record at 11:11 a.m. and went back on the record at 11:25 a.m.)

CO-CHAIR CROCKETT-JONES: Okay. If we're ready, we're going to welcome Mr. Geoffrey Patrissi, the Director of the Institute for Organizational Assessment at Navy Personnel Research Studies and Technology. Mr. Patrissi will brief on the Navy Safe Harbor enrollee and caregiver surveys. In February 2012, the Navy provided information to the task force regarding the 2009/2010 Safe Harbor annual care surveys.

We're looking forward to hearing updates on that information in this presentation.

We can find his information under Tab K and I'm going to turn it over to Mr. Patrissi, who is remote, I believe.

MR. PATRISSI: Thank you. Can you hear me okay?

CO-CHAIR CROCKETT-JONES: Yes, you're good.

MR. PATRISSI: Okay. All right. I'm going to start with just a little introduction. This is the third year we have done this survey and each year we're learning from past procedures. Basically, this survey, we tried to contact everybody on the VSI/SI lists, so it was a census survey.

We started with a letter from a Rear Admiral asking people to go to this URL, take this survey. The survey was in two efforts. One effort was to get the enrollee to answer questions, then the other was to get the caregiver, in other words, the significant

other, spouse, parent, or caregiver, to answer questions, basically, on the program from their perspective.

So that was our methodology. We sent out the letter, we had a URL link, the letter had a username and password for both the enrollee and the caregiver. I'm going to go to Slide 6 and, basically, because we have a half hour, this is the survey sections; demographics, this is for the enrollee, services used, customer satisfaction with the effectiveness of the care managers and services, use of related programs, challenges and barriers, and suggestions for improvement.

Slide 7 has our response rates. We kept the survey open for over five months. Besides the electronic version, we offered them the option of a paper version, and we also sent them two, at least, paper reminder letters, and several email reminder letters to take the survey, and we still only got a 17 percent response rate.

The demographics, Slide 9 shows you who the survey respondents were. Now, this is enrollees. The reason that you're going to have some parents and caregivers taking the survey for the enrollee is, the enrollee was incapable of taking it, so that explains how that has occurred.

Slide 10 has the pay grade information, which I think was indicated in your questions, and the active reserve components, and the gender. Slide 11 is other demographics, including reason for enrollment, whether an injury or an illness.

Slide 12 lists the primary treatment facility and whether it was an injury or an illness. 13 is the reason for injury, enrollment for an injury, and we're showing you a trend. Orthopedic and brain injuries still are the top two reasons for an injury.

Reasons for enrollment in illness; cancer and neurological illnesses are the top one and two, and they have been for the past

several years. Slide 15 is, when did you enter the Safe Harbor program? And most of them have come in the past four years.

Now, let's look at the programs utilized. That's Slide 17. This was a match to sample question. List all the programs that you've utilized. Pay and personnel and recreational leisure are number one and two this year. In prior years, it was housing and lodging. And pay and personnel has always been number one, but housing and lodging has occurred, and it appears to be down right now.

Now, the model we used to judge your satisfaction was a customer service model. Basically, people judge customer service on tangibles, responsiveness, reliability, sensitivity, and assurance. So we tried to frame our questions along those lines.

And, basically, your satisfaction, we had the non-medical case manager. We looked at responsiveness to my needs and family needs, reliability and sensitivity, and those were all

up from prior years. The next slide has the professionalism, the information, the helpfulness of the information, and the caring for me and for family, and overall, those are up.

Anticipation of needs, the next slide, availability, resolving problems, caring for the family, those are up. The next slide has the non-medical case manager. Some of these, the 209, 211 on the first form, we didn't ask these questions. These were first asked in 2011 because, earlier, they didn't have the non-medical care manager in '09 and '10.

We asked about the Recovery Care Plan and this is whether they had it or not. Slide 22, we ask about ancillary programs; the Anchor Program, and the National Resource Directory, you know, awareness of other programs to help them. And we saw a significant rise in the Anchor Program.

Slide 23, the content with the program representative, 1 to 10 times appears to be the most, but what's worrisome is that there

are 29 percent of the people who didn't have any kind of contact. Satisfaction with contact frequency was 67 percent and just the right number, 68 percent, and 32 percent says, not enough.

Slide 24 is an overall view of satisfaction with the non-medical care manager's support, and it's up; 69 percent were satisfied with it. 56 percent were satisfied with their quality of life. The reason we stressed customer service in our questions is, if customer service has been shown for medical research, if customer service goes up, the quality of life perception goes up, and you actually get better outcomes medically.

Family quality of life has also risen. Slide 27, is it much better or worse since entering the program? 53 percent say it has gotten much better or better. Overall program satisfaction, on 29, 69 percent are satisfied with it, recommend the program to others, 76 percent, and 30 and 31 are the top

three issues and concerns.

These were open-ended comments. 31 has the three things they like best about the program. And 32 has what you would like to see improved. 33 is our summary. Basically, 64 percent have entered the program since 2009, pay and personnel are the most utilized services. Non-medical care managers, on 34, rated higher this year. Most noticeable, the family issues.

Recovery Care Plan show improved ratings from previous surveys and the awareness of some of the programs remains static or could be improved. 35 gives the satisfaction with the quality of life. The overall program satisfaction was higher this year in this survey and more would recommend it to others.

Recommendations based upon the enrollee survey. It's rated very well by those who use it. What you need to do is get more people to use it is what we're finding. The low participation in the survey may indicate that you need a multimedia approach, maybe some

letters and phone calls from the non-medical care managers, recommend standardized surveys across the Wounded Warrior Programs to look at best practices.

We broke down the enrollees, and you don't have it here but, in terms of age, you know, which group had the best satisfaction? And basically, if you're ill, older, and have a higher rank, you have better satisfaction with the program than if you're injured, younger, and lower rank.

We also looked at those who were dissatisfied with the program and broke those out, and the one thing that they said that came across that they were dissatisfied with the program was, they did not have any contact during the past year with their non-medical case manager. So those are those 29 percent who said 0. That's probably where your dissatisfaction is coming from in the program.

Any questions on the enrollee?

CO-CHAIR NATHAN: This is Admiral

Nathan, I came in a couple minutes late during your presentation, but what is the total number of people who are enrolled in the Safe Harbor program?

MR. PATRISSI: Melissa can answer that, I believe, but I believe we sent it out to over --

CO-CHAIR NATHAN: No, not the --

MR. PATRISSI: -- 600.

CO-CHAIR NATHAN: I saw the number of people who responded to the survey, but what --

CAPT HALL: It went over a 1000 in the last couple of months, sir.

CO-CHAIR NATHAN: I'm sorry?

CAPT HALL: A 1000 total.

CO-CHAIR NATHAN: A 1000.

CAPT HALL: Two-hundred and seventy-four still on active duty.

CO-CHAIR NATHAN: Okay. And of that 1000, do you have an approximate breakdown of how many are severe illness versus combat

injury?

CAPT HALL: Yes, sir. It's about 50/50.

CO-CHAIR NATHAN: Okay.

CAPT HALL: Close. I have the data.

MEMBER MALEBRANCHE: I guess to follow-on on that, because I felt like we were speed dating a little bit here, on the 2009 and 2010 surveys, what was the total end for those, because we're looking at percentages and I'm just trying to get a sense of numbers?

MR. PATRISSI: When we first started this, I think it was about 400, then it rose to about 550, and this was 767 was our total end that we initially tried to mail.

MEMBER MALEBRANCHE: Okay. And then back on slide, or about the Recovery Care Plan, where you didn't have data for 2009/2010, because you said at that time, you didn't have a non-medical case manager, is that why, and then it picked up --

MR. PATRISSI: Yes.

MEMBER MALEBRANCHE: Okay.

MR. PATRISSI: Yes, we had a recovery care coordinator, but not a non-medical case manager, I believe.

MEMBER MALEBRANCHE: Okay.

CAPT HALL: I think the issue was that it was before we had Recovery Care Plans.

MEMBER MALEBRANCHE: Okay, before you had plans.

CAPT HALL: So there were no questions about it because we didn't have them.

MEMBER MALEBRANCHE: Okay. Because I was trying to see if there was any relationship to the one with the support, the satisfaction with the non-medical case manager support on 24, because it seems like it was high back in 2009 and 2010, but there was no plan is the issue.

MR. PATRISSI: Yes, I'm sorry.

MEMBER MALEBRANCHE: Okay. I got confused somehow. Okay. Got you. I'm with

you now. Thanks.

CO-CHAIR NATHAN: Folks looking at Slides 28, 29, which is recommending and overall satisfaction, of those that were in the red, either dissatisfied, and I recognize, it looks like it's trending in the right direction, but of those that remained dissatisfied or would not recommend the program, you listed, on Slide 30 through 32, the three most important things, and then you listed about 30 things.

Was there, among those areas, and I recognize that's a compendium of the three things that each person recommend, you sort of took those that came to the top the most, but if I ran into you at a function somewhere and I said, what are the top three or four things that are really on the minds of these? Do you have enough statistical data to tell me what they would be among these, even, that you've listed?

MR. PATRISSI: I can get that, but see, it's different for different people. And it's, basically, it would probably be dependent

on the functionality of the sailor or the enrollee, the physical well-being, or whatever, so the best way, probably, to look at this would be to stratify it in terms of certain kinds of -- you know, for those who have orthopedic injuries, what's their top three concerns?

Those who have, you know, TBI, so that might be the best way of understanding it.

CO-CHAIR NATHAN: So as you studied this survey, if I said to you, okay, I can do three things for you right now to improve the program, what would they be? What is your sense? I recognize it's different things for different people, but at some point, there's only so much we can do, so based on what you think your survey results are, the good news, we're improving, the good news, the dissatisfied are diminishing, and the satisfied are increasing.

It looks like everything is vectoring in the right direction. That said, at the end of this, what's the deliverable?

MR. PATRISSI: More helper

resources for the caregivers.

CO-CHAIR NATHAN: Okay.

MR. PATRISSI: Would be number one. And family support would probably go in with that. Retirement/future planning would be the other. And recovery and integration.

CO-CHAIR NATHAN: Any questions from the members on those particular ones? Can you say those again, please?

MR. PATRISSI: Sure. Family support. You know, more help and resources for caregivers and family support, I think, should be lumped into one.

CO-CHAIR NATHAN: Let's tease that out a second. If I were talking to caregivers, or based on your intuition from the survey, if I were talking to families and/or caregivers, what would they be telling me that they want in terms of more support?

MR. PATRISSI: Assistance with caring. The caregivers who I actually called, or some of them called me, had very, very

severely-injured sailors, in comas, you know, that kind of injury. Some of them were worried, had to leave their jobs because the sailor had some severe PTSD or psychological problems, and, you know, they're worried about suicide.

So that's kind of, you know, strikes me as just for two of the examples. Future planning, retirement planning, I think, would be the next one. What's going to happen to me and my family?

CO-CHAIR NATHAN: Right. So on the first one, what I hear you saying is what we've heard in other quarters as well from different services, there's a population, there's a finite population of caregivers who are overwhelmed.

MR. PATRISSI: Right. And it tends to be with the injured people.

CO-CHAIR NATHAN: No, no, I mean, they're overwhelmed because they've got, basically, somebody on their hands who's catastrophically recovering and what is there that gives them a break? How do they get a

vacation or a respite from the day-in, day-out requirements to be the care manager, the attendant, the this, the that?

Not dissimilar to married couples who one has a stroke and may not have the resources to bring in visiting nurses and bring in skilled care from the outside and ends having to spend seven days and 24 hours a day taking care of them. So again, that's what I hear you saying on better support for the family/the caregiver.

MR. PATRISSI: Right.

CO-CHAIR NATHAN: And so I think we need to look at that and see what programs may or may not be available through the Department of Defense and/or the VA, and there's some benevolent organizations, the Navy-Marine Corps Relief Society, and others, that can provide nursing support and caregiver for respite, but, you know, what are we doing to take care of those folks that are really dealing with catastrophic?

And they should be, you'd think, in theory, those catastrophic injuries would be

enough to trigger either the TRICARE and/or the VA disability system for visiting nurse support, either in LPN level or RN level, physical therapy support, those kinds of things. The next one, you said, was retirement, so tease that out a little bit.

MR. PATRISSI: Yes, future retirement planning. In other words, getting into the system. Again, what came out was, there's some problems transitioning from the military through the VA to the disability system. Okay?

CO-CHAIR NATHAN: Okay. And we've put a lot of center of effort on that as we were looking at the IDES programs and as we're looking at programs to create more situational awareness for the family. So that one resonates well, not only with families that are in duress, but many of the traditional families that are transitioning out. And your next concern?

MR. PATRISSI: Recovery and reintegration.

CO-CHAIR NATHAN: In what way?

MR. PATRISSI: Am I going to get better? How do I get better? How do I get back to a normal life? So you have people, basically, vectoring into different directions. Some of the people who feel they can get better, want to get better, and how am I going to do that versus those who realize they're not going to get better, go into another direction, so that's why I was trying to say, it's different concerns depending upon why you're in the program.

CO-CHAIR NATHAN: No, I appreciate that. I know I'm frustrating you because I'm asking you to try to figure out what's critical to some individuals, whereas, that's not even an issue to others.

MR. PATRISSI: Right.

CO-CHAIR NATHAN: But at the end of the day, we don't have a wand that can fix all 20 things. So, you know, if you happen to get on the elevator with the President and he said, hey, I'm in a good mood today, give me a couple

things that I can spend the next week on. You'd have to have those ready.

You'd have to decide what rates, either most in quantity or most in acuity, to this program. And you seem to have given those to us, because when forced to bring up the ones that would keep you awake at night, those are the ones. So that's really what we're interested, because we want to center our efforts on those things that --

MR. PATRISSI: Yes, see, look at the top one, opportunities for employment, education, and socialization. That rolls into the reintegration and recovery. So, you know --

CO-CHAIR NATHAN: What slide are you on?

MR. PATRISSI: Slide 30.

CO-CHAIR NATHAN: Okay.

MR. PATRISSI: You know, they cluster around some similarities.

CO-CHAIR NATHAN: Right.

MR. PATRISSI: You know, having

help with understanding benefits and paperwork would be the future retirement planning. Unanswered problems in pay issues, that would probably be future and retirement. So, you know, we can do an affinity diagram, maybe, and cluster those under two or three different kinds of buckets.

MEMBER REHBEIN: Sir, my name is Dave Rehbein. I'm another one of the task force members. Those three bullet points you gave us, and let me see if I can clarify this in my own mind, it sounds to me like the one about more support for family and caregivers is addressing a specific problem that they encounter in their lives, but I'm wondering about the other two, the retirement planning and the recovery and reintegration.

Are those addressing specific problems they encountered or uncertainties that they're feeling as they look at the future and wondering where they're going? Can you help divide that out a little bit, because I think

what I see and hear in those is they're expressing concern and uncertainties, not necessarily, specific problems. Is that somewhere near correct?

MR. PATRISSI: Okay. The future retirement planning is uncertainty. The recovery and reintegration is, how am I going to do it? So in other words, it's, I want to do it, show me how, you know, point me in the right way.

MEMBER REHBEIN: So in both those cases, any solutions that we might be able to help present would be in the more information categories that would help them understand, better, where things are going rather than specific support mechanisms, or problem solutions.

MR. PATRISSI: I think you could probably, you know, and I think I suggested this to Melissa, is, have someone who has gone through these problems, put them in touch with the new enrollees, so if I've got a new enrollee who is a paraplegic, is there someone who has

successfully transitioned through the system, who is also a paraplegic, that can coach them, mentor them, help with the family, or whatever?

So that's kind of, you know, it might be a good suggestion to -- you know, the greatest fear, I remember when I was a clinical psychologist, people have is of the uncertainty. You know, am I alone? Has anybody else done this? That kind of thing. So just having, maybe, somebody to say, yes, I know what you're going through, this is what happened to me, it's going to get better, might be an asset that you could foster.

MEMBER REHBEIN: Thank you. Appreciate that answer.

MEMBER CONSTANTINE: Sir, I'm looking at Slide Number 9, which is the demographics of the survey respondents, and it looks like, you know, obviously, a vast majority of the sailors, caregivers was 0, is that correct?

MR. PATRISSI: Hold on. Let me get

that.

MEMBER CONSTANTINE: Okay.

CAPT HALL: He has a separate slide deck for the responses from the caregivers. So the caregivers that are shown here are caregivers that responded for service members who were unable to respond.

MR. PATRISSI: Yes, I'm sorry.

CAPT HALL: So he's going to have some more data on what the caregivers said.

MEMBER CONSTANTINE: Do you have that available or is it coming at some later point?

CAPT HALL: Yes, he's planning to brief that to you.

MEMBER CONSTANTINE: Oh, okay. I got it.

MR. PATRISSI: Right. Okay. There were two separate surveys. One was, basically, for the enrollee, and one was for the caregiver. However, on the enrollee survey, if the enrollee could not take it, the sailor or the

Coast Guardsman, someone else took it for them and answered it from their perspective. So that's how the caregiver might have been involved in answering some of the enrollee questions.

MEMBER CONSTANTINE: Okay. Thank you, so I'll just wait and hear what the caregivers had to say. Also, one of your last slides said, you had a bullet point where you said you were rated very well, but some of them, you weren't rated very well at all on some of these. 69 percent were happy, I think, or were satisfied, or very satisfied with the services, and only 76 percent would recommend the program, is that correct?

MR. PATRISSI: Hold on. Which slide are you talking about, sir?

MEMBER CONSTANTINE: 29 and maybe the one before that or right after that talked about --

MR. PATRISSI: Oh, program satisfaction? Yes.

MEMBER CONSTANTINE: Yes, 28 and 29. And I'm not sure what slide it was towards the end where you had a bullet point where you said the program did very well, or you rated it very well, or something along those lines. Does that sound familiar?

CAPT HALL: Okay. I think, overall, the trend's in the right direction. Certainly, there's room for improvement. I wouldn't say, you know, I'm satisfied with, you know, 76 percent would say they would recommend the program. I think that's kind of a scary number, even though it's high compared to 0, you know, it's not a 100.

MEMBER CONSTANTINE: And maybe we can pull up the slide or maybe it was just from something he said, but where it said rated well or rated very well, that was a determination here.

MEMBER REHBEIN: Justin, I think you're looking for the top bullet point on 36, is where that statement was made.

MR. PATRISSI: Oh, 36? Is rated, overall, very well for those who use it. You're talking about the recommendations. We're having some audio problems here. You're breaking up. Are you hearing me okay?

CO-CHAIR CROCKETT-JONES: We're hearing you okay.

MEMBER CONSTANTINE: Yes, I can hear you. So I assume that 69 percent and 76 percent came about from people who use the program, right? I mean, you didn't have people who didn't use it, commenting on it, or recommending or not.

MR. PATRISSI: Correct. If it didn't apply or you didn't use it, those were factored out. Does that answer your question?

MEMBER CONSTANTINE: That does answer that question. Why do you think 69 percent -- why would you categorize that as rated very well?

MR. PATRISSI: Why would I categorize that as very well? Because what we

have in our surveys is that, if you ask sailors satisfaction about career, and pay, et cetera, anything over 70 percent is really well. Okay? Again, this is why I'm rating it very well. It's either close or over 70 percent.

In my experience of doing surveys for all these years, the 70 percent is like the four-minute mile.

MEMBER CONSTANTINE: What percentage do you use for not doing well or failing then; 40?

MR. PATRISSI: I'm sorry. You broke up. I think you said, what percentage for not well?

MEMBER CONSTANTINE: Yes, I mean --

MR. PATRISSI: Okay. Below 50 percent.

CO-CHAIR NATHAN: I think beauty's going to be in the eye of the beholder on this. I think that, probably, it's much more subjective to determine what someone thinks is good or not. If you went to the Disney

organization and you said, you're at 79 percent, they'd say that's woefully inadequate.

If you went to, you know, another system that was in a state of disaster a year ago and said 70 percent, they'd say that's great. So I think it's more important that we hone in on what the trajectory is; where we're at. I think it's important to say that we don't declare victory at 79 percent, we don't declare victory at 93 percent, we recognize that this is a journey, not a destination, for a certain percentage, so I think your point's very well made.

At the end of the day, as I said before, I'm still concerned about those people who would not consider us to be a marquee, to have a marquee program, or a first-class program. Those who would not recommend it. You articulated the challenge there is that, where somebody is very upset with one aspect of the program, their neighbor who lives next door is very distressed about a totally different aspect

of the program, and that is the challenge.

And so I think we're much more concerned with how are we measuring this, how we're pulsing this, how we're re-calibrating, and re-targeting the azimuth on this to better achieve satisfaction with those people who are malcontented. We are encouraged by the trajectory overall. More people are starting to like it than not.

We're not satisfied, yet, with the number of people who are not happy about it, and you're not alone. I mean, these are programs that, across the services, have their detractors and their advocates.

So again, I think it's goodness that you're thoroughly researching these. I think it's goodness that we've got a basis for comparison so that we can see, from a relative standpoint, how we're doing. I think it's also important from an absolute standpoint that we can't simply say, X amount of people not liking us is the cost of doing business.

That's probably true, but it can't be the way we focus our attention. So let's proceed on. Where did we leave you off? Slide 34?

MR. PATRISSI: I believe I finished the enrollee. Do you want me to move on to the caregiver?

CO-CHAIR NATHAN: Yes, if you would.

MR. PATRISSI: We're at your break point. Would you like me to come back after your lunch or --

CO-CHAIR NATHAN: We can keep going.

MR. PATRISSI: Okay. I will try and speed up. Let's move right into the --

CO-CHAIR NATHAN: You're fine. Don't go too fast. Einstein's theory of relativity starts to kick in here and we'll all start to grow younger. So please, take the time you need to present the material and we'll go from there.

MR. PATRISSI: Okay. We learned from our first survey in '09 that there were separate issues that someone who is a caregiver had that was different from the enrollee. So two years ago, we designed separate surveys for both the enrollee and the caregiver.

We developed these questions with the Safe Harbor program managers and continued to administer them and refine them from the 2010 to the this past survey. The problem is, again, we mailed out 763, we had 641 eligible, only 42 returned it, so we have a 7 percent response rate.

One of the hypotheses is that the term caregiver in the current surveys may have caused some confusion. They may have thought the caregiver was a physician or somebody. But anyways, Slide 7 has the background, the demographic background, of those who responded. 58 percent of that 7 percent were spouses, 24 percent were parents, another category might be a child, a neighbor, and 5 percent were

caregivers in terms of professionals.

Breakdown of the survey respondents, you notice the gender breakdown in the enrollees was 87 to 13 and it's 13 to 87 in the caregiver survey, the age is about the same, and they got no reserve component. We also had, you know, 83 percent who said neither. Okay? So they didn't fill that out at all.

Slide 9 has the medical treatment facilities. Slide 10 has how many children under 18 are at home and you have 46 percent have children at home, and the average age of the children is on Page 11. Okay. From Slide 12 on, basically, we asked the question, what was offered, what did you utilize, and what would you plan to use in the future?

So the services that were offered to you, what you actually utilized, and you plan to use, and these are percentages. What's interesting is the 59 percent who were offered no services, utilized none, but plan to use more, I guess. That area could point to some

improvement. Slide 13, did you receive invitational travel orders? 32 percent said yes, 68 percent said no.

And then 14, we followed up, were you geographically separated from the enrollee? 32 percent said yes and the contributing factors for the geographical separation; housing and lodging, financial, transportation, and school-aged children were the number one.

Now, one other things is, we're reporting percentages, we had a low response rate, so that's why, you know, the numbers are kind of chunked together, you know, 55 percent. 75 percent said that the non-medical case manager helped identify their immediate needs. Now, 16 is, we asked them what their immediate needs were and what their needs were at any point.

So financial, housing, and travel were immediate needs, and they continue to be almost chronic needs later on. What appears to come up later on is the TBI/PTSD services, which

were not immediately known or identified. 17, what support services were offered? Financial and housing were the number one.

18 of the ones that were offered, what did you utilize and what did you plan to use? Again, traumatic brain injury comes up a lot later. It's not immediate to the people when they're discussing the early enrollment. Okay. Slide 19, of those who had contact with the non-medical case manager, 64 percent agreed or strongly agreed.

Okay. 27 percent did not know the case manager, but if you use them, they strongly agreed that they were involved in the Recovery Care Plan and they were included in the updates the Recovery Care Plan. And the current status, on 20, of the Recovery Care Plan, and it lists actions that can be taken to reach their goals.

21, was the additional services that they were aware of, and that has increased; that has improved. And 23 starts our satisfaction with the program. 64 percent of the caregivers

were very satisfied, or satisfied, and that has increase from 58 percent.

MEMBER KEANE: Sir, I have a question on one of your slides, Slide 19. This is Lieutenant Colonel Keane.

MR. PATRISSI: I'm sorry?

MEMBER KEANE: I have a question on Slide 19.

MR. PATRISSI: 19, hold on. Yes.

MEMBER KEANE: Of those who had contact with non-medical case managers, 64 percent strongly agree/agreed.

MR. PATRISSI: Yes.

MEMBER KEANE: Where does that figure come from?

MR. PATRISSI: Okay. Imagine a Venn diagram with the ones that just had contact with the case manager, so take the "do not knows" off, okay, and that's where the 64 percent would come from. You follow?

MEMBER KEANE: Yes, I follow.

MR. PATRISSI: Okay. Slide 23,

satisfied with the Safe Harbor Program, basically 64 percent. The support provided by the non-medical case manager, 59 percent. That's gone down slightly. Recommending the Safe Harbor program, 71 percent would recommend it. How satisfied were you with the services that Navy Child and Youth Programs provided?

We kept the, was not aware or does not apply in there just to give you an idea of people who didn't have children and, you know, weren't aware, just, as a way of focusing on those for future. But you'll see that, if you use the programs, 71 percent were satisfied with that.

Overall satisfaction with the services of Navy's Fleet and Family Support Center, if you use the program 73 percent were satisfied with it. It's just getting knowledge out to the people, caregivers, that there is some support area out there.

28, stresses and concerns related to enrollee's injury. And I think this may

piggyback on some of the questions that were asked during the last session. 29 has things I like best about the program.

CO-CHAIR NATHAN: You know, it's interesting that the stressors include no help or contact from mentors and non-medical care managers.

MR. PATRISSI: Right.

CO-CHAIR NATHAN: Yes, the things people like about is, they're always available with advice, support, and guidance.

MR. PATRISSI: Right.

CO-CHAIR NATHAN: I recognize different people saying different things, but again, this is where it, sort of, comes down to trying to figure out where the center of gravity is on those things people like and the center of gravity on those things people don't like.

MEMBER CONSTANTINE: Sir, when you have these lists of bullets like that, like on 25, 29, and 28, are these in order of the responses that came in that, you know, reflect

that?

MR. PATRISSI: I'm sorry. You're breaking up. My guess is you're asking how these answers come about? It's an open-ended question.

CO-CHAIR NATHAN: Are they written in order? Are the responses listed in the order that they were frequently given?

MR. PATRISSI: Yes.

CO-CHAIR NATHAN: So the number one response to stress was worry about health and recovery of enrollee.

MR. PATRISSI: Enrollee, correct. And the number one thing that they like best was always available with advice, support, and guidance. And the ones who said no help or contact from mentors are the group that is dissatisfied. And, you know, throughout these surveys, both enrollees and caregivers, you know, I want to stress, if you use the program, you love it, okay?

It's the ones who fall through the

cracks who are not using the program who have no contact. They're the ones that think it's not worth it. And when we did the breakdown of the enrollees who were the most dissatisfied, that theme came up continuously. Basically, 90 percent of them had no contact with their non-medical case managers.

So that small percentage who are dissatisfied, 90 percent of them, I'd say that was the number one reason.

CO-CHAIR NATHAN: They had no contact with the program just because they didn't trust the program, they thought it was no value added, they didn't want to give it a try, they weren't made aware of it?

MR. PATRISSI: There's a variety of reasons. You know, when I went through the comments, they were either lost in the beginning, in other words, there was a critical point in their hospitalization when they were heading out to the medical process that, as somebody said, I went to the non-medical care

manager's office and it was closed. I left a note and nobody ever got back to me.

Others, it's, they're lost in transition. They'll move from one place to another and not get picked up. You know, we had a 120-some odd return to senders. So the database, there's a lot of churn in the database in terms of that.

There's also a lot of distrust. I'm saying a lot. When we looked at the rank breakdown of the actual enrollees, eight of them didn't put their pay grade, because, you know, in talking to some of the ones who called me up to complain about, you know, the survey, or the length, or whatever. I asked them, can I report some of these problems up to higher headquarters, that you're having, like, in terms of non-medical location managers?

And some of them said, no, I don't want my benefits screwed. So, you know, you're dealing with a very complex population here, and some of them have psychiatric or psychological

reasons which may foster mistrust. Did I answer your question?

CO-CHAIR NATHAN: It gives us a little better breakdown of why people aren't using the program. The challenge, I think, the onus, is on us, the federal sector, to try to get these folks more engaged. Why do I say that? I say that because you can pay me now or you can pay me later.

In other words, if we don't get into the beginning of these families and help them before they hit failure or before they lose hope, we're going to end up spending -- of course, it's, morally, the correct thing to do. Secondly, it's critical because we're going to end up spending more resources on these families and trying to repair damage than we are trying to prevent it.

And so I think it's incumbent on us to say -- and I know you're not saying this, but somebody might be inclined to say, well, you know, the heck with them. We've made it

available to them. They don't trust us. They don't like us. They left a note on the door. You know, we gave them a call and left a number on their phone machine.

Check, got all that, and there is some personal responsibility the families have to take, but their lives have been thrown asunder by this and so I think it's incumbent on us to try to figure out how we can resonate with those people who are not taking advantage of the program.

If what you say is true, if you use the program, you will become a believer, then the trick is not to figure out how to get people to believe, the trick is to get people to use the program.

MR. PATRISSI: Right. And you may not be aware of this, but we asked, in another poll, we have some experimental questions, that goes out to the fleet, are they aware of Safe Harbor; the Safe Harbor Program? And 69 percent of the enlisted are not aware of it and 55 percent

of the officers are not aware of it. And this is in the latest poll that we did in 2012.

So it's not getting out to your current active component sailor that there is a program like this.

CO-CHAIR NATHAN: And I think that's okay for that active sailor and/or reservist who ends up at one of our bigger facilities where they're going to be introduced to the program right away. I have greater concern for those, as we have with all the other services, people who are out there in the Hinterlands --

MR. PATRISSI: Correct.

CO-CHAIR NATHAN: -- who need to initiate the conversation because it won't be initiated for them. So again, I do think it's nice to have that available, but if you were to ask the average sailors, you know, and I don't know what the age is these days, it's somewhere in the 20's, the average age of a sailor, you know, if they want to memorize what Safe Harbor's

all about, while they're feeling good, doing well, healthy, not injured, it's going to fall off their radar.

But we do need a system that somehow tickles them as soon as we get a casualty report, as soon as, somehow in the reserve community, they end up in illness or injury, how we tickle them with the Safe Harbor capabilities and get them to use it.

MR. PATRISSI: Okay. In our future -- okay. Well, let's finish up the caregiver survey. Slide 31, 32, and 33 are the summary.

MEMBER DRACH: Sir, excuse me. Can you go back to Slide 30?

MR. PATRISSI: Sure.

MEMBER DRACH: The last dot point on the financial assistance with travel for care, is that the spouse or the family member's concern, or the sailors concern?

MR. PATRISSI: This is the caregiver's concern.

MEMBER DRACH: And travel from

where to where? If they're at a military treatment facility, there wouldn't be a need for travel. Is this somebody that's at home and they need travel to go to an MTF?

MR. PATRISSI: Yes.

MEMBER DRACH: Thank you.

MR. PATRISSI: You know, they had problems, you know, they had kids in school, they may have had a job they had to keep, so when you talk about travel for care to be with the enrollee, whatever financial assistance is available is outweighed by their having to stay at home.

MEMBER DRACH: Thank you.

MR. PATRISSI: Okay. Any other questions on the summary?

MEMBER CONSTANTINE: One question, going back to that Slide on 19, and I'm looking at 32, the last thing, 64 percent satisfied with the program. We asked you about Slide 19 and how you took out a significant chunk there because they did not know, is that a standard technique

that you take out a portion of that if the person didn't know about it, because it seems to me, that means they didn't use it, those services, and that's a problem.

MR. PATRISSI: Right. And that's why we kept it to show you that they're not aware of the opportunity to use these, however, if you used it, you liked it, okay? So we're trying to show a lot on these two slides with these two graphs.

CO-CHAIR NATHAN: I agree with the question. On the one hand, it's a good news story, on the other hand, it throws us under the bus. The good news story is, if you know about the program -- here's our good news, for those people who knew about the program, everybody liked it. Here's the bad news, nobody knew about the program.

So we have to figure out how to do a better job of socializing this, and yes, on the one hand we're heartened because if you use the program, it seems to have capabilities that make

a difference in people's lives on the whole.

I'm disheartened because there's a large chunk of people who don't use it or don't know about it.

MR. PATRISSI: Right.

CO-CHAIR NATHAN: As the poem goes with Robert Frost, we have miles and miles to go before we sleep on this one. Okay. And your recommendations?

MR. PATRISSI: Recommendations, to increase the survey response rate, we recommend involving the non-medical care managers in the distribution, market your services to increase awareness, the fact that there's changing needs of the caregiver suggests you need the continuous involvement with the non-medical care manager, we suggested support groups for caregivers to facilitate transition problems, and then the standardize the surveys with other branches, and have the non-medical care managers share successes and failures to improve the program internally.

So in other words, when you get your non-medical care managers together, have them discuss, among themselves, what's worked and maybe get some best practices. Future surveys, what we are planning doing. Do you want me to move into that at all?

MEMBER EVANS: Well, I think the -- standardize the surveys, I think all the services should be using one survey. I'm not sure why we have three or four different surveys out there from each of these services. So, you know, maybe that's something we need to look at in the future.

MEMBER MALEBRANCHE: I was thinking the same thing. I really like that recommendation and maybe if there's something service-specific you could have a breakout section for the service if you're particularly looking for something in that service, but it seems like we do need have the standardized survey with the standardized way of reading.

And then two, when you have such low

numbers it's helpful, I think sometimes, to know the actual number as opposed to percentages because that's a very different dynamic there.

MEMBER TURNER: Absolutely. I would just agree with the two young ladies that, not only do we need, like, a standardized survey, but I think we should move, actually, towards tri-service metrics, a standardized metric, and I think that way we can more clearly understand what's going on.

MEMBER CONSTANTINE: Sir, I have a quick question on the first recommendation. I assume the first two years of the survey you had, you know, equally low numbers of participation. Did you, for this year, consider involving the non-medical case manager in the survey distribution and decide against it or are you just now coming to that?

MR. PATRISSI: Here's what we're going to try and do. You were breaking up, but I think you want to know what we're going to do to increase the response rate, correct?

MEMBER CONSTANTINE: Sure.

MR. PATRISSI: Okay. In order to keep the trends going, we're going to ask the same questions to new enrollees in the survey in the Safe Harbor process, but I think it's not going to be that beneficial to ask people who we polled three, four times, the same questions over and over again.

So what we're planning on doing in the future is a phone interview with the non-medical case managers to discuss issues that they may have in caseload, travel, getting contact with people, et cetera. We do a similar survey for the Department of Defense for casualty assistance officers and so we can model the phone interviews on that.

The second one is, we want to contact the Safe Harbor members by telephone, or their caregivers, and, you know, put a voice on to the survey, and get them to ventilate and talk. There were several people who would call me up and say, I don't want to answer this survey. I

want to talk to somebody. I want to talk to somebody who can do something. You know, I can answer surveys all -- you know, et cetera, et cetera.

So we would like to offer those services in the survey. You know, we've got some trained psychologists here who can, you know, do the structured interviews and maybe cull out some issues that you've asked about, you know, in terms of transition planning and that kind of thing. So that's recommendations for way ahead when we do the re-analysis of the program this coming year.

MEMBER PHILLIPS: This is Steve Phillips. I had one question or something to add, and this may not be the case, but would you speculate, perhaps, is the low response rate and the low utilization rate, perhaps, a result of the folks being able to achieve their goals through other means?

Maybe they're satisfied and this is why they, perhaps, didn't response and there are

other ways that they were achieving the care and treatment they needed.

MR. PATRISSI: You're asking me to predict something I don't know. I would hope that would be the case, however, this is an extremely difficult population to sample. Let me give you an example. On the open-ended comments, I picked up, please call me at such and such a number. I want to discuss future benefits.

So I called that number and the phone was disconnected. Others would call me and say, send me a paper survey. I haven't got Internet access, and we'd send them a paper survey and we'd never get it back. So, you know, I would like to say that, yes, maybe people have been successful, and transitioned, and don't need our services, but that's another problem.

I actually had calls from people saying yes, I'm better now, I used it for a year, and I'm okay. And then Merissa mentions that they're on this program for life, so the message

isn't getting to them, that even if they were successful in transitioning, they're still part of the Safe Harbor family.

MEMBER PHILLIPS: Just follow-up again, lessons learned, I mean, I think we learned a lot from this. One, and I think you would probably agree, the numbers, perhaps, are too low to make any meaningful direct decisions, but a 7 percent response rate, I mean, these are all pretty good questions and information that we'd like to know.

Is there another vehicle, another way to get that information?

MR. PATRISSI: Right. We would use a phone system. This was a combination paper and electronic. They had the option, initially, of electronic, and if they wanted a paper, the introductory letter said, contact me and we'll send you a paper copy.

So the third method would be phone, and the fourth method, which would be very expensive, would be knock on doors. So we're

going to try the phone method next.

CO-CHAIR NATHAN: Okay. Thank you. I think we need to wrap this up, but what I'm taking away and what I think I hear others taking away is that, number one, the program needs better socialization, better visibility, there's a red light blinking on my dashboard right now when I see a 7 percent survey return, when I see a 100 and change people who don't know about the program who could know about it, and so it's a team sport and we need the families to be engaged, but we need to meet them more than halfway on this.

So hopefully this is a wake-up call to the program that we need to figure out how to get a more robust, ambient working knowledge, and interest in it, among the participants. The good news is, and again, not statistically really relevant, given the low turnout, but the good news is that the data tends to indicate that the make-up of the program meets the needs of most people and most are satisfied with it.

The other point being that, we would never quit there. First, I'm not sure it's statistically relevant, and second, even if it were, success isn't until we've figured out why we're not meeting the needs of any one individual anywhere.

And so I appreciate -- you've given us a fairly meticulous breakdown. You've asked a lot of questions. You can tell that we, I'll say me, has tried to focus you on, you know, what's the crux this committee can attack. We can't attack world hunger, but we can go after and make specific recommendations on certain things that'll help you do your job.

And then when we next hear from you, we'd like to hear how you've done a better job of socializing the program, what you need from us, if you have resource issues or if you have policy issues that need to be changed, what you need from us to help lean against the door with you to make a difference in socializing this program, and then, how we can better get a more

statistically relevant sense of how people enjoy the program.

So the good news is, the program looks like it's on solid footing and tends to be successful when applied. The concern is that not enough people know about it and not enough people are utilizing it. That's going to mean families failing down the road that don't necessarily need to, so we've got to figure that out.

So I very much appreciate your perspective on this. I appreciate the groundwork that went into this. Our job and your job now is to take all this hard work you and your folks have done on this and make it more representative of more people so that all your good work means more to more.

Any parting comments before we say goodbye? Okay. On behalf of the members, again, thank you for phoning in and taking your time to do this for us. We appreciate what you've given us and we'll look forward to

follow-ups down the road. Thank you.

MR. PATRISSI: Thank you, ladies and gentlemen. Appreciate it.

MS. DAILEY: Lunch, ladies and gentlemen. We have lunch to 1:15. It'll be in the Madison Room, same room it was yesterday. Thank you, everyone. Appreciate your time.

(Whereupon, the foregoing matter went off the record at 12:30 p.m. and went back on the record at 1:20 p.m.)

CO-CHAIR NATHAN: Okay. I've got 20 past the hour, so we'll go ahead and get started. Welcome back, folks. So this afternoon, our brief will be informational from the Marine Corps Wounded Warrior Regiment. We welcome Colonel Willard Buhl, Commanding Officer of the Wounded Warrior Regiment and his supporting staff.

This session will begin with a briefing on their response and the status to the specific FY '12 recommendations that apply to the Marine Corps. As additional briefers add in

to the task force during the session, we ask that you introduce yourself and what you do. You can find Colonel Buhl's and his staff's briefs on Tab L of our binder. Colonel, the floor is yours.

COL BUHL: Admiral, thank you very much. Good afternoon, Task Force members, Ms. Dailey, and your support staff. I sincerely appreciate this opportunity to answer your questions about the Marine Corps' Wounded Warrior Regiment.

This is my first presentation to the Task Force, but I am no stranger to your good work. I'm inspired and thankful for your efforts, not just to capture the concerns of our nation's wounded, ill, and injured, and their families, but to propose solutions for the betterment of their lives, something that we are all working toward.

Long before I assumed command of the Wounded Warrior Regiment, I witnessed firsthand the complexities of wounded warrior care. While the job before you is undoubtedly

difficult, I can think of no higher purpose and no work more rewarding. Blessed duty is how I would refer to it.

I was pleased to note that your questions reflect a high level of interest the results of our surveys. As a survey proponent, I know that without the solid feedback of those we serve, we cannot make sound improvements. I'd like to point out that our trend data shows the Wounded Warrior Regiment's satisfaction levels continue to remain steady and/or to improve.

Nonetheless, we do not, I do not, rest on our laurels. We continue to identify and execute methods to improve care, such as post-service support, enhanced communication through social media, town hall meetings, wounded warrior complexes at our battalions, and a newly invigorated command inspection and training program.

Before we begin, and given the current tumultuous budget climate, I would be

remiss if I did not reassure you that the Marine Corps is firmly committed to protecting our ability to keep faith with our wounded warriors and their families. As our Commandant, General Jim Amos, has stated, it is a top priority for the Marine Corps.

As you know, we submitted our brief last week, it responds to all of your questions regarding the Marine Corps' position on various Task Force recommendations, survey findings, and backup data. I defer to your judgment as to whether we review each slide individually or we focus on certain areas of concern in terms of guiding the presentation. How would you like to proceed?

CO-CHAIR NATHAN: If you would, go ahead and just start by addressing the recommendations.

COL BUHL: Okay, sir. And before that, may I just very briefly introduce Mr. Paul Williamson, who is the -- probably should be no stranger to the Task Force, and is our command

advisor, none finer. And Erica, my gosh, Flores. Erica is an analyst in our future initiatives team and she is an analyst par excellence and a survey expert, and the rest of our support staff is here, part of the future initiatives team, call center director, recovery care coordinator, deputy director, and so I'm proud to have them with us today.

First recommendation here, to provide Marine Corps Air Ground Combat Center Twentynine Palms needed resources, and particularly, a VRE counselor at that installation. And we partially concur with this. I certainly, we, we actively desire to have more counselors at all our installations.

It is a question of available resources, and in this particular cases, available space, private space, an office, for that counselor. And we are in the process still of identifying that space for a counselor there. And in fact, I've spoken with the battalion commander, and the detachment commander, and the

base chief of staff to re-energize that effort. This has risen to the forefront of our concerns in terms of an actionable item.

MEMBER EVANS: So let me just -- this is Captain Evans -- so you're saying that because of space allocation, we can't get a counselor there?

COL BUHL: Well, that's what I understand, honestly, that that counselor will require a private space to work at and at the facility that our detachment is located, the office spaces are, in every case but one, shared. Our RCCs share an office space, all the section leaders, et cetera. Only the detachment commander has his own office space.

Now, there are other office spaces on the base and that's what we're working through, and in fact, we think this counselor, certainly, would support far beyond the detachment's needs proper. We have some cases that are -- RCCs that are supported by the regiment and not physically joined to the

detachment there.

And, of course, there are other service members transitioning out that would benefit from that counselor. So in terms of us housing and facilitating that, that's precisely what the problem is.

So we just identified one at Camp Pendleton and that is happening, and these are, I understand, looking into it. It isn't a fast process to do this. One, to find that counselor, to get that counselor assigned, and of course, the space requirement. We're working on this.

MEMBER EVANS: I know at other commands we don't have them assigned to the regiment or to, you know, particular units. They could go somewhere else on the campus, because they will benefit other service members.

COL BUHL: Yes, ma'am. I realize the population, the needs, are far greater than simply the detachment there at Twentynine Palms, but we welcome it.

CO-CHAIR NATHAN: I think the sound bite we need for this is, if we believe there's a legitimate need for the counselor, then space cannot be allowed to be the choke point. So, you know, we'll work that. But at the end of the day, we can't really say to the public at large, this is something we really need, we just don't have any room to put the person.

So I think it's tempered with need, some would err on it's essential to have, others would err on it's nice to have, unless you can do the remote capability from Pendleton, or the Southern California area, to this. But at the end of the day, Colonel, you know, if you need it, then my responsibility, and it's not my job on the membership here, it's my responsibility supporting the Commandant for medical capabilities at my base, not my base, but the Marine Corps base, with my hospital, then we'll find space. Thank you for bringing that up.

COL BUHL: Thank you, sir. The next item of addressal would be the Marine

assignment to the Wounded Warrior Regiment proper. And we have a number of methods for our wounded, ill, and injured to be assigned. They can be assigned. They can be referred by their commands. They can be referred by medical staff.

The Marines, themselves, can advocate and request to be joined. And in response to that question there, we are not seeing -- I outline here for you, a few of the 90 days of sustained medical treatment and/or rehabilitation, three or more medical appointments a week -- basically, demands that a normal unit might not be able to support.

Otherwise, it is always our policy and practice to encourage that the Marines recover in their own units with their parent commands, with the men and women that they are serving side-by-side along with, and in many cases, were injured with, wounded in action with, et cetera.

But if there are medical needs that

are, as I indicated there, of course, we welcome them and can afford them specialized care in an environment where the rest of the population are patients and recovering warriors.

As far as referrals that aren't being addressed, we have simply not seen that at Twentynine Palms. I have no evidence that we are turning people away.

MEMBER DEJONG: Sir, if I may, sir?

COL BUHL: Yes.

MEMBER DEJONG: Part of what -- now, correct me on some of my percentages and some of my numbers, it's been about a year since we were out there for the site visit -- some of what drove us to this recommendation was understanding that, I believe it's around 70 percent of the Marine ground forces are at Twentynine Palms. Is that correct?

COL BUHL: No, that would not be correct. We have an infantry regiment at Twentynine Palms, the 7th Marine Regiment, which would be one of six -- in fact, seven infantry

regiments, active duty infantry regiments. We do have a tank battalion, a light armored reconnaissance battalion as well, some engineers, et cetera, but the percentage that you just stated wouldn't be accurate.

MEMBER DEJONG: Okay.

COL BUHL: I could get back to you with the exact percentage. I do not know it off the top of my head.

CO-CHAIR CROCKETT-JONES: Yes, I think he might be thinking of what percentage cycle through it as a training platform.

COL BUHL: Oh, Twentynine Palms, the Air Ground Combat Center, is the preeminent location for our air-ground combat training, and nearly every unit deploying to theater rotates through there in what, recently, was called Exercise Mojave Viper. We're in the process of adjusting our pre-deployment training based on the draw down in Afghanistan. Is that what you meant?

MEMBER DEJONG: Okay, yes, sir.

Let me stand corrected on that. What we noticed was that we had made other recommendations and talked, you know, is it needed, is it not? As a Task Force, we see a definite need for that detachment to be there. We also, in talking with the focus groups there, both the staff and the recovering warriors themselves, see that it does get stressed at some points in time, which drove us to Recommendation 6 of providing the resources needed to maintain, and allow, and to adequately staff and facilitate that detachment, as well as the east and west coast have, because we see that it's not going away.

We just hear some feedback from some of the Marines that Camp Pendleton, for instance, has far greater access to benefits and/or resources than what Twentynine Palms itself does. So part of the driving force behind the recommendation is to bring that detachment up to par with something like Camp Pendleton.

COL BUHL: Yes. I actually

wholeheartedly concur with you on that, and in fact I believe the next time you go back to Twentynine Palms and have a look, you'll be pleased to see the changes. Also, our demographics have adjusted. A year ago, we had 43 patients on the rolls there. It's 24 today. So the numbers have come down.

Twenty-two percent of the RCC contacts are outside. They're being supported at their local commands. So the numbers have come down. Our staff numbers have come up. I assigned an active duty lieutenant colonel who just returned from Afghanistan as a regimental executive officer to be the detachment commander, and he is command slated this coming summer. He's been there since November. He is a high-quality officer in the Marine Corps.

I redirected him from the regimental headquarters. He was due to become our OPSO, Lieutenant Colonel Don Wright, and we assigned him there to put the emphasis that you are describing in your remarks to ensure that I have

that quality leadership there. The facility has been modernized. It is now, I think, when I saw it, I would be pleased to work there. I'd be proud to work there.

It's small, but it is sufficient, I believe, for the population that we have, and the activities that we have for our Marines there are engaging and positive. What I will tell you is, there's still, for some of the more sophisticated or elaborate procedures, medical assistance, we still have to commute to Balboa Hospital, and that is a haul from Twentynine Palms.

And some of our Marines there are going three times a week or so to Balboa. They could go as much as that, in which case, we start to really look hard at whether or not a PCS move, or extended TAD, would be in order, TDY for that Marine. You know, the family, et cetera, factors in, but we're running a commute to the hospital and I thought that morale was high in my recent visit there and that our Marines have

what they need and are thriving.

And I can look at you and tell you that because I saw it with my own eyes.

MEMBER DEJONG: Okay. Thank you for that, sir, and some of what we were referencing was, for instance, job fairs, other things, because Twentynine Palms is kind of out on its own.

COL BUHL: It is.

MEMBER DEJONG: And that was just some of the quick takeaways out of my file that's clouded and way back there from a year. So that's what I was -- thank you for your comments, sir.

COL BUHL: Yes, sir.

CO-CHAIR NATHAN: Any other questions, concerns on --

MEMBER PHILLIPS: Colonel, I just wonder if you had a handle on the timeline it takes for a line injured, or ill, or wounded Marine, if they're recommended to go into the Wounded Warrior Regiment, how long that process

takes?

COL BUHL: Well, sir, I think it varies on a case-by-case basis. Every Marine and/or sailor's situation is unique to he or she and their family situations. I have seen people joined, in the eight months that I've been aboard, in a matter of days. Just a matter of days.

And we can certainly assign somebody TAD by service record book immediately, same-day service, and at least get them on the rolls and under care, and getting expert advice immediately. Yes, sir.

MEMBER EVANS: I would say -- so how many Marines that are there that are not assigned, I think we have over a 100 that are not assigned to the battalion there at Twentynine Palms, how many are -- they've been wounded in war, but they don't meet the qualification to be assigned to the regiment or to --

COL BUHL: Well, I'm not sure if my staff knows the answer to that either, the total

wounded population of Twentynine Palms, which is fluctuating, obviously, all the time with transfers and rotations.

CO-CHAIR NATHAN: Are you talking about the Marines that were organic to the Twentynine Palms area to begin with, got injured, but not to the degree that they need to be under command and control of the Wounded Warrior Regiment and are simply returning back to their duty station?

MEMBER EVANS: Exactly. And so what we have, they are assigned to their unit there, but they have been injured, and so referrals have been made that these individuals, because of their, you know, PTSD, mild, moderate, or but then they develop some additional symptoms of PTSD that they need to be closely monitored through the regiment.

I think what I'm trying to get to is that we have had some other issues where we tried to refer Marines to the Regiment and been turned down. So it'd be nice to track those, how many

-- I think that question came upon us, do you have as, you know, referrals and are you tracking those referrals?

COL BUHL: Every Marine or sailor that applies or is referred to the Regiment, I am the final authority. If a battalion commander should decide, in this case, our battalion commanders are men, the two of them, at each coast, if they should decide they don't want to accept someone for whatever reason, that recovering warrior, that service member, has the right to appeal to me, personally, for a second look.

I haven't had any cases in eight months like that.

MEMBER EVANS: And that may be, because we met with the Regiment, we talked about this issue of, what's our option? And they actually referred us to the MEDCELL website to say, for injured Marines that are not assigned to the regiment, refer them to -- this is your resource.

COL BUHL: Absolutely.

MEMBER EVANS: And so that's what the case manager's been utilizing, so we probably have decreased that. But, again, I would note that they may not have made it to your level, but we definitely have some folks that we have referred and they've been denied, at least that's what's coming from the field case managers.

The second part of it, your numbers, again, I guess we just need to kind of cross-match our numbers to make sure, because we report to SECNAV how many folks that we're monitoring, and so yours are coming a little bit different from our numbers. So we'll just need to get with you to make sure we have an accurate --

COL BUHL: Absolutely.

MEMBER EVANS: Because I didn't know you were down to about 24 out there, and I still have a lot of case managers that are trying to case manage.

COL BUHL: Great.

MEMBER CONSTANTINE: Captain Evans, when your folks refer someone to the Wounded Warrior Battalion, does that go to the line unit or does that go directly to Colonel Buhl's folks?

MEMBER EVANS: It goes directly to Colonel Buhl's folks.

COL BUHL: I welcome any comments, Paul, anything from the staff, if there's anything that I might not have addressed in my response.

MR. WILLIAMSON: When you say assigned to the Regiment, are you referring to a physical relocation of that Marine from his parent unit into the detachment element itself? Because as you point out, there is a referral process that may result in the detachment working with the commander saying, look, it's not appropriate to bring him into residence, but these are the levels of support that we can provide to that Marine.

We can assign a recovery care coordinator as an external case. That means that that Marine will have a comprehensive recovery plan and there will be an addition of other members of a multi-disciplinary team to ensure that that comprehensive plan is executed.

If that's not the level of support required, then that Marine may be referred to our call center, or our contact cell, who would periodically call that Marine to ensure that his needs are being met by his unit, and if not, then engaging some of our subject matter expertise. Most often, this comes about in the world of the IDES process.

The Marine may not have a condition which would warrant them to be joined to us, but they still need some information and support in the IDES world. So that could be a referral to the desk legal coordinator or our own tracking system to advise that Marine where they are in the process and how their unit can effect a better outcome for them in that system.

So there's tiered levels of support that are provided to those Marines that remain with their parent unit.

COL BUHL: And I absolutely have an open commander-to-commander door policy and we reach out to commanders. It is, I would think, actually, more common, if I may say, that I reach out to commanders when I become aware, we become aware, of people with needs that we think are not being addressed at their units.

We actually reach out and talk to commanders and say, do you know Lance Corporal Johnson, his wife, through this particular avenue, indicated her husband is dealing with this, this, and this, and so we think that, from what we see, and the notes we're seeing in MCWTS, and et cetera, we think he is a prime candidate for joining the regiment.

And so I'll actually call and engage commanders. I've done this frequently in my command. And if a commander has a need, I had a district commander out on recruiting duty who

had a sergeant whose PTSD and TBI symptoms manifested themselves about a year into his recruiting tour. He had had three successive combat tours before that and he was having significant issues, and we expedited his transfer to the regiment. Couldn't have him out in an isolated recruiting station suffering. And PCS'd the family, et cetera, to it.

So we're proactive in that regard. There are people out there. I don't want to turn people away with needs.

CO-CHAIR NATHAN: Okay. So we need to bring Recommendation 6 to a close. What I heard was, the genesis of this was data points gathered about a year ago where there was a fair amount of consternation and frustration and dissatisfaction, which may or may not indicate any systems issues out there, but it was enough for the Task Force to recommend that it get a hard look.

Marines a little different in their aggregation of wounded warriors, because unlike

Army, and Navy, and Air Force, who tend to be more spread out among different bases, they really lie resident in these epicenters in Camp Lejeune, Camp Pendleton, to some extent, Twentynine Palms. And Twentynine Palms is out there. I heard you say it's sort of out there, it ain't sort of out there.

COL BUHL: No, it's a whole out there, sir.

CO-CHAIR NATHAN: It's out there.

COL BUHL: It's several hours from Balboa.

CO-CHAIR NATHAN: Well, or Palm Springs, depending on what you're looking for.

COL BUHL: Las Vegas.

CO-CHAIR NATHAN: So that's one of the issues. And the hospital that supports the command there, I think, up to about a year ago, was staffed with a lot of junior personnel, the commander was sort of pulling their hair out because they didn't have some seasoned people, as you would expect, you know, people who have

more time and accrued more horsepower get the more garden spots.

We aggressively re-detailed that facility to put more senior medical officers there, more senior medical support personnel there. What I've heard is that the footprint has dropped to about 50 percent of what it was a year ago.

COL BUHL: Yes, sir.

CO-CHAIR NATHAN: The staffing has increased.

COL BUHL: Yes, sir.

CO-CHAIR NATHAN: And the other thing you've highlighted is, and I think it's the gorilla in the room, is the difference between the Marine Corps and some of the other services and how they approach the unit integrity of their wounded warriors, and how they want to keep as much cognizance and control of a Marine, who may be wounded or not, under their chain of command as opposed to relegate that command over to another detachment that is resident at the

medical facility.

So all those things come together, but bottom-line is, you've heard this -- and the only thing we'd ask you to do, well, I would ask you, is you've heard that, maybe, some of the turn-downs that are occurring, some of the requests, referrals, that are being denied for Wounded Warrior Regimental acceptance, are not possibly not making it to your level.

COL BUHL: Yes, sir. I heard that.

CO-CHAIR NATHAN: So the only thing we'd ask is that you pulse a little bit, active sonar for the Navy, a .50-caliber round for the Marine Corps, if you think that's going to -- let's just see if truth. So we'll move on to the next one, if we would. Recommendation 11.

COL BUHL: Okay. Provide recovering warrior and family access to the CRP. We partially concur in terms of viewing and commenting rights for Marines and families, I absolutely concur with that, but we believe that there should be a single editor for the CRP. And

that families absolutely should be able to view that, they should be able to view it daily if they want to, weekly.

We have a weekly policy in place, but no one is going to be turned away, and they should be an active part of that, because the family, we know that our recovering warriors are going to heal better with full family involvement in their loved one's recovery. So I'm surely a proponent of that.

We do have an opt-out option for family members to be -- Marines and sailors, to have their family members be excluded from this, but they have to sign it. And we have what I would say is a very aggressive staff approach, up to the commander, to not encourage that, and in fact to keep that Marine's family closely involved and a part of the CRP.

I will say that, at the end of the day, it is the commander's responsibility there to ensure that the family is integrated in that CRP. We are hesitant to, in fact, we do not want

to have multiple editors working on this. There needs to be one single point and it's that commander who is responsible for his or her Marine.

CO-CHAIR NATHAN: So I'm trying to find where the partially comes in.

COL BUHL: Well, the partial is, we just don't believe, sir, that we can give families full editing rights. We don't want multiple, unless I'm mistaken in my interpretation of the -- I think the families should have absolute transparency and a part of the CRP. I think there should be one editor writing and entering.

CO-CHAIR CROCKETT-JONES: Yes, this was a result not of our wanting families to be able to have input and editing, as you're calling it, it was because many, many installation visits that we've conducted, families did not know what the CRP was, had never seen one, had no idea who to go to to look at one, didn't know what it was supposed to do, they were

completely disconnected from the process, and so they couldn't provide any support for their recovering service member in that plan since they didn't know what it was.

And so we wanted them to start having access to it since we were concerned that one of the reasons was because, in the same way that you have said, you know, they can opt-out, I also know that, pretty much, your commanders want an explanation why they opt-out.

COL BUHL: Yes.

CO-CHAIR CROCKETT-JONES: We just wanted to make sure there were no barriers at some other level for families to keep a good look at it, that sending these things home with a service member does not indicate that that means a family members sees it.

COL BUHL: Okay. And we have a lot of education for our families and we have a lot of, from the RCCs, the family readiness officers, family support coordinators, et cetera, et cetera, and it is our intent to

include the family every step of the way. Absolutely.

CO-CHAIR CROCKETT-JONES: Yes, and our trips, I think, in the interim to Lejeune were very positive.

COL BUHL: Okay. Pleased to hear that.

CO-CHAIR NATHAN: Anything else on Recommendation 11?

MEMBER REHBEIN: May I ask one quick question?

CO-CHAIR NATHAN: Yes.

MEMBER REHBEIN: When the family does want to submit input into the CRP, then, how does that process work? Who do they submit it to? Do they submit it to the non-medical care case manager or the squad leader?

COL BUHL: Both. The squad leader is the immediate uniformed member that is responsible, directly, to the commander. I think in most cases, honestly, it's going to be that RCC that's going to be the primary on that.

MEMBER REHBEIN: I just didn't know if there was a standard who that single editor was and how information got to them.

COL BUHL: Yes, sir. And in nearly every case, it's going to be that RCC. Yes, sir.

CO-CHAIR NATHAN: Thank you. Okay, let's move on to Recommendation 13.

COL BUHL: Okay. I couldn't agree with you more on this regard, with one caveat, that we defer to the DoD in terms of full resourcing for our RCC training. But we are cross-training our uniformed staff, and others, really, with our RCCs.

I just recently sat in on some RCC training at our call center and we had a number of uniformed staff members in the room getting that very same training, and vice versa. The RCCs are involved in section leader training as well. So we're doing this. We've been doing it. I think it's a very good idea. We want to cross-pollinate and we want a left seat/right seat with the new RCCs coming aboard.

And frankly, expounding out of my talking points, the RCCs are really, I think, the glue in the Wounded Warrior Regiment because many of them have been aboard for some years, where a uniformed staff comes and goes with mobilization orders and what not, it's these recovery care coordinators that have been the constant. And so their knowledge and experience is the glue that keeps the Regiment going.

CO-CHAIR NATHAN: Okay. Recommendation 14.

COL BUHL: Well, we have a robust protocol, and that would tie into that previous discussion on the CRP. We have improved, in fact, our communications with a revamped website. Our app, you've probably heard of, that has, really, the regimental handbook, you know, available on your small telephone, your handheld telephone, and it's easy to use. It's easy to navigate. It's very clear. It breaks down all the various -- you know, everything from

entitlements, et cetera. We have a Keeping It All Together handbook, KIAT, that we implement to family members in a digestible way. Not all at once, because it is a thick document, but very useful. If you haven't had a chance to look at it, I can make one available to you.

Everything from checklists to explanations, as I said, of benefits. What to expect in the various phases of the IDES. So we're reaching out and those family readiness officers, family support coordinators, RCCs, are engaging our family and they're educating.

So the surveys that you see there at bottom, recently conducted to discover, or to confirm or deny, whether we're up to snuff on that, were very favorable and positive. I was pleased to see that. And we did that across the Regiment.

CO-CHAIR NATHAN: Thank you. And I think this was a generic concern across the services. I would ask you, as an aside, how do you, in the Wounded Warrior Regiment and in the

combat casualty care management, de-conflict or integrate benevolent organizations, especially robust ones like the Semper Fi organization?

COL BUHL: Well, sir, that's a very good question. And, for example, the Semper Fi Fund, they are connected to us at every detachment. They have representatives assigned to every one of our detachments. They have a case management database. They follow our Marines into veteran status. They stay in touch with them and so we work as closely as HIPAA and, you know, DoD, and Department of the Navy regulations enable us to do in terms of communications.

Often, we find out about issues, I talked about referrals to the regiment, I get them from benevolent organizations too, like the Semper Fi Fund. Many of the case workers are volunteers and they are senior officers', or staff non-commissioned officers', wives, spouses, and they are connected through the command network as well.

And I'm just talking along, Admiral, but it's one of the, I knew that they were embedded, but I didn't realize it until I actually became a part of the unit, just how much they're embedded. We share all significant celebratory events with them. I attended a Valentine's dinner at Walter Reed, not too long ago, put on by the Semper Fi Fund, and it was well attended.

Most of the detachment was there. They're extraordinarily supportive, if I've answered your question.

CO-CHAIR NATHAN: You have. They, sort of like the Walter Reed Society, which is mostly centered around the Bethesda/Walter Reed area, the Semper Fi Fund is distributed throughout the Marine Corps. I found it to be very additive for family support issues. Sometimes, maybe, we take those benevolent organizations for granted sometimes that, they're going to kind of be there and we don't have to, so I think it's careful that we

negotiate that.

Sometimes we let them get a little too involved in the care, which is only natural, and it depends on the facility, specifically, how we do that, but I use that as an example of what I think is a very synergistic relationship between the federally-funded appropriated funds systems that the Wounded Warrior Regiment has partnering with the benevolent -- I forget, what are they called in Congress?

Type 3 something 13 c, 501(c)(3).

COL BUHL: 501(c). Yes, sir.

CO-CHAIR NATHAN: There'll be a quiz later.

COL BUHL: The synergy is powerful, sir, as you say, and it is not something we take for granted. And I am very attentive to ensure that we recognize what they do every day. I do tell them that we could not do what we do without their help and I just came, this morning, from California. We have the warrior trials going, the Marine trials, the qualifiers will go the

games in Colorado Springs in May.

The USO, among a number of, Ride to Recovery, the Semper Fi Fund, a long list of non-profits, but the USO, principally in Southern California, is enabling those trials to happen. We could not do it without them and they harness all the volunteer efforts. We don't have the staff to do that.

So I'm rambling along. One other thing I failed to mention too, is, we have a very active town hall program. We're running those town halls to get the feedback directly from the families, you know, real time. We'll pat ourselves on the back with the survey results, but things can change in a week, or a day, and the town halls are an effective communication tool as well.

CO-CHAIR NATHAN: Okay. Recommendation 15.

COL BUHL: Identifying the principal point of contact for the family as caregivers, I'm going to say that, I'm going to

go back to an earlier answer, sir, ladies and gentlemen, we partially concur. Really, we think that it is that commander who is responsible as the single point of contact.

I realize that there is a multi-disciplinary team there in support of that commander, whether it's that section leader, RCC, et cetera, but it's that commander who is the single point of contact, from a Marine Corps perspective, the commander will be accountable for his or her Marine, or sailor, and their family.

CO-CHAIR CROCKETT-JONES: I think my only concern with this is that a family member will probably be a bit too intimidated to call a commander if they're having a problem.

COL BUHL: Well, they call me and they write directly to me, and I --

CO-CHAIR CROCKETT-JONES: I'm sure not all of them have a problem.

COL BUHL: At every level.

CO-CHAIR CROCKETT-JONES: I know

that not all will, but I'm worried that if you told, you know, some of these folks, perhaps some of the folks under the most stress, that the way they solve a problem is by calling the commander, they won't. They're not going to do that. They'll fall into crisis before they call you.

COL BUHL: Right. Well, again, there is a multi-disciplinary team there. There is that recovery care coordinator, the section leader, the family readiness officers, the Chaplain, there are a lot of support staff in attendance available all the time, but at the end of the day, it's that commander who is responsible and answerable. So I think I hear what you're saying, ma'am.

Are family members comfortable approaching the command with issues that they may have?

MEMBER TURNER: Yes, I think what we -- Colonel, we absolutely concur, that I believe you're correct, there should be a single point of responsibility, which is the commander.

Absolutely. I think on a more day-to-day basis is what we were looking for, is where you have one person up here that you're looking across to.

MR. WILLIAMSON: I think, back to all these family issues, one of the things that we recognized as the Marine Corps when we first setup the recovery care program, knowing that the Commandant's intent was that Marines would recover with their parent units, was to ensure the delivery of information to those Marines no matter where they are, no matter when they need that information, and particularly, the families.

If you look at the demographics of the Marine Corps' Wounded Warrior population, they're typically single or they're newly married to a young wife who's not that experienced in the military culture to begin with. So our effort was to try to provide, to those individuals, information that they could consume with a tease to go seek more information later on.

If you look at every one of our fact sheets that the Colonel referred, or on our application, all the topics that are germane to a recovering wounded warrior have been addressed in a one to two-sheet piece of information, with a constant encouragement to go back to your recovery care coordinator, or to call our call center, in the middle of the night if you wished to do that, or go to the app to seek additional information.

Again, time and delivery of information when it's needed by those who seek it is our effort here. And if you take the family of a young Marine who has just suffered a casualty, they're coming from Iowa, they know nothing about the Marine Corps, they know nothing about invitational travel orders, it is the detachment leadership that's responsible for receiving that family, embracing them, putting them in touch with the resources that we have, just in time, at the right interval, in that recovery care continuum to ensure that that

Marine and family receive the support that they need.

CO-CHAIR NATHAN: So that's critical, and that's one half of the mix, which is getting that family, which is naive -- and you're right, Colonel, I think some people don't realize that the Marine Corps paradigm is such that, it's not designed to have people stay in the Marine Corps. It's designed to have people do one, maybe two tours, and then replenish with a small cadre of elite Marines moving up into the senior NCO ranks and officer ranks.

And so you do have a younger crowd. You do have a crowd that's a little less seasoned in the service when they get injured. That said, you do a good job of acquainting the people. I think what Madam Chairman is referring to is, if a family member feels that they're having difficulties along the way, if they feel that there are issues that are not being met, if they feel they have a child who's failing, if they feel they can't meet bills, if

they feel that their spouse, who is either in the hospital or out of the hospital engaged in care, is becoming abusive or whatever, who can they talk to about that?

Who is the person that is designed to be there? And I would contend, having served with the Marines on and off throughout the years, that of all the services, the one that has, perhaps, the most degree of stigma, and a lot of it has to do with the way we build our Marines to fight in an amazing organization, is the Marine Corps.

And so spouses tend to be a little recessive in coming forward, sometimes, when those issues are going on, because their Marine husband or their Marine wife is saying, you know, what happens with our family and the Corps stays between me and the Corps.

So that's the question we're asking is -- and you're not alone in this. We've said this to every group that's come through, how do we make sure that, rather than just simply say,

you know, there's the old joke about the clergyman, you know, he says, how did you get so rich? He says, well, you know, I take the offering, at the end of it, and I throw it up in the air, and I say, God, take what you want and leave the rest for me.

And so I offered it, you know, but it was all left for me. And what we're hearing sometimes is, people are saying, well, we put this out there to the families, they know they can reach us if they want to, but how do we pulse them actively to make sure that they are getting the care they need?

So what I would offer is, you know, how well do we know how are families are doing? Are we having families that fail? And if they do fail, or if the recovering warrior is failing, and we don't know about it, how are we going back and looking and saying, gosh, you know, if we'd engaged the family more, if the family engaged us more, we wouldn't be in this predicament.

COL BUHL: Well, sir, it is a robust

engagement that the regiment has undertaken at every location and it is a formal, or command-directed, various methods. We're talking about the CRP and that the RCC is involved with that family every step of the way, the section leader is involved, we have people like our family readiness officers, and family support coordinators, whose whole reason for existence is, in fact, to do just what you're describing, and the chaplains.

So it's a wide array of people whose expertise and attention is focused precisely on that family engagement, but it is also happening, as we talked about a few moments ago, with those benevolent organizations that often set the conditions for the relaxed engagement to occur and where people will communicate.

I just attended the USO Caregivers Conference, I made opening remarks there, and if I got nothing out of my attendance there, what I was pleased was, there were families willing to, in an open forum, talk about some of the

things you just mentioned; children failing in school, husbands that were acting irrationally, dangerously, and they didn't know how to do deal with it.

And there were a number of panels that addressed various strategies and resources to address those things, so it's happening. Can it ever be enough? I don't think so. But it is on our charge to ensure that we're doing everything that we think of, and as I said, we have follow-ups, town halls, and on that individual level, people's antennas must be up.

Sometimes these things don't manifest themselves till the Provost Marshal is at the family quarters after a domestic dispute. That's when we find out what's been going on behind closed doors. And I do have more cases like that than I would wish.

CO-CHAIR NATHAN: No, I appreciate your response, and I think from a leadership standpoint, certainly, the Commandant's spouses throughout history have always been very active

in going to the bases, having town halls, and showing that family is critical.

And Marine Corps liaison does a good job, say, at Bethesda-Walter Reed, of pulsing the families when they're hospitalized there, talking to them, and seeing what's going on. A little bit more concerned about those that are out and about, that are not at the mother ships, and the family is lost, as you said, they don't have the experience.

They're failing because of a war injury. They're failing because of a severe illness. And there's help for them, but they're not getting it because they're not asking for it. And what we want to make sure is, if they're not asking for it, it's not because they're reticent to come forward because we're not engaging or their spouse has said, don't come forward.

COL BUHL: And we are particularly concerned about our population, our veteran population, as they transition to the VA and return to society. Our call center generated

119,000 calls last year in a 6:1 approximate output to input, so people are calling in for information, they're also calling in crying for help. We've had some interventions come through the call centers, averting things we, for certain, would have been tragic.

But for the most part, it is outreach and engagement. How are you doing? Is there anything we can do for you? We see from the last call, here's where you were. Has anything changed? That type of engagement, I've found, is the secret weapon of the regiment. And additionally, our DISCs, our District Injured Support Coordinators, we have 33 of them spread across the country, and their whole mission in life is to ensure that that transition is smooth, effective, and they're our quick reaction force for Corporal (Retired) Jones is in jail in Butler County, Kentucky for multiple felonies, and the family's in trouble.

And so Staff Sergeant is sent out there to develop the situation and see what

resources we need to bring to bear to assist, whether it's a pro bono lawyer, it's what's going on with the VA locally, what are the counselors saying, and I'm talking a bit, but again, I don't feel like we can do enough.

CO-CHAIR NATHAN: Okay. Well, thank you. Let's move on to --

MEMBER EVANS: Well, sir.

CO-CHAIR NATHAN: I'm sorry.

MEMBER EVANS: Before we move on. Just one quick question. I'm sorry. So your last statement on Bullet 3 is, in all cases, the Marine's command has the ultimate authority and responsibility for the successful execution of recovery and transition. And so, again, the Marines are there on the base, on the campus, at any MTF because of medical care.

COL BUHL: Yes.

MEMBER EVANS: And so it's a challenge, and I think, again, this is maybe something where we need to ensure that we have the right oversight of transition of care, or

coordination of care. When you look at the civilian community, they don't have, you know, whatever organization, Apple, being responsible for care or coordination, they want to know where their staff, where their member are if they're hospitalized, but they don't say we're responsible for care and coordination.

So I, you know, think we need to look at that process because it does bring challenge. It brings a lot of challenge to us to implement a lead coordinator and who really is the responsible party to oversee. We need the Marines to be responsible for that Marine getting up and getting to his medical appointments, making sure he gets paid, making sure those family are taken care of. We do depend on you.

But when we get ready to transition that Marine through that process of care and coordination, handoff to the VA, another medical entity, we want to make sure that we have some medical oversight. And I think sometimes we

forget medical and think that --

COL BUHL: Paul, would you mind adding a comment to this for me?

MR. WILLIAMSON: No, I think those civilians are unfortunate not to have the Marine Corps overlooking them, in my opinion, but no, to your point, Captain Evans, in that medical environment, you're absolutely correct that the medical team is most competent to look after the medical care to ensure that handoff is accomplished.

The Marine Corps' point on this has just always been that, at the end of the day, when our corporate executive, the Commandant, wants to know how his employee, our Marine, is being cared for, he doesn't normally go to the medical community, he goes right here to the Wounded Warrior commander and says, what is the status of this Marine and his care?

Obviously, we then have to turn to the medical community to work in that multi-disciplinary environment to ensure that,

whatever is necessary for that Marine, and family, to receive, is being provided by the appropriate deliverer. But at the end of the day, the Marine Corps is holding accountable, this commander for the delivery of that care coordination.

COL BUHL: And I have a MEDCELL to do that, to advise me closely on that medical care, and I have the man next to you, Sean Keane, Lieutenant Colonel Keane, in our VA headquarters to ensure that that interface is occurring and occurring the way it's supposed to. And he intervenes in specific cases.

CO-CHAIR NATHAN: Okay. Thank you.

COL BUHL: Yes, sir.

CO-CHAIR NATHAN: Let's go to 16.

COL BUHL: The education of family, or caregiver, on post-separation benefits. I think, to a degree, I mean, we concur, and we're educating them every step of the way in the care continuum of their recovering warrior. So I

would, to a degree, rehash old ground from previous comments, but this is occurring as part of explaining all the benefits that our Marines are entitled to.

And we're not just explaining them, but we're actively engaging the family members to take advantage of everything that's available to them. One of my, you know, big talking points to our Recovering Warriors is, take advantage of all the resources you have here in the time that's available to you.

I attended a Semper Fi Odyssey Camp put on by Major General T.S. Jones (Retired) in Pennsylvania, and I listened to 32 Marines standup and describe, with very little prep time, the best thing that had occurred with them in their life in the last year.

And the thing that they were most disappointed in, and almost 25 percent of the respondents indicated that they had failed to take full advantage of the resources of the regiment. They stated that publicly. And I

took that back to the commanders and said, this is what I'm hearing out here from Marines at the backstretch of their preparing to return to society, so we have a real onus to push the information out.

CO-CHAIR NATHAN: Okay. 17.

COL BUHL: Paul, do you -- I think this is --

MR. WILLIAMSON: This issue is to ensure that the Marine who is departing through the Disability Evaluation System, or through any process that has exceptional family members who will be entitled to TRICARE benefits, understands that there's a change in what those benefits will be like once they are a retiree.

We will be working with our Marine and family division, which the Marine Corps Wounded Warrior Regiment is a part of now, to develop a fact sheet, much like many of these others, but the real brains behind delivering this information is, obviously, the TRICARE advisor there at the MTF level.

So we'll provide the tease to the Marine to advise them that the benefits will be changing, put them in touch with the TRICARE counselor, and ensure that they fully understand what that change in benefits will be.

CO-CHAIR NATHAN: Okay. 18, unify family and caregivers with wounded, ill, and injured Marines.

MR. WILLIAMSON: Right. The effort here is to try to bring those families together with the recovering Marines when they're in the IDES process and our objective here, and I think you heard earlier today from Mr. Powers on the Integrated Disability Evaluation System, and the improvements that are being made in that program, the Marine Corps has worked very close with the Bureau of Medicine and Surgery, and the Secretary of the Navy's PEB staff, to increase, or if you will, reduce the processing time that the Marines are in the IDES process.

I think Mr. Powers may have reported

to you that -- well, I will tell you now that, in June of '11, the time frame for a Marine to go through the MEB process, there were 610 who were exceeding the 100-day goal that was assigned to that particular phase. There are 66 Marines who are currently exceeding that phase timeline.

On the PEB side of the house, the processing goal there is a 120 days. They have been able to bring that down to an 86-day average across the system. That, too, is a part of the Marine Corps' intrusive leadership being very clear and pointing out what our expectations are in the process.

The Marine Corps doesn't own the MEB phase, we don't own the PEB phase, but we own the Marines, and we advocate very strongly for them. The overall processing time for Marines in the IDES process, the goal is 295 days total, the average Marine is taking 361 days, but when you look at where is that time being consumed? It's in the transition phase.

The transition phase is allotted 45 days. The Marine Corps could very quickly meet that objective, to the detriment of the Marine's transition, it simply could be stated, you have 45 days from the time you accept your findings to be in receipt of your DD-214. We choose not to do that.

These Marines have accumulated leave in excess of the 45 days, they are entitled to permissive TDY that will allow them to search for a job, and in the event that that Marine is set for separation in the middle of the school year, many of them will request the opportunity to remain on active duty until that child has completed the school year.

So any impact on that transition time to reduce it would be to the detriment of the Marine and the Commandant has chosen not to do that. So in that transition phase, which is a 112 days, once that Marine has accepted his PEB findings, he can be home awaiting orders until his actual separation date comes about.

CO-CHAIR NATHAN: Right. So again, what I hear is consistent with, sort of, the culture. The goal here is to keep, however it's done, Recovering Warrior and family together as much as possible.

MR. WILLIAMSON: Yes, sir.

CO-CHAIR NATHAN: Whereas, some of the other services tend to look at a way to bring the family to the Recovering Warrior. The Marines, based on their unit and integrity, want to make the separation as short as possible, logistically, as short as possible, so the Marine can get back to family.

MR. WILLIAMSON: Yes, sir.

CO-CHAIR NATHAN: Either one is okay as long as we don't try to -- if we have a Marine who's bogged down for a long, long time somewhere, we don't keep saying, the goal is to get the Marine back to the family. At some point, we stop cutting bait and we fish, and we get the family to the Marine.

MR. WILLIAMSON: Absolutely,

Admiral.

CO-CHAIR NATHAN: Okay. Right, now I understand that.

MEMBER TURNER: Once, real quickly, you had mentioned some of the Marine-specific metrics that you follow. Could you comment a little further about the Marine-specific metrics that you follow, who they are reported to in the Marine chain of command, and how they are used?

MR. WILLIAMSON: Right. Well, the Deputy Commandant of Manpower and Reserve Affairs, who we report through the Marine and Family Division, he is the recipient of the information. He actually had knee-to-knee sessions with Admiral Niemyer, who works with the Bureau of Medicine and Surgery on Warrior Care policy, the regimental staff is engaged with a number of different working groups that are monitoring these various programs.

So what is the outcome of the delivery of those metrics to the Deputy

Commandant for Manpower and Reserve Affairs? He has ensured that the Physical Evaluation Board, every Marine unit has a table of organization or a structure, but very few actually are manned to that specific number.

In the case of the PEB, the Commandant for Manpower and Reserve Affairs said, they're going to get a 100 percent, plus he assigned additional five overstaff Marines to that staff for specific administration of cases, and put into the field, five additional senior NCOs to be disability counselors at those high concentration points where our Marines would be receiving their results from the PEB.

CO-CHAIR NATHAN: Okay. Thank you. Let's go to Recommendation 20.

COL BUHL: Yes, sir. Recommendation 20, to specify a Recovering Warrior program relationships with Marine Corps Community Services, MCCS, and family assistance facilities. Yes, we, as Mr. Williamson just mentioned, where we fall in the Marine's and

family's division in Manpower and Reserve Affairs, so we're a part of that, and a big part of it.

And we're working very closely with MCCS to ensure that we are integrated in terms of supporting our families at our bases. A couple of notes, there is a policy in the works right now, that will be published soon, regarding this, but basically, every MCCS office across the fleet will be queued to support wounded, ill, and injured.

I really, truly believe looking at all of you, that they are now, already, but we're going to formalize the policy and have it published so it is, indeed, an order. We're fielding a pilot, our life skills, MCCS life skills section, with our family readiness officer, Ms. Shandra Hardy; it's called Scared of the Call.

And basically, it walks families through the initial steps should they learn that something has happened to their loved ones in

terms of an accident, an injury, sickness, et cetera. So that's being piloted in Camp Pendleton. Our hope and care centers, one-stop shops.

If you've seen those firsthand, you know that it's counseling, it's rehabilitation, it's family-friendly, family readiness officers are stationed in there, those are great facilities, and that's where our families can go immediately to get assistance.

And as I just said, my boss, immediate boss, is Brigadier General, Major General-select, Hedelund, and he is the Director of Marines and Families Division for our Commandant.

MS. DAILEY: Sir, we appreciate you formally putting that in there. We believe your MCCSs are supporting your troops, but it becomes a lesson learned the next time this gears up where people have forgotten it over time and now you have it in policy, and it becomes a part of the --

COL BUHL: Yes, ma'am.

MS. DAILEY: We know it's a part of the culture. We really appreciate you making it a part of the literature.

COL BUHL: Thank you, ma'am. And as I've served a few years in the Marine Corps, I realized that the higher up the chain of command, the more time it appears to take, sometimes, to get these policies published, but I have assurance from my general officer in charge that we will have this done soon.

MS. DAILEY: And your staff will send that to us, right? When the policy is done. Yes. Thank you.

CO-CHAIR NATHAN: Okay. Thank you. Recommendation 34.

COL BUHL: Okay. Paul, do you want to do the legal average?

MS. DAILEY: And also, if you need a little extra push, we love putting that in recommendations, waiting on policy to be published, just in case it falls off their radar.

We're out of here in 2014.

MR. WILLIAMSON: This recommendation was to provide legal outreach to the wounded, ill, and injured Marines who are referred into the disability evaluation system process. As I pointed out earlier, the Marine Corps' involvement in the IDES process is pretty extensive. In our initial roll into this IDES, we put out an information booklet for Marines to help them understand what the different roles and responsibilities of the various actors within the IDES process were there for.

And one of those key features was the access to legal assistance. And that booklet provides them with the number where they can call for assistance. What we've done since that booklet was publicized is, we've been working with the JL staff to ensure that they know, by installation, where Marines are being referred into the IDES process so that initial contact can occur.

Now, it's on the individual counsel

to go, then, to the patient administration office, knowing the name of the Marine being referred, and knowing the name of the PEBLO, how do we contact that Marine to ensure that they've been provided the legal advice and counsel they need.

In addition to that legal advice, we also apprise that Marine of his opportunity to request an independent medical review of their case prior to it being sent off to the PEB for adjudication. So JL is very committed to ensuring that those Marines, at the earliest opportunity, have that legal advice available to them.

CO-CHAIR NATHAN: Thank you. Under the genre of Marines who chose to either leave through disability evaluation system or stay, this is more of just a general interest, and maybe a personal interest, I don't know the answer to this, although, I should. The Commandant tells every Marine who's been wounded, regardless of severity, if you want to

remain a Marine, you can remain a Marine.

We'll find a job for you in the Corps; somewhere. No matter how severely wounded you are, you can stay a Marine. Do you know, roughly, after one, or two, or three years, what percentage of Marines take him up on that?

COL BUHL: Admiral, we've had 32 Marines successfully do the EPLD Program. I cannot tell you what the percentage is. It must be very, very low. Do you want to add, Paul?

MR. WILLIAMSON: If you just look at the actual number of Marines who go through the disability evaluation system in a year, that's right around 2000 Marines who go through. And I think the longest Marine we've had in the EPLD Program has been in since 2007. You know, typically, those Marines will request to remain in the EPLD, be approved for it, within a year or two, some of them make the decision themselves that, I've demonstrated that I have the ability to do this, I don't want to do it anymore, so they'll opt to exercise their disability rating

and separate from the Marine Corps.

But again, as the Colonel said, 32 is what the current population is.

CO-CHAIR NATHAN: And you've got 260? 260 in the Army. Okay. And as you would expect, my point of intersection through my time has been at the bedside after acute injury. And almost every Marine, at that time says, sir, I'm going to take you up on it. And then they see the educational programs, they see the disability system, they see what, sometimes, the private sector is offering towards employment, and they think about it later on.

But I think it's an amazing thing that the Commandant and the Chief of Staff of the Army do, to be able to go to the bedside of a critically-wounded soldier or Marine, who's either lost a leg or more than one limb, or suffered a debilitating head injury, and basically say, if you want to stay in the organization, if you want to keep wearing the uniform, I'll find you a spot.

COL BUHL: Yes, sir.

CO-CHAIR NATHAN: And I think that's a real testament to the ethos of the organization. Any other questions on 34?

MEMBER CONSTANTINE: I have one along the lines of what we were just talking about here, sir, and I just heard this the other day, and I think it's a BUMED issue, but relates to Marines who are, and I may not have all the facts right, but Marines who, and probably soldiers too, who are at Walter Reed-Bethesda, and I think it's the EPLD Program, where typically they would stay there a year or a year and a half for their recovery, but now are, after a matter of months, I think it's six months, are being pushed out to the VA and told to recover there.

Is that accurate from what --

COL BUHL: Of course, every Marine's case, or sailor, is going to be that individual case, case-by-case unique circumstances, everything else, but I can look

you in the eyes and say, we're not pushing anybody out. And Paul described the extra time we take for the transition piece. We've now, with the tension, really brought the phases of the IDES down with resources and command attention.

We can move people through the process there quickly, but it isn't a process. It's a relationship. And we're going to carefully -- at a certain point, it just simply may be time for that service member to transition and we have to, you know, educate that, because, of course, there's a lot of trepidation out there, especially after severe trauma, an injury, et cetera.

But no, we're not pushing anybody out and I err to the side of -- I recently extended a First Sergeant, first 30 days, and then 90 days, and we got him into, he's in Texas in resident inpatient alcohol counseling, because we just weren't quite sure he was really ready, and before we -- and yes, so that's where

we err to.

CO-CHAIR NATHAN: And I'll add to that, Justin --

COL BUHL: Keep faith.

CO-CHAIR NATHAN: -- you know, since you made it specifically about Walter Reed, there is a couple of reasons, one is, not only the VA, but sometimes when we decide we're going to send somebody to the CFI in San Antonio because their family is back in that area, or San Diego, and all they know is that Walter Reed must be the end-all, be-all and why would I ever want to leave it?

And we've actually created marketing videos to show the CFI in San Antonio and what they do, and San Diego, and then they're much more comfortable, and the family is much more comfortable, but to the Colonel's point, it's hard to leave the nest sometimes. You're critically injured and you're immersed in this cocoon of care with a plethora of nurses, physical therapists, liaison personnel who are

really just supporting your every wish, and you get to the point where the care team says, he or she is not going to advance unless we make them, sort of, have to do a little more on their own.

They're ready for the next level of care. And sometimes that comes back anecdotally to the Congressman, or to the Commandant, or the hospital commander as, they're kicking me out, they need the bed, whatever, I said something and the nurses didn't like me, and that's just, as a rule, not true.

And now, especially, given the drawdown in the fighting season, the numbers, they're still much too high for anybody's liking, but they're much lower than they have been traditionally, and they have plenty of room at the inn, and it shouldn't be a problem.

COL BUHL: Yes, sir. Exactly. Earlier in my tenure, we were approached, we had a number of months where we were in danger of near capacity issues and that would affect our regulation and where we sent people, but we're

in a good place right now in the sense that we can -- where there's no pressure on this command to move people through the transition phase any faster than we need to.

CO-CHAIR NATHAN: Okay. Let's go to the last recommendation; 35.

COL BUHL: We concur here and we have a MARADMIN that requires the DS Logon so that Marine gets the information he needs for his VA care and benefits. It's a part of our transition readiness seminar, which has been recently revamped, re-energized, and improved. And as I mentioned to Lieutenant Colonel Sean Keane at VA headquarters, we recently hosted Sean's entire command staff down to present the Wounded Warrior Regiment brief.

We have John Smart in our headquarters from the VA. We're fully integrated and we fully concur. We're going to have our Marines approximately, and sailors, two years or so. A few, with special needs, will remain for longer periods, but the VA will have

them for the rest of their natural lives; and their family's.

MEMBER TURNER: Just a quick question. On your last bullet it says, MARADMIN 592/11 negates this requirement. What does --

COL BUHL: We used to teach that at PME schools, this, but now, because we have a mandatory -- every Marine now registers, so we felt that it no longer was a required curriculum in the formal schools because everyone has to do it now, that we didn't have to, that it need not be in the formal school requirements.

MEMBER KEANE: Admiral, another thing to add is that the regiment, pending a join of an FRC co-located, much like the Navy Safe Harbor, FRC will be co-located at the regiment headquarters.

COL BUHL: We're looking forward to that.

CO-CHAIR NATHAN: Any other questions, comments? Okay. Thank you very much for your time, Colonel. We appreciate it

very much, and Mr. Williamson as well.

MS. DAILEY: We'll do a break and come back for the survey at 3:00, please.

(Whereupon, the foregoing matter went off the record at 2:44 p.m. and went back on the record at 3:02 p.m.)

CO-CHAIR CROCKETT-JONES: We now welcome Ms. Erica Flores, a research analyst with the Wounded Warrior Regiment's Future Initiatives and Transformation Team, who will brief us on their survey program. In February 2012, the Marine Corps provided information to the task force regarding their survey and we look forward to hearing updates to that information.

The presentation can be found under Tab M and I'm going to turn it over to you all.

COL BUHL: I have just a couple of front end remarks before Erica speaks, Ms. Flores, and one is, if I can get the, who's armed with -- ah, there we go. Oh, thank you, sir. Thank you very much. I want to stay with the procedures here. Okay. We began surveys in

2009 and have run them continuously since that time.

As you can read there, they're producing reliable data for us, actionable data, to improve what we're doing. We are certain that we're getting better because of the surveys we're conducting. I have a list of things on here. Our care coordination consistently improved the evolution of our RCC program since its inception. I said that. I believe the RCC program, really, to be the glue of the Wounded Warrior Regiment.

I believe that now. Eight months of close observation and I believe that you identified this as a best practice; greeting families at Walter Reed, for example. IDES advocacy, megalink IT solution, IDES handbook for the RCCs, for Marines, and really, family-specific information on IDES status and management of expectations.

Warm handoffs to the VA. RCC coordination with members of that Marine's VA

recovery team to ensure enrollment in his benefits, schedule for payment, et cetera. We talked about our embedded staff at VA headquarters and VA reps in our headquarters, with increases expected.

RCCs with various types of expertise, inpatient, outpatient, reserve, terminally ill, et cetera. We have 49 RCCs and they are extraordinarily skilled and we can reach out across the regiment for specific skillsets and experiences. Our DISCs, voc rehab, Wounded Warrior staff, as I just mentioned, at VA headquarters, OEF, OAF coordinators. Our FRC embeds, that's coming, at the Wounded Warrior headquarters.

Command inspection program. When I came aboard, we did have a command inspector. I dedicated a Lieutenant Colonel, specifically, with a retired Master Gunnery Sergeant to energize this program, and they have systematically gone to every detachment in the regiment, no notice, and they normally spend

two, three days, more at a battalion headquarters, and the feedback is provided immediately.

Yes, it's a train and assist emphasis, not catch you doing things wrong. They're out there to get us better, but it's the first time we've had, really, some teeth in the program, I think. And it's just something, not that my predecessor failed to do, it's an evolution, just as I talk about the surveys here, of us getting better at what we do; never good enough.

We've talked about it here already, the importance of consistent communication to all audiences; staff, wounded, ill, and injured, their families, the caregivers, the non-profits in support, and the social media initiatives that we've had, I think, have gone a long way to help us with that.

Enhanced transition to support, and if I had to identify an area that I think we need the most continued emphasis, it's in that

transition support piece. I think that we have the acute care and the rehabilitation. I think we understand it now, the numbers, thank God, at this time, are in the realm of something that we can manage. It's the transition piece that becomes the emphasis.

Are we doing enough to set our Recovering Warriors and their families on a positive tangent, to the VA and beyond, for a full life, whether they're, you know, returning to some form of education, they're learning a trade, et cetera.

So the 90-day Post-Service Support Program that's in place to provide additional support, more than 850 of our recovering Marines have received that support in that over the past two years. And I've talked about a number of times already, the FRCs, the DISCs, our non-medical case managers, or care coordinators rather, and our call center.

So those are a few things that I wanted to highlight. Survey methodology, I

think Ms. Flores is going to bring out some detail for you there. Erica, could I ask you --

MS. FLORES: Yes, sir. Can you go to the next slide, please? Good afternoon, everyone. With regards to the questions that you asked on this slide, the next few slides, we have all of that information outlined in a table, and before I ask if you have any questions on that, I just wanted to address the question here on the bottom of the slide where you asked if we, in any way, assessed whether the respondents or non-respondents differed on our efforts.

The only surveys that we looked at that was on the care coordination surveys, which were the efforts that we just conducted in January. And the only place, or the only area, where we saw any difference was in a variance in location, and we actually just saw an over-representation of Battalion West for our section leader survey.

In all other areas, the respondents and non-respondents, we didn't see any

difference. Do you have any further questions on that? No? Okay. We'll go to the next slide, please. And I'll address any questions you have if you want to -- I'm not sure if you've had a chance to look over these, but if you have any questions with regards to what we've put in the table to answer these questions, I can definitely do that.

MEMBER CONSTANTINE: Erica, when it says, web-based, did you send an email to everyone asking them to come do it or did they come on their own to Facebook or Web site?

MS. FLORES: The web-base survey instrument that we use is actually a software that's just utilized through the web. So an email is sent to individuals that have been selected to take the survey and within the survey is embedded a link. And so they just click on the link and that takes them to the actual instrument.

Everything is collected online; it's a great tool that we have found to be very

useful. When we utilize an email invitation like that, it allows us to track those individuals as well, which then allows us to follow-up with anyone that has not responded, which we've found increases our response rate.

MEMBER CONSTANTINE: Thanks.

MS. FLORES: All right, sir. Next slide, please, and the next one. So with the question asked on if we have modified any of our survey methodologies this year based on our past year's experience. We utilized several different methodologies, paper and pencil where need be, we'll utilized a web-based instrument, we'll also utilize our call center for our rapid action polls, so our methodologies differ from survey effort to survey effort.

However, we did modify the care coordination survey this year. Last year, we looked at it from a more holistic approach too; we went out to our respondents and asked them about all of the care coordination elements. So we asked them about their RCC, we asked them

about their section leader, we asked about their interaction with the call center or the contact center, and it was a very lengthy instrument, but we wanted to look at it from a holistic approach.

And what we found is that, we thought we would probably get a better response rate if we segmented those populations and only focus the instrument on that one particular population. So an individual that had a section leader this year, only received the section leader survey, an RCC, so on and so forth, knowing that the section leader and RCC populations do cross.

That's why we chose to do a sample this year rather than a census method for those, so that's the only methodology that we really changed. And we did, in fact, see an increased response rate with that survey this year and we plan to utilize that same methodology as we go forward.

To address the second question, just as I mentioned, we utilized several different

methodologies. We learned from our best practices and from the mistakes that we find within those survey efforts, and always are trying to make them better as we go forward.

The one methodology that we do like to use most often is our rapid action polls, which we utilize the call center. It not only allows us to capture our quantitative data through the survey, but it also allows us to conduct outreach.

So if an individual, at that time the survey is being taken, says that they have a problem or an issue with, maybe, a resource that they haven't been provided, that call center representative can immediately turn in that survey and being to assist, and help that individual with the need that they have. So that's the methodology that we try to use most often.

MEMBER REHBEIN: If I may for just a second, do you find that the length of that survey instrument affects the response rate?

If you got, like, six questions, do you get a better response rate than if you got 20?

MS. FLORES: So for the rapid action polls, we typically tried to keep those down to ten questions and we also utilize our web-based survey, which has skip logic in it, so if they answer no, then they're not going to get the proceeding questions if they would have answered yes.

We have not seen with our web-based surveys, based on the number of questions, the response rate lower or raise based on the number of questions, but we do try and keep those rapid action polls to a minimum.

MR. WILLIAMSON: We are sensitive to the fact that these individuals could be surveyed till they're exhausted, so what we try to do is utilize the rapid action poll to go after something that may have been identified as an issue in a larger, broader survey. One of the things that we used it for, specifically, was to address our transition assistance side of the

house with, so what kind of employment opportunities are these Marines interested in?

That rapid action poll told us, as you might expect, many of them are looking for a trigger-pulling opportunities, security force, police, those kind of things. That allowed us then to engage with those industries that had those kinds of opportunities for them, so again, anything that we think we can immediately act on.

And as Erica said, in the conduct of that employment survey, you know, the tail end part of that survey was, do you need some specific help? Well, yes, I do. Okay. Well, let's refer you over to our transition cell. They'll be contacting you. So the Marine starts to appreciate that they're not just bothering me for information, they're actually doing something with that information.

MS. FLORES: All right, sir. Next slide, please. With regards to this question, how effective are our programs? Well, to date,

we've measured the effectiveness of support that we provide to wounded, ill, and injured Marines, and monitored all of their satisfaction levels through various research efforts.

And as Colonel Buhl mentioned in his opening remarks, our trend data is showing that our satisfaction levels are either retaining or they're improving. For example, our overall satisfaction with the regiment increased by 5 percent this year from last year; going from an 84 percent satisfaction rate to an 89 percent satisfaction rate.

And additionally, we also assessed overall satisfaction with how Marines feel that the care coordination elements are coordinating with each other, and we saw an increase in this area as well, by 4 percent; going from 81 percent to 85 percent, so we are seeing improvement in those areas through our research efforts.

MEMBER CONSTANTINE: Also, Erica, how did you know who to send the emails to to survey for this?

MS. FLORES: So for the care coordination survey, which is our most robust survey, we looked at our joins populations, so those that are joined to us and those who are TAD to us at the time of the survey. And about, at that time, I think the population was, roughly, around 800 is what we were looking at. So we just did a sample of that population and, like I said before, we know that that population has RCCs as well, but we know that that population, the RCC population, also has those that are being supported.

So we utilized RCPSS to get a list of all individuals that currently had an RCC, knowing that that was inclusive of our joined population and then those that were being supported. Did a sample of that, we gained email addresses, RCPSS has email addresses within it, and then from there, we're able to populate that into our web-based instrument and shoot out the email.

MEMBER CONSTANTINE: Thanks.

MS. FLORES: Next slide. Sir, this back over to you.

COL BUHL: Three most encouraging results: staff and the staff sitting at the table in front of you could be doing other things with their lives. They're all highly-skilled, very talented people. They choose to serve with the Wounded Warrior Regiment. From the TSGLI clerk to me, there is a sense that there is no more blessed duty than serving in the Marine Corps' Wounded Warrior Regiment.

And I had coaches that I just left, we had a coaches' dinner last night, for the Warrior Trials, the Marine Trials, and many of these coaches came, they came from all over the country, they took their personal vacation to do this for our Marines and sailors out there, and international competitors as well.

That's the theme and you can read some of the comments there. And as I was mentioning just a moment ago, Marines know, they know, if it's sincere, they know, and it is.

Transition is an encouraging result. I'm here to tell you, I'm not satisfied with it; by any means. I think we can do a lot more. We're doing great things, Marines are very happy, yes, they Wounded Warrior Regiments transition cell, and cells at the battalions, it's a Super TAP, TAMP. It's a Super TSR.

It's nothing like the home -- if only every Marine could have it. Extraordinary resources and so many people with a bias to help us, to advocate and help us, and find opportunities for us. In fact, one of the hardest things is managing all the inputs of offers, but I know we can get better.

Camaraderie and focus on recovery. Wounded Warriors in the task force know that when you are recovering with peers who have experienced something similar to you, and your situation, that there's a special connection and bond, and as the one quote says, we are the mission, and we tell them that, because they are.

So those are some of the positives

that we're coming out with. We have a command, it's a regiment and battalions, and that's a powerful thing. Some of the top issues and concerns, well, it has come up thematically through the course of the entire briefing today: communications. We just can't be good enough at it and I think this is internal as well as external.

It's as the Admiral suggested, maintaining that sea of goodwill as the wars draw down and we want to keep the public engaged supporting us, as they do in so many ways, and not just forget. And it's the years to come that I worry the most about, but it's internal as well.

And we can't educate our families and our Marines and sailors enough on what's available to them, and how they can best integrate it and use it, leverage it, in their recovery. And we're doing a lot more in terms of the electronic media that I talked to. We talk to every commander's course and senior

staff non-commissioned officer's seminar.

We have roadshow briefs that go around to various commands on call. We tell commanders, we'll come to you, we'll educate your officers, your staff NCOs, and we bring Wounded Warriors to these commands to participate in the seminars; discussions.

School of Infantry West, remarkable program of that where our Marines are coming down and teaching the combat instructors down there what to expect.

MEMBER MALEBRANCHE: Colonel, excuse me.

COL BUHL: Yes.

MEMBER MALEBRANCHE: When you mentioned you go out and do these briefings for the command, do you bring VA folks when you do this?

COL BUHL: We do, but I would have to -- we don't have that many VA reps to be assigned to briefing teams, so I can't -- Paul, can you help me with that?

MR. WILLIAMSON: No, it's not a regular feature, but it's certainly a good idea to do that. Now, it depends on what specifically you're talking about, because when we have our transition briefs for our Marines who are going through the IDES process, there always is a VA representative there. You're aware that there's this big effort between DoD and VA to put the voc rehab counselors in bed with the -- I'm sorry, embed them in the bases where Marines are going through the IDES process, but there's also an effort to put vocation counselors -- I'm sorry, VA counselors at bases and stations across the country.

I'm not as aware of that effort as I am the voc rehab effort though.

MEMBER MALEBRANCHE: Okay. I just wondered. I know I had briefed once in California at the, It's been a while, because it was with the medical management group, and there were, I think, about 50, it was a huge number of Marine Corps officers, mostly physicians, that

were assisting, so I'm just wondering if they had a course out there.

But the other thing, just because I didn't see it anywhere, written here again, and I see percentages, what was the total number on your survey again?

MS. FLORES: Any one in particular?

MEMBER MALEBRANCHE: No, I mean, you're listing percentages in your tables.

MS. FLORES: Yes.

MEMBER MALEBRANCHE: What was the total number of respondents to your survey?

MS. DAILEY: Your most recent care coordination survey, please.

MS. FLORES: Okay. So the section leader survey, 158 individuals responded out of 256. For the RCC survey, a 199 out of 384. For the call center, 108 out of 858. And then for the contact centers, it was 172 out of 1236.

COL BUHL: I just had a discussion with our Marine for Life representatives last week and we agreed that a VA rep would be very

important as part of our road show panel to come and talk to all of their -- they have a two-week annual training because they're mobilized reservists, and one of the points was to make sure that we have a VA rep present as part of that panel, so Mr. Smart would be attending it.

And I know we have a VA rep going to our DISC training out in Camp Pendleton the second week of March, but it's a good pointer that you bring up on that question.

MEMBER MALEBRANCHE: Well, thank you. I was going to offer, if you couldn't find someone, I'll find you someone.

COL BUHL: I might take you up and I'm looking over to the right to that Lieutenant Colonel over there that I love. Staffing --

MEMBER REHBEIN: Colonel, before you leave communication, if you would, return to Twentynine Palms for a minute.

COL BUHL: Yes, sir.

MEMBER REHBEIN: I see some of your plans to address include face-to-face meetings,

the town halls.

COL BUHL: Yes.

MEMBER REHBEIN: How do you plan to extend that capability to Twentynine Palms?

COL BUHL: They have, in fact, held town halls already. Colonel Wright has held a number of them out at Twentynine Palms. He told me that he was having weekly gatherings, initially, to get his feet on the ground with all the families there. I mean, it's a fairly small group, but he had everybody together and he used a couple of forums where a meal was provided to everybody by a local non-profit supporter.

They would all gather and then he'd use the opportunity to talk to them all and, literally, hold a town hall.

MEMBER REHBEIN: So you're able to continue that capability out there too.

COL BUHL: Absolutely.

MEMBER REHBEIN: That's good to hear. Thank you.

COL BUHL: And again, I assigned a

top quality officer to energize the program there; make sure we're taking care of them. In terms of staffing, we have, with -- the regiment has staffed itself 84 percent of the uniformed members of the Wounded Warrior Regiment are mobilized reservists, paid for by contingency operational funding in support of the war effort.

As I think everyone knows at the table, that funding is going away steadily. It's being halved each fiscal year and so there was some great concern in terms of competition for limited resources within the Marine Corps and the results, initially, were that some of our staffing levels slipped as we waited confirmation that the funding would indeed be there.

A recent decision by the Deputy Commandant for Manpower and Reserve Affairs confirmed the Commandant's intent that we do receive the full funding, not only for the remainder of this fiscal year, but for next year

as well. The Deputy Commandant and General Amos both said they will not accept risk with the Wounded Warrior Regiment and our Wounded Warrior programs.

So we have, indeed, had some under-staffing and we've experienced it, in fact, recently. We desire a 1:10 section leader to Recovering Warrior ratio and in a couple of our detachments, locations, it was as high as 1:17, 1:18, but we're fixing that immediately. And I am positive reporting to you that the money has been released and we're addressing that.

And of course, we're using the surveys to get a sense of that from the family members and the Recovering Warriors. Sustainability of our capacity. Our capability, really. Our Commandant has said that he cannot imagine not having the capability of the Wounded Warrior Regiment in the future.

Never before have we, under one headquarters, combined all these resources, this expertise, with a single sole focus on

taking care of our wounded, ill, and injured. 44 percent of our current 804 patient population, Recovering Warrior population, are non-combat related.

This is an enduring requirement. These are people who are sick with cancer and other illnesses. These are people who are in car accidents, who fall off ladders, you name it, and so we're going to need this. And we're not going away. And that's what General Amos has said and that's what we tell -- because that is the most common question I get as the commanding officer of the regiment; are you going away now that the war is over?

And if that were simply the case, realizing that the average stay is two years in the command as people heal, if the shooting stopped today, we would need the current capabilities that we have for a minimum of two more years, but this is an enduring requirement for the Marine Corps. This is our Commandant's message, so I will continue to, of course, advise

my leadership what our needs are, and I have done that.

We're going to tell the world what I'm telling you, I am telling them every chance we get, and that final bullet on the right, my sense is that it will be around for a long time.

MS. FLORES: Next slide.

MS. DAILEY: Sir, I would like to highlight your top three concerns and plans to address. Your top two for sure, sir, we see when we go out to the field, and they're pernicious issues, trying to create better communications and your service members feeling the staff is overwhelmed.

So we kind of look to you because we had seen your fliers, we had hoped that was a good tool, we had hoped that the apps would also be penetrating and would be easing some of that as a top concern. More frequent communication, more emails, benefits information, any other ideas? We thought you tapped out the comm piece.

COL BUHL: Well, I think there is no substitute, frankly, for the interpersonal human-to-human communication. You know, it starts one family at a time, but those town halls, as I said, are effective. I think that they are. And when they're conducted in such a way that the participants feel relaxed and able to communicate, at a minimum, the command can transmit its messaging out to the families.

But a lot of it is done on that individual caregiver level and it happens in every aspect from section leader to RCC, to, as I said, Chaplain, to FRO, and it happens with people that are supporting us, who, people will reach out to and talk to. So in a lot of words here, I think the stepped up interpersonal communication is the answer.

And when I looked over these notes as we prepared to come to speak with you, it caused me to, in fact, focus and reflect on what you were seeing, not just what the surveys tell us, but what you're seeing and providing

feedback to me, and in turn, I took this back to the commanders because, at the end of the day, I'm speaking for them too, up here, and I think this bullet will be here again next year.

I don't want it to be, but I'm highly aware of it and I'm energized to try to take the bullet off the screen because, you know, we have to talk to people. And everywhere I go, I gather them together and talk, and I expect my subordinate commanders to do the same thing.

MR. WILLIAMSON: If I might add to that Colonel, Denise, that's the basis for creation of all those fact sheets. You know, we constantly have to refute misinformation. You know, I mean, I'm a young Marine who's receiving something, I'm going to tell this Marine about it, this Marine may not qualify for that, so the fact sheets are there to -- behind the fact sheets are more expanded information that our section leaders and our recovery care coordinators have to work with.

But still, it's difficult to ensure

that, when that individual needs the information, and is ready to receive it, that we have a vehicle to deliver it. That's the hope behind those fact sheets that they will consistently deliver what the commander is saying on this particular topic and whether it's a recovery care coordinator, a section leader, or anyone in the organization, they can point to that document and say, this is what it says. This is where it's at.

But it's that constant drumbeat of reminding those Marines and their family members, again, many of them have no military culture background to understand-- things. So it's just, okay, when you need to know this information, the app is there. If you can't find it there, come back to me, the recovery care coordinator, call the call center, but as the Colonel said, this may be a topic that's there next year, but it won't be because we're not trying to take it off the sheet.

COL BUHL: Yes. And those apps,

younger people, particularly, some of us older folks as well, but they really rely on those and I love to hold the big handbook up and tell them that this is all here right on your little telephone. Just dial this up and download this app, and you can see it, and it's very easy to use.

Now, our Web site recently revamped. I'm putting focus and attention on it, personal commander's focus. It's the right thing to do.

MS. DAILEY: And also, too, we hear, too, not only for you guys, but for the perception among the service member that the staff is overwhelmed, and that is ubiquitous.

COL BUHL: I've been in the Marine Corps for 31 years, this is, easily, the most complicated, difficult billet I have ever held, and I have commanded units in combat. I had an infantry battalion in combat. I've been a regimental commander. My legal report when I joined the Wounded Warrior Regiment was multiples of my entire two-year command

experience at the 5th Marine Regiment, and during that time, every one of my battalions went to and from Afghanistan, to include two to Sangin, 3/5 and 1/5, with very heavy casualties.

I have never been so challenged, so yes, ma'am. I'd agree. It's complicated. It's caregiving. It is the most sensitive, complicated, unique, difficult, engaging, rewarding duty one could ever have. And I'm trying to master it and it's challenging me. So yes, ma'am. I think so. But we're getting better and we've never been this good and we're getting better.

MR. WILLIAMSON: There are ratios that are assigned for the recovering care coordinators. It's intended to be 40:1. We're operating at about 28:1. The Marine Corps generously provided the Colonel with section leaders at a 10:1 ratio at the detachment levels. As he stated before, we didn't have that two years ago. We didn't have it fully in place a year ago.

So as time goes on, the resources are coming to meet the demand.

COL BUHL: We had a recent Force Optimization Review Group, FORG, where a large group of seasoned Colonels assessed the needs of the Marine Corps in the outyears, and the Wounded Warrior Regiment faired very favorably there. Permanent structure was identified for us, beginning fiscal year '17.

Our big challenge is to bridge the gap to the baseline funding between now and then with the OCO money disappearing. So airing some laundry here in terms of manpower to you, but our leadership has said, begin to do that now, so it's happening. Reassuring, to me, and all of us. Next slide, Erica.

MS. FLORES: Which I think the staffing conversation is a good segue into what we're going to present on this slide as far as satisfaction levels with our RCCs and our section leaders. Overall, respondents are very satisfied with their section leaders, and their

RCCs. 92 percent of respondents this year said that they were either satisfied or very satisfied with their current section leader, and 96 percent of respondents said they're very satisfied or satisfied with their RCC. That's very high.

And not only in overall satisfaction, but we also asked respondents with regards to specific attributes that either the section leader or the RCC had, and it was on a 1:4 scale, and for the section leaders, it was very favorable. Their attributes were at a 3.5. For the RCCs, it was at a 3.6. So attributes were ranked very high as well.

Some of those attributes include things like addressing transition challenges, anticipating needs, resolving problems promptly, things of that nature, so the attributes were rated very high as well.

With regards to the transition services, we don't have that data yet. That will be available. That survey is currently

being administered right now. Are there any other questions?

CO-CHAIR NATHAN: Anymore questions? Colonel, any closing comments?

COL BUHL: No, as I said, Admiral, ladies and gentlemen, I thank you for the work that you are doing for all of us, particularly for our wounded, ill, and injured, and their families. And I look forward to continuing to serve with each of you in any capacity. And the Wounded Warrior Regiment stands ready to assist you in any way, and I thank you for the opportunity and the honor to have spoken with you today.

And on behalf of my staff, thank you.

CO-CHAIR NATHAN: Thank you, Colonel, and an appreciation to your staff as well, who have come. You articulated some of the challenges well. Nowhere in history have we had combat for this duration or this period of time. We've migrated through, sort of, a bimodal distribution of wounded, ill, and

injured in the early part of the way, in the more Iraq-centric places.

We saw huge numbers of people coming back with, more or less, single-limb injuries or gunshot injuries, and the occasional injury from explosives while riding in vehicles. And those swamped us in numbers, but not in acuity. Battle of Fallujah being an example. Suzanne and I were talking about this.

And then we migrated from those kinds of injuries to a dismounted mission in Afghanistan which became more Marine-centric at that time, and resulted in people being catastrophically injured from explosives while on foot. And so we saw the advent of not as many patients coming to us from the Battle of Fallujah, but the patients who were coming to us were requiring massive amounts of acute care for multiple amputations; gunshot wounds, and closed-head injuries; TBI.

And then you intersect that with the fact that, in this war, people get back from the

battlefield, from a severe injury, on the average of three to five days, whereas, in previous conflicts, Vietnam and World War II, it was anywhere between 45 to 60 days, giving the family the time to adjust and reconcile themselves, and so we're hit with that.

At the same time that we have the highest population of service men and women in history that have families, prior; no other conflict has had such a degree of our soldiers and Marines being married with kids. And so that's a whole new paradigm, along with the fact that we know more now than we ever did in Vietnam, or World War II, or Korea, about TBI, about post-traumatic stress, about the consequences of them if left untreated.

And the technology has allowed us to have people come back from the battlefield with severe injuries that never returned before. And so all those things which are somewhat goodness, create a very compounding and confounding care paradigm, you season that with

something that becomes, sort of, an explosive issue like Walter Reed in 2007, which now, sort of, clears the Congressional bench and clears the press bench, and all those players empty on to the field to look at what we're doing, so your care is under a microscope.

So you're worried at any minute, if there's an adverse, either real or not real, issue, is it going to occupy your entire day because it gains Congressional or press interest? And so we worry about care for the caregiver at that time. So you've articulated that well.

This is a very challenging job because people's welfare, and lives, and families hang in the balance as they come back, and we've made a covenant with each and every person, and their family, that we'll take the care that's required and necessary to give them as good a chance for recovering their life back as possible.

So again, challenging, and what

we've heard, I think, today, in concert with what you've said is that, overall, based on site visits in general. We're seeing improvements. We're seeing some reconciliations of some of the issues. We're seeing some of the staffing issues get better. We're putting out some of the obvious things that happened over the last few years, and that is good, and that's allowing us to concentrate on some of the things which are a little more subtle and nuanced as we march towards perfection.

And we recognize that, again, this is a journey, not a destination. This will require a lot of work. And we hope that not only given the fact that we're in, somewhat, of the lull of the winter season of fighting, that drawdown and our strategic initiatives, and our strategic victories, are, we've seen, hopefully for a while, the end of these large boluses of injuries that, basically, perpetuated backlogs in the IDES system, and backlogs in the care system, in the rehabilitation system, and in the

VA system.

And now we're on to the next frontier, which is, potentially, a drawdown of 20,000 Marines over the next five to ten years, 80,000 soldiers over the next five to ten years. What will that mean to the VA system? What will that mean to the disability system? What will that mean to the mental health system? What will that mean to the DoD system?

And so, hopefully, we've learned things here that we can put into place. So again, thank you for your time, thank you for your service, and thank you to the committee which met.

COL BUHL: Thank you, Admiral. Thank you, all.

MS. DAILEY: That wraps it for us. Thank you very much, Mr. Williamson, Colonel Buhl, Ms. Flores, Mary Petrella, really appreciate everyone's coming up here today. Long haul from Quantico. I think I made the commitment we'd get some of the task force down

to Quantico next year. I put them on my list. That's all I have for the task force. Thank you all again.

CO-CHAIR NATHAN: Thank you, everybody. Thank you very much.

(Whereupon, the meeting was concluded at 3:47 p.m.)