UNITED STATES OF AMERICA
DEPARTMENT OF DEFENSE
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RECOVERING WARRIORS TASK FORCE

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OCTOBER BUSINESS MEETING

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TUESDAY
OCTOBER 29, 2013

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The DoD Recovering Warrior Task Force met in the Commonwealth Ballroom, 300 Army-Navy Drive, Arlington, Virginia, at 9:00 a.m., Vice Admiral Matthew L. Nathan and Suzanne Crockett-Jones, Co-Chairs, presiding.

PRESENT
VADM MATTHEW L. NATHAN, MD, USN, Co-Chair
SUZANNE CROCKETT-JONES, Co-Chair
RONALD DRACH
TSGT ALEX J. EUDY, USAF, USSOCOM
LTCOL SEAN P.K. KEANE, USMC
COL KAREN T. MALEBRANCHE (Ret.), RN, MSN

MG RICHARD P. MUSTION, USA
DAVID K. REHBEIN, MS

ALSO PRESENT
COL DENISE DAILEY (Ret.), Executive Director, Designated Federal Officer
LUCILLE BECK, Department of Veterans Affairs
LAKIA BROCKENBERRY, RWTF Staff
DAVID CHANDLER, Department of Veterans Affairs
JAMES DAVIS, Director, Physical Disability Board of Review
COL JILL FARIS, Deputy Surgeon, ARNG
RACHEL GADDES, RWTF Staff
RAYMOND HOLDEMAN, Deputy Division Chief for Personnel, Army National Guard G-1
CROSBY HIPES, RWTF Staff
COL CARL JOHNSON, Director, Army Physical Disability Agency
JOHN KUNZ, RWTF Staff
SUZANNE LEDERER, RWTF Staff
STEPHEN LU, RWTF Staff

MATTHEW MCDONOUGH, RWTF Staff
DAVID MCKELVIN, RWTF Staff
JOSEPH NAGORKA, RWTF Staff
MICHAEL PARKER, Wounded Warrior Advocate
LISA PERLA, Department of Veterans Affairs
JOHN RICHARDSON, Navy Reservist, Wounded Warrior
ASHLEY SCHAAD, RWTF Staff

JOEL SCHOLTEN, Department of Veterans Affairs

TABLE OF CONTENTS

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

(9:10 a.m.)

CO-CHAIR CROCKETT-JONES: Good morning, everyone. This morning we have two oral statements for contribution to our public forum. We welcome Mr. Michael Parker, a Wounded Warrior Advocate to provide his statement to the Task Force. The members can find Mr. Parker's information in the front of Tab G. And I will turn things over to Mr. Parker. Welcome back.

MR. PARKER: Thank you and good morning.

The use of administrative discharges for conditions that require DES processing simply has to stop. I have raised several such cases to this Task Force in the past few months. Admiral Nathan has provided assistance on many of these cases but not all were properly adjudicated. We simply must bat one thousand and ensure that all Wounded Warriors who have compensable medical

conditions are properly evaluated and compensated by the DES.

I provided with this statement my email to Admiral Nathan last March that provides deeper details on the condition not a disability problem. In short, the Navy and Marines are improperly deeming compensable disabilities as a condition, not a disability. This leads to administrative separation without DoD disability benefits.

Enclosure 5 of DoDI 1332.38, which I have attached to this statement lists conditions not a disability that are eligible for administrative separation. The list is short but the Navy and Marines continue to designate all kinds of compensable disabilities as conditions not a disability to avoid paying disability benefits. One such case is that of Petty Officer 2 Todd Bruder. Last November PO2 Bruder broke his foot during Command physical training. Even after Admiral Nathan's intervention, medical authorities at

Camp Pendleton stated that surgery could not be performed and that PO2 Bruder's broken foot was a condition not a disability. PO2 Bruder was administratively separated for a condition not a disability and he and his family were kicked to the curb to fend for themselves. PO2 Bruder remains unemployed at this time and his TRICARE health insurance will soon expire.

I have attached my email to Admiral Nathan on PO2 Bruder's case to this statement.

Upon separation, PO2 Bruder sought treatment from a civilian orthopedist. The orthopedist confirmed his foot, which was a sesamoid bone is still broken and that surgery would fix the problem. The orthopedist wonders why the Navy would not perform surgery to fix the problem and PO2 Bruder and his family wonder the same.

I have attached relevant medical documentation to this statement, demonstrating that PO2 Bruder's foot was broken on active

duty and it remains broken today. PO2 Bruder wants to return to service, have his foot fixed, and continue his naval career.

I have also attached a paper discussing several other improper conditions not a disability cases that I have been recently brought to my attention. Please read through the details to get a deeper appreciation of the problem. Again, the practice of calling a compensable DES condition as a condition not a disability to avoid paying disability benefits simply has to stop and past cases need to be rectified.

If you have any questions, I will be glad to answer them.

CO-CHAIR CROCKETT-JONES: No, I don't think anyone has any questions.

MR. PARKER: Okay.

CO-CHAIR CROCKETT-JONES: We now welcome Mr. John Richardson, a Navy Reservist and Wounded Warrior to provide his statement to the Task Force. The members can find Mr.

Richardson's information in the second portion of Tab G.

MR. RICHARDSON: Good morning.

While many of us are physically present, we are not home. I returned in 2011 but I am still not home. Not realizing the full extent of my training injury and, despite the back pain I began experiencing six months later, I completed my deployment and was selected for promotion to Commander.

As to my medical status, I initially refused my doctors' advice to retire. But when I was told my presence in any danger zone would place others at risk, I acquiesced and accepted placement on the Temporary Disability Retirement List, a designation this Task Force has asked Congress to eliminate.

My TDRL status had an immediate, devastating impact on every aspect of my life and family. First, because Navy regulations state any member on TDRL cannot be promoted,

my hard-earned promotion was withdrawn. Second, once discharged, I had to direct my own medical healthcare, which was a complex task for my extremely competent MEDHOLD case manager. For over a year, I attempted to handle referrals to five different civilian providers in preparation for the TDRL Board I am to face this spring. Despite my education and experience, this proved impossible.

Third, my overall healthcare rapidly declined when I returned to federal employment at DHS in September 2012. Because my back pain prevents me from sitting or standing for extended periods of time and degrades my ability to concentrate, I requested a transfer to a non-sedentary job. This request was denied.

The legal challenges and maltreatment I am still enduring directly violate the spirit of and intent of USERRA and No-FEAR Acts. I have been on leave without pay since November 2012, forced into five

separate legal actions, and burdened with over $40,000 in debt.

The last letter I received from DHS makes no reference to my disability rating and acknowledges, "[I} have been absent for compelling reasons beyond [my] control" and "there is no foreseeable end in sight to my absences," but states I will be terminated for "excessive absenteeism."

DHS has refused mediation offers from the Office of special Counsel and Merit Systems Protection Board, and even an offer to terminate me for "the inability to perform my job," which would expedite my application for disability retirement.

My story is stranger than fiction but I assure you it is real. I have notified every relevant oversight agency and Congress yet, due to bystander apathy and politics, I remain in this "perfect storm" of a bureaucratic nightmare, a "poster example" of a Veteran left behind.

Employment for disabled Veterans is absolutely essential to our health and our identity. Many of us still feel the fierce need to serve our nation. If you help me fully return home, I know other Veterans will benefit.

Thank you. I will take any questions you may have for me.

MR. REHBEIN: I guess the first thing that comes to my mind, if there was one thing that someone could do for you, where would we start? I think that is what causes me the most confusion in cases like yours, sir, is where is the starting point?

MR. RICHARDSON: Yes, sir. And I did submit a second document with -- I have always been taught you don't present a problem without solutions. I did send a second document.

But primarily with DHS, based on the medical advice I have provided, one letter is from one of the most respected doctors,

back surgeons in this area, who says that I should retire. What I need is for someone to reach over to DHS at a high enough level and simply tell them, let this man go.

I have saved lives. There are people that are still alive today because of my actions. I have put two terrorists behind bars. One of them, I put my hands on him myself and took a backup weapon off of him after he was wounded.

There is no public record on it but Admiral Clark, Mrs. Clark, the Commander of the Pacific Fleet at that time, his wife, and the marine driver, owe their lives to this day to a change I made in motorcade operational procedures. And if a voice had not told me to wait that day, I would have been killed by a metro bus.

No one knows. Admiral Clark doesn't even know about that story to this day. But I am telling you, I have kicked in my part. My wife has kicked in my part.

I have my father-in-law's papers. He was one of the first African American Medical Hospitalmen. My father served in World War II. He has a Pacific Theater Ribbon and a Victory Medal. He later became one of the first African American CDs, after Truman integrated the services.

My paternal grandfather graduated from Meharry Medical School in 1918 at the age of 40. My mom was an occupational therapist for over 30 years.

My family has served this nation proudly. I love this nation. And my greatest fear is not just me. There is a gap in USERRA legislation. The minute your complaint mentions disability or accommodation, it goes into the EEOC process that is nothing more than an abyss that will cost anyone $200,000 to finish their federal complaint.

So, primarily the short answer to your question is, ask DHS, based on this guy's medical documentation and his service to this

nation, let him retire. Let him go. That would at least stabilize my life to this point.

I have been going through this for over two years. I tried to make the TDRL program work. And I had no idea that it was a designation this Board had recommended to be eliminated but I went on my way. Once I was discharged in September 2012, I went about the business of making the program that I was assigned to work.

The military medical system is about cost savings right now. The civilian healthcare system that I am dealing with is about revenue generation and cost savings. So, trying to get civilian healthcare providers to document my conditions in a way that will protect me from the TDRL Board I am to face this spring, which I know is a business decision -- that is a business body. And they don't understand, the civilian healthcare providers, they don't understand

the documentation requirements that need to be part of your medical record. They want to get you in, treat you, get you out and get to the next patient.

And while I was on medical hold, I went to physical therapy several times a week. So once I was discharged and I was on my own and I was trying to work full-time, it just proved to be impossible. My back pain, I just I can't -- I was an analyst. I worked the dossiers on Border Protection agents and Customs officers who were accused of corruption. So in my job, I had to analyze border crossing data, bank data, real estate data, car data, people who are trying to hide money. It is a very complex issue. So, it wasn't just the act of physically sitting or standing, it was also the sort of intuitive things that went into me doing my job that were no degraded by my pain.

So hence, put me in a job where I can move around. But because there is a bias

against military people in certain components under Headquarters DHS, I was just not one of the people that was favored enough to be given a job transfer. And right now, the efforts are to still place me back into a job that all of my doctors have agreed I should not be in.

So, again, primarily what I need is for someone powerful enough to reach over to DHS and simply say, let this guy go.

MR. REHBEIN: Thank you.

MR. DRACH: First of all, I want to thank you for your service. And I am sorry to hear of the circumstances surrounding your return to work.

It sounds like you have either pursued or are pursuing several legal and administrative remedies. Did you go through the USERRA process with Department of Labor, Veterans Employment and Training?

MR. RICHARDSON: Yes, sir. Under USERRA right now as a federal employee, there is the Department of Labor process that is

long-going and a very experienced process. However, under a three-year, the third year of a White House pilot project, my social security number ended in an odd digit; therefore, my case was referred to Office of Special Counsel. They are overwhelmed.

But in spite of my documentation, my medical documentation, the fact is even under USERRA, if you mention disability or accommodation, that means your case can be thrown out of whatever that USERRA expedited process is supposed to provide. And my understanding is the spirit and intent of USERRA is to protect the financial and employment stability of folks who mobilize and return to their jobs.

I fell through a huge crack. I have been on the Hill. I have visited with high-level staff members and actual members of Congress. I have written the ranking member of the DHS, of the Homeland Security Committee. They know about me. They all know

about me. They all are ashamed of what is happening to me. But, I have got to tell you, the panic that was going on during the government shutdown, part of me said welcome to my world, people, but when I saw the fact that families of five fallen members in Afghanistan were being caught up in the government shutdown, I knew that there is something very wrong here. There are people in Congress, in the Senate, and in the White House for that matter, I will say it, that have enough money to have underwritten the cost of sending those families the money they needed to get to Dover, Delaware.

So in terms of my case, the USERRA legislation has no punitive damages. There needs to be some teeth put in the legislation and there needs to be an expedited process for any federal employee who has a USERRA complaint. It must be expedited. It cannot go into the abyss that is the EEOC. The lawyers know it on both sides. The agency

lawyers know they can drag this out and their objective is to financially and emotionally break the employee so they drop their complaint.

The attorneys that you go out to hire, they tell you to keep quiet, let us do our job and you get a monthly bill from them. My bill, my $40,000 bill is conservative. As a matter of fact, it is low because I was telling them I cannot afford to go completely down this road. And I actually was naive enough to believe that the legislation would actually protect me. And hence, here I am a year later and I am still in this stalemate.

And what is so incredible is that I work for Customs and Border Protection Internal Affairs. I work for the guardians of the guardians. My senior executive member has been rebuked by the Chief Privacy Officer and I have the letters. But even his boss, who was the Inspector General for DHS, Charles Edwards, has been rebuked in writing by the

Senate for nepotism.

So, there are a lot of issues that are way beyond me. So, as a single person, I only took up legal action because that was my only recourse. I don't enjoy suing the federal government. This is not how I was brought up. I was brought up in a family where you were responsible. If you had anything to do with the taxpayers' money, you were supposed to be a good steward of the taxpayers' money. That is my upbringing.

And as a matter of fact, I have my father-in-law's discharge papers, I have my dad's discharge papers, and I have the documentation on my father for anyone who is interested in seeing it.

But my issue is fixable. It is just I need someone with the guts enough to get in someone else's face and tell them, you fix this problem.

CO-CHAIR CROCKETT-JONES: Thank you very much, Mr. Richardson.

MR. RICHARDSON: Thank you for your time. I appreciate it.

And Ms. Crockett-Jones, it is very good to see you again, ma'am. Thank you for your time.

CO-CHAIR CROCKETT-JONES: Thank you.

At this time, we will be hearing about the Polytrauma Rehabilitation Center. We will welcome Dr. Lucille Beck and Dr. David Chandler, Consultants for the Department of Veterans Affairs. They will brief the Task Force on the VA Polytrauma care, including long-term needs for the current generation of Veterans and challenges with records transfers.

The information for their briefing is found under Tab H.

DR. BECK: Okay, a lot of high technology here. So, we will start with the first thing. And let me ask, can everyone hear me this morning?

Okay, good morning. My name is Lu Beck. I am the Chief Consultant for Rehabilitation and Prosthetic Services. I work for the Department of Veterans Affairs in the Veterans Health Administration Branch in the Office of Patient Care Services.

I am delighted to be with you this morning and to have this opportunity to talk about the Polytrauma System of Care.

As we begin, we are going to do two things. And the first one is I would like to introduce this team of individuals I have here to my right, starting with Dr. Chandler, who I think many of you may know or certainly heard his name. He is my deputy chief consultant and has responsibility in our office for all things related to our collaboration with the Department of Defense, including our Centers of Excellence and my office is responsible for the Hearing Center of Excellence. And the Amputation Center of Excellence also has a role in the

Psychological Health Center of Excellence and the blind rehabilitation portion of the Vision Center of Excellence.

So, Dr. Chandler, in addition to all the other things he does for the operation of our services, has particular oversight for the DoD part, works with Ms. Malebranche's office for our coordination with DoD.

To his right, is Dr. Joel Scholten, who is the TBI Special Services Director in my office. And he is responsible for all of the clinical program development that we are doing around polytrauma and traumatic brain injury, along with a team of individuals who work with us.

To his right is Ms. Lisa Perla. Lisa is our Care Coordinator Case Manager responsible for all things related to care management and case management in our system of care.

The reason I asked them to be with me this morning to talk with you is that as it

relates to our TBI program, both Dr. Scholten and Ms. Perla have first line experience, extensive experience over a long period of time, happens to be in Tampa, Florida, and are very connected to and aware of the programs and needs that we have to provide a really good system of care.

So with that introduction, we were going to -- are you able to do this? I wanted you to see a short film clip that we have. And we have prepared, we are distributing the information to you.

VIDEO: A land mine blew Ben through the door of his patrol vehicle.

When I came here, I couldn't move.

David was broadsided on the highway.

They weren't very hopeful at the time that he would survive at all.

An IED wounded Mike in Afghanistan.

I don't remember all of the blast.

It was over 500 pounds of explosives.

Their physical injuries have healed. Their traumatic brain injuries, TBIs, haven't.

The way I could describe is just you are afraid. Am I going to start forgetting things?

TBI is as serious as any battlefield injury.

You are just not the guy you used to be.

Thankfully, VA has made important advancements in TBI, seeing it, treating it, understanding it, and they are here to help Veterans affected by it.

I can see that we are doing here at the polytrauma unit is to move from survivability to thrive-ability.

If you think you or a Veteran you know has sustained a brain injury, get screened.

DR. BECK: Okay, thank you. The

reason I wanted you to see that is, first of all, is to talk about our polytrauma website and to also share with you that one of our biggest challenges in the Department of Veterans Affairs has been communicating the message that the services are available. And it is truly through the collaboration, integration, and coordination of our services with the Department of Defense and particularly with Walter Reed and what used to be Bethesda and the clinical teams there that we have been able to learn from each other and be successful in managing the needs of the seriously injured Sevicemembers and Veterans.

So this morning, I am going to talk to you about our system of care and describe for you what we think are the needs of the current generation of Veterans. And you asked the question of how prepared is VA to care for our most severely injured, which we will talk about. And then some issues about our information and records transfer.

All right, so just a word about our office. My office is Rehabilitation and Prosthetic Services. Our job is to meet the rehabilitation and prosthetic needs of Veterans. We are providing lifelong support.

As I begin, I do like to echo the words of our Secretary, Secretary Shinseki, who always talks about three important things when we develop and focus on programs. The first being that we have a program that is Veteran-centric and meets the needs of our veterans; that we have results-driven outcomes that we can demonstrate that what we did is helping and making a difference. And more importantly, and most importantly I think as we face the future, is the forward-looking aspect. Are we facing forward and developing programs that will be institutionalized properly to provide care and to meet the needs of future combat eras, as well as providing the life-long services that VA is committed to providing to Veterans.

So, as you listen to my presentation today, please think about those three points and we welcome your feedback on how good a job we are doing with that.

So, today we have 2,500 moderately severe or severe brain injured Servicemembers and Veterans who have been served in our inpatient units since 2003. We have given you just some 38,000 Veterans with major limb amputations, 21,000 Veterans receiving care for spinal cord injuries and disorders, 50,000 blind and visually impaired on our roles who are receiving care from us and mild TBI, which I don't believe we have the numbers there but we are taking care of over 60,000 mild TBI. And that is an important component. That is our returning Servicemember who is discharged, comes to the VA, and is screened and managed for mild traumatic brain injury.

MR. DRACH: May I ask a question?

DR. BECK: Yes.

MR. DRACH: If you have got 50,000

blind and visually impaired, of those that are blind or visually impaired, do you have any idea how many of them, their condition has been caused by trauma? And of those that have been caused by trauma, have you evaluated them for TBI at all?

DR. BECK: So the statistic that I can give you this morning is that approximately 150 combat injured Servicemembers have been through our inpatient blind centers. Their care and needs are coordinated and managed on an individual basis. So, I will give you an example.

The term polytrauma you know means multiple injuries. And so if we have an active duty Servicemember who has significant visual loss and also a brain injury, our brain injury centers, our polytrauma centers will work with our blind centers. Typically what we will do is we will have the traumatic brain injury treated first because we need the brain to recover. We need people to begin to learn

how to be able to concentrate and do those things and then they will go to a blind center.

So, the issue a milder TBI where there are visual disturbances is a little bit different and I don't have those numbers with me, but I think we can get to those numbers. Because you are going to hear me talk about interdisciplinary teams and we have visual specialists on our teams who work with us to assure that we are treating all of the conditions we need.

MR. DRACH: Well, I guess my concern is really the evaluation process. So, if somebody files a claim for visual impairment or total blindness or partial blindness as a result of trauma, do you automatically when they get evaluated or at some point, do they automatically get screened for TBI? Because if there is a trauma to the head, to the eye, it is trauma to the head. You know and I am making a leap. I am not a

doctor but if I get shot and lose and eye or otherwise lose an eye as a result of trauma, I have had trauma to the head.

DR. BECK: So, the way I would answer that at this point is to say that when a Veteran files a claim, if there is any -- if they file a claim for traumatic brain injury, they go through a comprehensive evaluation of TBI and it looks at a number of functional elements because, as you know, TBI can manifest with many different kinds of injuries.

So the folks, the medical staff who do those examinations do get input from the various specialty services and there is a chart and a review form that is standard, that is used to evaluate all the different aspects of traumatic brain injury.

Actually Dr. Scholten who is right there to your right participated with VBA in the development of the strategies that we are using to manage what we call the sequelae of

a traumatic brain injury.

I don't know, Dr. Scholten, if you want to add any comments.

DR. SCHOLTEN: Can you hear me? Okay.

So, but in addition, any Servicemember or any Veteran that access the VA for healthcare will be screened for TBI if their separation date is after September 11 of 2001. So that screen becomes active and then if they are previously diagnosed, the screen is completed but they are still consulted to the TBI specialist.

DR. BECK: So that would handle the treatment of it. The claim aspect is handled with a very rigorous protocol that addresses traumatic brain injury.

MR. DRACH: Okay, thank you.

DR. BECK: Okay, so let's move on.

We have given you a time line here. And the real purpose of the time line is to tell you -- to show you the degree of

collaboration and integration, as well as the way we have grown and developed this system.

So, going back to the 1980s, the Department of Defense established a Memorandum of Understanding with VA which is still in place and used today. And that is the basis for the rehab programs that the VA has, spinal cord injury, traumatic brain injury, and polytrauma, and blind rehabilitation. And we have been serving active duty Servicemembers in those centers since the 1980s.

The recognition of brain injury and head injury and the effect that those kinds of injuries have on active duty Servicemembers and Veterans I think was recognized again in the early '90s formally with the development of the Defense and Veterans Brain Injury Consortium. So, there has been an active group of individuals from DoD and VA working in the area of traumatic brain injury and developing expertise since the 1990s.

To talk about the system that we have today, what we did in February of 2005 is we leveraged the assets that we had in traumatic brain injury and there were four sites around the country, which we are going to talk about in a minute, that were lead TBI centers. And we designated those centers as polytrauma and began the work of developing a very rigorous or more extensive acute and rehabilitative care team that could meet the needs of the returning combat injured.

One of the points I want to make to you is this has been, as you will see as we go through this presentation, this has been an area where we have worked very closely with our colleagues at DoD in the clinical side of the house who have managed the trauma aspects of the care, developed programs, worked particularly with veterans and their families to identify what the needs are and to work to meet those needs.

So, we began with our four

polytrauma centers. From there, VA is a regional network and I am not going to assume that all of you are necessarily that familiar. And I am going to show you a map in a minute, which will lay out for you the regional system of care. But today, we have five polytrauma inpatient centers that are responsible for the seriously injured polytrauma patient. What we have developed from that is a network of care so that we are able to provide expert services around the country. And we call that our Polytrauma System of Care. And so we have 22 networks around the country. We just divide the country up in regions. And we have a center of excellence for polytrauma care in each one of those networks.

We also have teams. And Dr. Scholten talked about the traumatic brain injury teams which we set up in I guess March of '07 and we are now up to 82 teams are able to provide care for polytrauma and do provide that care.

And where we are not able to have expert teams, we have designated points of contact who can refer patients and get them treated. So in some of our smaller, more rural hospitals, where we might not have comprehensive services, we have a system in place to manage, case manage those patients.

Along the way, we have developed a number of programs to meet Veterans' needs. One is the Emerging Consciousness Program. I am not going to spend a lot of time on that today but there is a slide about it because it has been one of the most, I think, dramatic programs. We set it up very, very quickly, worked with again our trauma colleagues at DoD and developed a program to help our active duty Servicemembers emerge from what is called a coma but really to come back to consciousness.

We have published the results of that. We have had remarkable return to consciousness with this special program and

even some of the Veterans that or one of the Veterans that you saw in the clip was a Veteran who had gone through this program. So, it has been an amazing contribution to the literature and to the state of knowledge in this country and around the world related to this kind of care, emerging consciousness care.

Dr. Scholten also talked about our Screening and Evaluation Program. That is another program that we developed with our colleagues from DVBIC because really we were asked how will you know that a Veteran who comes to the VA seeking treatment, how you will know whether or not they have had a brain injury. And the answer was, we wouldn't necessarily know, unless we screened them. And so we began a screening program in all of our clinics, our primary care clinics, any of our clinics where veterans would come into the clinic for care and we identified a number of questions to ask them. And it is part of our

electronic medical record. It is documented in the record. And if they screen positive, this does not mean they have a traumatic brain injury, but if they screen positive we then refer them to a team, a traumatic brain injury team, which then will conduct a comprehensive evaluation.

In June of 2007 -- I want to talk just a minute about the Amputation System of Care because it is an important unit of care. You may know that we have approximately 1400, I think major traumatic amputations from this conflict. And I think you know that the Department of Defense, two facilities in the Army and one in the Navy, are managing the primary rehabilitation for amputation care. So, VA has partnered with the Department of Defense to assure that we are teaching, training, providing the same level of advanced technologies and that we are managing the transition and providing the lifelong care for our amputees. We are well-equipped in our

polytrauma centers to provide services to an amputee who is also brain injured and has multiple traumas. But it is important to connect those networks and we do that.

You probably know that assistive technology and technology in general has exploded in our world and this is even more true in the world of rehabilitation. Between mobile apps and iPads and iPhones and global navigation systems, and I could just go on forever, computer control, environmental controls in your house, assistive technology becomes one of our most important strategies to manage and provide the highest level of independent function. And that is really our goal, to return our Servicemembers and Veterans to their highest level of independent function. Technology helps us do that and so we have been very focused on having the most advanced assistive technology in managing the needs of our patients.

All right. So, our fifth

polytrauma center opened in San Antonio in 2011. It is a state of the art facility. Although, as you go around, our centers are in Tampa, Richmond, Minneapolis, Palo Alto. We generally distribute it around the country and then in San Antonio.

San Antonio is our newest center and if you are in that area, I would really encourage you to go and see what is a state of the art facility. We just opened a state of the art facility in Richmond, which you can also visit, and I think Tampa will be opening a new center soon, and Palo Alto has a new center on the books.

And what is important about that is that the space, the criteria, the design is focused on wellness, recovery, family needs, interdisciplinary care and you can see that firsthand in the setting, as well the most advanced gyms and technologies and communication, et cetera.

All right, so I think to

summarize, we have got 110 specialized rehabilitation sites across the VA distributed as I have just described. We have a Memorandum of Agreement that is in place that facilitates our transfer. And we have a system of care which we have matched geographically with the needs of Veterans and Servicemembers.

So here is our map. And if you are not familiar with the VA, we are divided into 22 regions. You see 23 there because we combined 13 and 14 a long time ago. We go from the Northeast VISN 1 down to the Southwest, I guess, California VISN 22. And you can see the red bars that show where our Polytrauma Centers are.

So our is always two things; highest level of independent function, get the patient home.

Yes?

DR. PHILLIPS: Ma'am, I'm sorry to interrupt.

In the Memorandum of Agreement with the DoD, does that include transfer of personnel as well, utilization of personnel or is it just technology?

In other words, an expert team and the DoD with our draw down coming, will the VA pick those people up or is there any interest in picking those people up?

DR. BECK: Picking up the staff who are affected?

DR. PHILLIPS: Yes, the staff who are actually seeing these people in the DoD system.

DR. BECK: Well, I can tell you that we have a lot of folks from DoD who are now working in the VA. Because as they retire or leave active duty, the medical personnel have been coming to the VA. So, I think we have hired just about everybody -- Joel looks like he wants to say something. So, let's let him.

DR. SCHOLTEN: We have shamelessly

recruited from some of the larger military treatment facilities.

DR. BECK: Yes.

DR. SCHOLTEN: But the MOU is specifically for patient care.

DR. BECK: It is, right.

DR. PHILLIPS: Thank you. That is what I was --

DR. BECK: It is for patient care.

DR. PHILLIPS: I was hoping to hear that.

DR. BECK: Yes.

DR. PHILLIPS: The personnel.

DR. BECK: Sorry, it is for patient care.

So, this gives you -- so our goal is as a nationwide healthcare system is to have regional distributed expertise and access around the country to provide these services.

So, I have talked a lot about integration. And the other word I want to really emphasize today is interdisciplinary.

And what you see here are some of the individuals or some of the disciplines and programs that are on the team that manages this care. So we know that the brain, when the brain is injured, it can affect and does affect many, many parts of the body and systems. And so, we have found that what works is to have the patient and the family in the center. Our goal is to meet the recovery and rehabilitation for the Veterans and the Servicemember and to meet the needs of the family. So, it is very, very important that we manage, and that is one of the things that the families has taught us the most. The family is part of the team. We meet the family's needs and we assist the family.

So, when you go to a Polytrauma Center you will find that if a family needs childcare, we will provide the childcare. We have Fisher Houses at all of our sites so that we can provide the families with lodging and just a host of other things that we will do.

Our case managers, care coordinators, our nurses, and our social workers who manage the clinical coordination of care, as well as the psychosocial needs of the families are very, very tune into working with these families.

So, the coordination of support is key. And I am sure you are finding that, as you have discussions about the transition piece, when you transition from being a Servicemember to a Veteran.

But the other key is interdisciplinary. Everybody meets together. The Veteran sets his or her goals. The family sets their goals. And the treating specialties co-treat, manage together to help the Veteran meet their goals. These are not clinics that a Veteran visits one after the other.

So, it is really important to recognize, and it has been very important for us to recognize the interdisciplinary nature

of what we do.

So, as I have talked a little bit, we have developed a continuum of special programs. In particular, and I didn't mention this earlier but let me tell you a little bit about it today, the first program has been the Transitional Rehab Program. And that is primarily an inpatient program. It is at all five of our Polytrauma sites. And it is sort of the next stage of care.

We find that when our severely injured TBI polytrauma patients have finished their initial recovery, the learning to walk, the learning to talk, then they begin to face the reintegration into the community and the environment.

So, these transition programs which are not like hospitals, and again, I would invite you to visit one of our sites, they are sort of community living places where there is dining, and there are gyms, and people have private rooms. And it begins the

hard work of beginning to live independently, take care of myself; get up in the morning; get dressed; manage my laundry; answer my messages; return to work.

And I am going to use the term and I know here to my left is someone I have worked with a lot on vocational rehab but I want to make an important distinction here. We are talking about medical vocational rehabilitation. We are teaching an individual to get up in the morning and be able to navigate to work. We are teaching an individual to study again, to learn an environment, to concentrate, to focus. Because when you have a brain injury, you probably know that you are fatigued easily. You can get frustrated easily. You can forget things easily. And all of those sort of functions that many of us take for granted to get through our day are things that our Veterans and active duty Servicemembers have to relearn and have to practice.

So, the Transitional Rehab Program allows them to do that. So, if you do go visit a site, when you get there during the day, I hope you will not see a Veteran or Servicemember because they will be out working. And that is really our goal, to teach them how to do that.

We do a lot of study programs there because we teach our Veterans and active duty Servicemembers how to study again, if they want to go back to school. If you want to be in the VA Voc Rehab Program, you have to be ready to go back to school.

So, I want to leave you with this thought of medical vocational rehabilitation. It is part of medical rehabilitation to practice and learn that.

All right. I also wanted to mention just for a minute the Telehealth Network because I think that one of the most important things we have done is to create collaboration and integration capability.

As you probably know, clinical providers want to know if they are going to refer a patient to another site or put the care of their patients into another setting, they want to know what that setting looks like. So we learned early on it is so important to have the providers at Walter Reed who are taking care of the seriously injured Servicemembers -- and I mention Walter Reed and Bethesda because, as you probably know, as that time as we were setting up the system and even today, the seriously injured, particularly with head injury do come back to Walter Reed from Landstuhl.

So, the Polytrauma Telehealth Network, while we knew it was going to help us communicate with our sites around the country, I think a bonus may be that we hadn't expected was it created a way to interface with the clinical teams at Walter Reed and Bethesda and also with the families. So the families and the clinical team at Bethesda would have a

teleconference with the Richmond team, for example, and begin to discuss the transition of care, build the confidence that you need to feel comfortable as a spouse or a parent sending your loved one, bringing your loved one, and making a commitment to be a resident in that area for quite a while, while you managed the rehabilitation.

So, the Telehealth Network I can't emphasize enough how that has helped us. It has also, we have even used it to have meetings with some of the staff, medical staff overseas at Landstuhl. And at one point, we sent some of our Polytrauma Team to Landstuhl, so that people could learn from each other, understand. And that has been an enormous program.

Drivers' training, what is the number one thing you want to do when you are 22 years old? Right? And if you have an amputation, you have a traumatic brain injury, well, yes, you are right about that. I saw

that. But at least in the hospital. So you want to be able to drive. And so we have the VA has very comprehensive drivers' training programs. We have expanded these programs considerably. Again, if you visit a site you can see it but there is a simulation program where you relearn how to drive and then you actually are able to take a test and drive again.

We also have vehicles that we take veterans and Servicemembers out in for really on the job or training on the site. A hugely important program and a big motivator. Because what we are always looking for is what is going to motivate this individual to work hard because rehab is hard work. You can't take a pill. Someone else isn't going to do it for you. So you have to make a commitment to work hard and our clinical staffs, in addition to providing the expertise that they do, they are also the coaches. And driving is just great.

So, I have talked about the other programs as I have gone through the list here. So, let's see.

All right, I did want to talk to you for a minute about something that I think has been a very important key to our success. And that is that we have learned as we go. We have asked our Servicemembers and Veterans what they want and what they need. We have asked our families. And one of the organized ways we have been able to do this is through our research initiatives. And VA has a special research -- it is a health services type of research where it asks the question what kind of services are needed. What is the best way to deliver these services?

And so we have had a very excellent team working with us, probably since 2006 or 2007 assessing the needs of patients and families and staffs in studying the issues. I will give you one example.

We did what we call a

collaborative with the families where we said to the families what do you need. How can we help you? From that initiative came something called the Family Care Map and it is an interactive map. So you would go on a website and be able to get your questions answered, put in your information as you manage your loved one's care.

So I can't emphasize enough how important that has been. That group is still active today. It has an executive committee and it has a Veteran, an injured Veteran, a TBI Veteran who serves as a member of that executive committee. So, we are trying to really represent all kinds of cares and needs.

The other thing I think I mentioned to you before is what has made this work has been the collaboration. So, we learned early on that for us to help manage and transition, the best thing we could do is what we call polytrauma nurses at the DoD sites. And so, the Commanders at Walter Reed

and Bethesda, and the nursing staff in particular, were very open to this and we were able to embed VA nurses as part of the teams at the trauma sites at Walter Reed and Bethesda. So, they rounded with the team. They were the first face of the VA to the injured Servicemembers. They managed the transitions and the handoffs. They got the nursing staff and the clinical staff at the VA ready to receive, understand what the individualized needs of each patient was and the families as they came.

So we still have the nurses there today. They still act in that capacity today. And that has really helped us.

And of course, all of the programs we have developed, we have had DoD representation. And some of those folks now work for the VA, as they have left the military, which has been just great for us.

So, we have talked about the team to team importance as we network and I think

you know that there are many VA staff assigned to various medical centers and our care managers and coordinators work with them as well.

The other really important thing I think that we did is we put military liaisons at each of the polytrauma sites. So, we recognized and our patients and their families told us the uniform is important. And in the old days we used to think about the VA is where you went when you couldn't be in the military anymore; it was only taking care of old people, or whatever the particular impression, especially that a 20-year-old would have as the VA was sort of a stigma that we had to overcome.

And we also wanted our teams to learn. As you know, many VA employees are Veterans and so we have that. But in addition to that, we wanted our teams to really understand and appreciate what it means to wear the uniform and to honor all aspects of

that. And also, the military liaisons really help us solve problems. Whatever there were issues with the way you were transferred, I mean all kinds of things, questions about benefits, our military liaisons are able to work that with DoD and VA. And they can also sometimes go in and sort of give an order that our VA clinical staff may not be able to do.

So, that has been an enormous also way that we have been able to use that collaboration to help our seriously injured.

So, I have talked about collaboration. I wanted to just give you a little bit of a feel for the kinds of things we have been doing. I talked about the Emerging Consciousness Care protocol. We have developed clinical practice guidelines for amputation care. There are clinical practice guidelines -- and I am mentioning these because they are jointly developed between VA and DoD -- clinical practice guidelines for post-traumatic stress disorder.

An important common definition for mild TBI and clinical practice guidelines for mild TBI. And actually not only did we do that for VA and DoD, we engaged NIH and some of the other groups who are interested and do research in TBI in that because I don't think we really in the community had a common definition for mild TBI. And you probably know it is easily missed.

In fact, if you are watching what is happening, particularly with the NFL these days with concussion and sports in general for young people in grade school and high school, I think that very much that initiative has been driven by what we have learned about concussion and concussion syndrome and repeated exposures to blasts and physical injury. So, I think that is changing the way we manage care for head injuries in this country and probably around the world.

EXECUTIVE DIRECTOR DAILEY: Ma'am?

DR. BECK: Yes?

EXECUTIVE DIRECTOR DAILEY: Ma'am, can I ask you to talk about the DoD, VA, and NIH collaboration? Give us just a little more background, time frames, how it was set up. Is it through the JEC?

DR. BECK: No, --

EXECUTIVE DIRECTOR DAILEY: Okay.

DR. BECK: -- it's not through the JEC. And I am going to give you an overview --

EXECUTIVE DIRECTOR DAILEY: Good.

DR. BECK: -- and I would be happy to give you more information.

EXECUTIVE DIRECTOR DAILEY: Good.

DR. BECK: Because really the way we began the initiative is you probably know and it should be here down at the bottom that the Department of Veterans Affairs was charged with developing a TBI registry, which we have done and have. As part of that, we are aware that there are many organizations who participate in research with TBI. If you

follow research in all areas, one of the compelling, or one of the important problems is that we define things differently, we have different outcomes, we use different methodologies.

So, what we were able to do is we engaged, which it is actually the National Institute of Stroke, I believe, at NIH that manages neurological problems, worked with them, and worked with a number of other consortiums around the country to identify and agree on data fields and definitions so that when people do research, we are all saying the same thing in the same way so that we can compare results and understand results.

So, I am happy to give you more information about that but I don't have the details with me.

EXECUTIVE DIRECTOR DAILEY: And real quick, approximate time frame, 2007 to 2008, 2009?

DR. BECK: So, I'm thinking 2007.

DR. SCHOLTEN: Six to seven.

DR. BECK: Six to seven, when we were first developing the registry.

EXECUTIVE DIRECTOR DAILEY: Okay.

DR. BECK: Yes. And we also were, our Office of Public Health was involved in that as well, our epidemiology group.

And I think we are using that. And it is interesting, I am seeing other research groups also beginning to do that kind of work.

And I think Dr. Scholten has a comment. Right?

DR. SCHOLTEN: And that was the same time that the common definition was developed and that was rolled out in early 2007. So that work had started about a year before that.

DR. BECK: And also, and I don't know how familiar you are with ICD-9, you wouldn't have any reason to be familiar with it unless you are in medical care. But it is

the way we code encounters and diagnosed diseases. And one of the things that Congress asked us to do in some legislation was to develop codes, better ICD-9 codes that would clarify and characterize traumatic brain injury more completely. That even though it is covered under psychological health, it had been more on the mental health side of the house than it had been on the ICD physical injury side of the house actual blow to the head. So, that was an important distinction for Veterans and Servicemembers. And we had a VA/DoD that worked probably for three or four years, went through the coding, that is Medicare coding departments and everything, and achieved that goal.

That, to me, was the most miraculous thing we did because not only did we get VA and DoD to agree, we got Medicare to agree and all the professional associations. So, I think it has helped us all now characterize better.

We talked about the screening tool and how VA is using that now. I want to emphasize again the need to educate, train family members to provide care and assistance. I talked about that a little bit in terms of the importance of education, information, management, teaching. One of the hardest things to do, and maybe you have seen this in some way in your own life, is to watch a loved one struggle, struggle to walk, struggle to try to remember something. But it is so important that families have that balance of letting the individual work hard so that they can get to that level of independent function they need to do. And also, that families need to take care of themselves as well. How do you manage your own psychological health? What do you need to do? Where do you get assistance?

Today, VA has caregiver legislation. I am assuming you are familiar with that and that has been highly utilized by

families and TBI patients.

CO-CHAIR CROCKETT-JONES: Can I ask you a question?

DR. BECK: Sure.

CO-CHAIR CROCKETT-JONES: Are there any programs in place to educate your other medical care providers outside of the polytrauma? Because I think that sometimes there is a real gap in understanding when a TBI patient is going in for other specialty care or general care. Their instructions, their medication protocols, all of these things can be compromised by some of the hallmark problems of TBI care. And if the other medical service providers aren't really aware of sort of the special needs of TBI patients, are there any programs to sort of best practice and educate your other medical providers on TBI patients?

DR. BECK: Thank you for that question and you have identified a very important component of training for a

healthcare system.

And actually the VA has a program called the Veterans Health Initiatives. And what they are are curricula that look at a number of conditions that occur to -- have a much higher incidence in the military than they do in the general sector, general public. I think there are ten or twelve of them. Traumatic brain injury is one. And we have an extensive program which is available online and we did mandatory training for all of our clinical providers a number of years ago and it is also included as part of new orientation so that all of our providers can understand.

I believe the curriculum has been picked up by the American Medical Association or one of the residency programs and they are also using it.

DR. SCHOLTEN: Yes. And the third to the last slide is specifically on polytrauma education as well that lists the link.

DR. BECK: Okay, so we have got the link for you as well.

Okay, so moving on to results driven, if I could. We wanted you to see some of the numbers. Since March of 2003 through 2013 in our Polytrauma Centers, we have treated 2,735 patients; 56 percent of them were active duty Servicemembers; and 74 percent of the active duty were injured in foreign theater.

So, and you can see the statistics for FY13. And FY13, as you know, the operations are winding down now and we are not seeing the numbers that we have seen in previous years. We have 54 new patients in FY13 -- well, 54 new Servicemembers in FY13 injured in theater and a total of 140 new patients in FY13.

So to give you a feeling for what we talked about, one of the outcomes that we look at as a result of our services is where do patients go after they leave us. What are

their needs? What is their recovery like? Oh, well, sorry, I jumped to the outcomes. I always do that.

So, I should tell you first the referral. So you can see where the referrals have come from for the foreign theater injured. And I think you probably know very well that what the injury on the battlefield, treated in a battlefield hospital, Landstuhl, and then to Walter Reed. And it is amazing that a patient who has been injured can be back in Walter Reed within two or three days. I mean, it is just amazing, stabilized. And we have worked very hard to move those patients to the Polytrauma Center as soon as possible as well. So, there you can see.

And then here is our discharge. And this is where our goal, of course, is to discharge people to home, that they are able to go home. That doesn't mean that they may not need additional rehabilitation of some type later on as we planned, but that they are

functioning in recovery.

A lot of the patients go back to the MTFs for various reasons. But they can see the statistics, which we think are really pretty good.

Occupancy rates. So, today I talked a little bit about that. So, each of our centers -- four of our centers have 12 beds each and our fifth center has 18 beds. And so we do monitor our occupancy rate from year to year. And you can see in FY2013 the ranges have been from 53 to 88 percent occupied with polytrauma patients.

Now, 85 percent is kind of a benchmark when you are getting close to maximum for an inpatient unit. In previous years, we have had running 85 to 90 and even sometimes 100 percent occupancy. So, as we all know the number of seriously injured in theater is declining, has declined a lot.

Community discharge or ready to move onto the next phase of recovery being at

home has been a goal that we have attained at 83 percent for our combat injured.

MR. DRACH: Dr. Beck, excuse me.

DR. BECK: Yes?

MR. DRACH: On your community discharge, I was just thinking going back to one of your earlier slides about transition or rehabilitation, what level or what type of independent living services do you provide and/or do you coordinate with the VR&E to provide independent living services? Is there an overlap?

DR. BECK: There can be an overlap. We are more likely to use VA services like home-based primary care where we have VA clinical folks going into the homes. Independent living is, we do coordinate that but it occurs probably at a later time in their recovery, when they are more stabilized. And when they are making the decision about whether to go back to school and apply for voc rehab benefits, and I think you know they get

evaluated for voc rehab benefits, and then get referred to the independent living program is the way it works.

MR. DRACH: But if 63 percent are being discharged to home and some may of these may be more severely injured, what types of independent living services are provided prior to discharge to include ADLs so that this individual can live independently in the community and mitigate going back into the hospital or some level of care?

DR. SCHOLTEN: So there is a variety of services that are provided at the Polytrauma Rehab Centers and the Transitional Rehab Programs. So, the focus is to maximize independence, so they would get the traditional types of therapies, PT, OT, speech therapy. And then that focus on the community reintegration piece, so transitioning from the inpatient unit doing community outings and then training the families and caregivers to support the individuals in the community and

ready them for going home.

Once they -- if they go into the Transitional Rehab Program, there is more extensive training because as they advance on their level, through their level of independence they may take on more of the self-medication administration, look at driving, begin to look at the medical vocational rehab aspects of things. And then when they transition home, an individualized plan is developed with the Veteran and the family or caregiver to determine what additional resources they will need to be safe and further their independence at home. So that could be additional therapy coming into the home or going to an outpatient therapy center.

So, it is really individualized, which is the hallmark of TBI rehabilitation care.

DR. BECK: And I think one of the other important points is it is primarily at

this point a clinical service, the therapies, the care in the home, the support to the families, to allow the patient to be at home and to be as independent as possible, and to continue working on their rehab.

And I think when some of those goals have been achieved, and this is an important message that our families have told us, then they are ready to think about a more traditional kind -- and again, this is the intersection between medical rehabilitation and vocational rehabilitation and the important distinction. We are getting people ready to do all of those things. Does that make sense?

MR. DRACH: Yes.

DR. BECK: Okay, thanks.

All right so, I have talked about the Telehealth Network a lot and the way we are linked to the various sites and the kind of work that we do throughout the presentation. But that we have got provider

to clinical provider we have coordinated the patient transfers, the care. Very often, we will have the families with the teams getting a chance to meet each other. Our Telehealth Services are just exploding in the VA, as well, and we are now able to do team meetings in the home. Our providers can do team meetings right in the home. In fact, Dr. Scholten has done a number of those this year for our TBI patients. So, really the capability that we have with these kinds of networks to manage the care and manage the care in the home is really, it just has driven a very different and important way to stay connected with our patients.

So, you asked a question about information transfer and technology. And we are going to talk to you a little bit about the JANUS or Joint Legacy Viewer, which is the newest capability we have. But we have been managing the records transfer, medical records needs for this population since 2006. And so,

it has been very important for us to get the medical record, to get a comprehensive record to know what has happened, if the patient has had surgery on the battlefield or in Landstuhl, but to really be aware of every condition. And so we set up -- the VA working again collaboratively with DoD set up a number of servers that were dedicated to each of our Polytrauma Centers so that we could transfer information. And what we wound up transferring was what is a PDF of the medical record.

Since that time, added to that is the patient comes to us with a CD that also has their patient record. In addition now, as the IT capability has progressed, we also have remote access to some of the medical records through the DoD/VA remote access.

And most recently, and I don't know if you have heard of the JANUS Joint Legacy Viewer but it is a graphic user interface which allows us to get an integrated

view of VA and DoD patient electronic health records. It is just being deployed now and rolled out in a number of pilot sites. We signed up in Polytrauma to be first because, obviously, it meets a really great need that we have. It allows us to transition better.

So, to date actually there is an update to this but, as you can see, our five Polytrauma Centers are using the JANUS viewer, along with Walter Reed and a couple of our Alaska and of course our Joint hospitals. And I think we have added about ten additional sites, one of which is Washington, D.C., where we have also deployed JANUS.

So, we are hopeful that the JANUS Legacy capability will be extended to all of our hospitals with Polytrauma sites because that will, again, give us a good way to coordinate care.

So, to leave you with I think this is the best overarching sort of conceptual, a way to conceptualize what we are calling our

integrated healthcare. We talked about the trauma care that is being done primarily DoD on the battlefield, Landstuhl at the military hospitals, and then we are talking about the rehabilitation, the acute primary rehabilitation that we are doing initially for our inpatients.

We talked a lot about community reintegration, the kind of programs that we have available to support community reintegration, transitional, our day programs, and just overall outpatient care, management of our TBI patients and teams.

And then we are working very hard now on our lifelong community care. What are the needs of this population going forward? What should we be prepared? What is the forward-looking aspect? What kind of extended care programs? We know that as people age and live with a disability like this, they are going to have special needs and it is our job to have the programs available to them.

So, you are seeing us talk about supported living. We have a pilot. It is called Assisted Living Traumatic Brain Injury Pilot. It is in its fourth year, where we are able to put Veterans into they are not exactly assisted living, they are specialized assisted living so that they allow a TBI patient to live independently but they would require services to be available. And they may need help with their medications. They may need help with managing their leisure time, various other aspects of care. But this is a program that I know you have heard the concern about we don't want these young people to be in nursing homes, where they are just in a nursing home and not able to have the support they need to be independent.

EXECUTIVE DIRECTOR DAILEY: And ma'am, excuse me. Can I slow you down just a little bit? I think this is an important point for the Task Force members about long-term care over the course of their life. They

are young. They are strong now. They are compensating in many ways but as they get older, that ability to compensate will diminish. And so, you have that as a vision for being able to care for them that far down the road?

DR. BECK: Yes and I am going to talk a little bit more about that because actually -- so, looking at the lifetime community of care and all of the different types of care that will need to be available is an area where I am going to talk to you just a little bit more about that in a minute, as I also want to highlight for you family support is important and has to be in place throughout all of these levels of care; case management, benefits management important, and then of course managing the medical information as people move from site to site.

So, --

MR. REHBEIN: Ma'am, if I may, --

DR. BECK: Yes?

MR. REHBEIN: -- because that brings up a follow-on to what Ms. Dailey just said.

Over the years we have seen the VA get farther and farther out of the long-term care business as facilities have been closed down and people have been moved off, moved out into publicly provided, privately provided facilities, what is your vision then for these folks that multiple amputees, TBI problems, some of the continuing health problems that are going to develop? Do you see VA being the provider for those folks? And if not, who is? Because there is almost no one out there, that I am aware of right now, that is capable of providing those kinds of services, particularly as we hear about NFL concussion problems and maybe early onset Alzheimer's. There is a multitude of issues here that have to be dealt with and I am not sure who the provider is to deal with them.

DR. BECK: Yes, I would say, first

of all, that VA is the provider. And VA has a commitment to providing lifelong care. And we actually have a number of initiatives. And we have a number of extended care programs. And what I would ask you to think about is we, number one, want the patient or the Veteran to be as close to home as possible. And number two, we have a number of programs. It doesn't always mean being in an institution.

VA has, we have a geriatrics and extended care program. And it is really the extended care programs that we are working on now. We have a number of programs that are serving Veterans very nicely, and I will talk about a few of them. And what we are doing now is we are really looking at those programs to see how they need to be extended, expanded, or changed to meet the needs of our younger Veterans.

So, we talked a lot about home-based care. So, we are sending folks into the home. And I think the caregiver legislation

really helps us do that because the caregiver gets a stipend. Respite care can be paid for or is paid for. And there are a number of other services available to support the caregiver if the patient wants to stay at home. There is a medical foster home program where, and this is very active in the communities now where a veteran can live with the family that is going to provide care and support but they would live in a home, like your home or my home where they are not in an institution. They are in a home.

And the term nursing home as our geriatrics folks like to tell me is one I shouldn't be using anymore in VA. I should be talking about community living centers. And so we are changing that whole mode of making it a person's home and having services and things available to them that are appropriate for the residents. And we do have some places in the VA right now where we have our younger veterans who are living in community living

centers.

My point is, I could go on. We are looking at something called veteran-directed care. And we are actually using that lot now with our polytrauma patients. I can think of two of them recently that went home using what is called Vet-directed Care, which is money that the Veteran can decide what services are need and how to pay for those services.

So, we are working on a continuum of programs. We have a group that began this work several years ago and has identified the processes and the possibilities and is now working on the outcomes. And I don't know, do we have a slide on that?

DR. CHANDLER: Slides 22 and 23 really sort of highlight the long-term services that you were talking about.

DR. BECK: Okay. Yes, so I wanted to be responsive to your question now but I do want to tell you that in the forward-looking

part of this, I will go over this again.

CO-CHAIR CROCKETT-JONES: I want to ask one question.

DR. BECK: Sure.

CO-CHAIR CROCKETT-JONES: Sort of there is a mirrored situation in the DoD that has occurred to me in looking at this. Your polytrauma cases that get referred to you and go to your centers are a pretty small population. And what I am wondering is, is there a vision of the perhaps larger population that is out there that, in some ways, are polytrauma but other injuries did not warrant them long -- they weren't amputees necessarily. Their injuries didn't quite make it to the point where they are going to rise up to this level but who will have long-term TBI complications, multiple diagnoses and, in many cases, are going to need the same kind of extended life-long intervention. Are there programs to reeducate or bring them back up to date or retrain them on their TBI protocols?

You know, I think that from what I have seen, I feel pretty confident that if someone is in that smaller cohort of severely injured and in a polytrauma sort of line of care, that they are going to get what they need. That they have a lot of people gathered around them for a long period of time and lots of resources.

I am a little concerned that a lot of these same issues are out there for folks sight unseen. And so, if you want to address that.

DR. BECK: And we are concerned about that and Dr. Scholten is going to tell you what we do about it.

DR. SCHOLTEN: Right. And I think if you remember back to the time line slide that Dr. Beck -- toward the beginning of the presentation. So, as the system of care was stood up, the focus was particularly on those very severely injured that needed the acute inpatient rehabilitation. And then we became

acutely aware of the much higher number of cases of mild traumatic brain injury and multiple comorbidities, particularly pain, post-traumatic stress, depression, insomnia, substance abuse and the line goes on down the line.

VA then implemented the TBI screening program, which screens every Veteran that comes to the VA for care. Now, that obviously can only catch Veterans who access the VA for care. So there is still the other non-VA cohort. So that cohort is out there. And that is, I think, one of the challenges that we have identified later on in the slide deck.

But those individuals that screen positive are seen by a TBI specialist. And if they have ongoing rehabilitation needs, have an individualized community reintegration -- rehabilitation and community reintegration plan of care developed and actually given to them. And the team works on that plan with

the Veteran.

Now, the vast majority of those Veterans have mild traumatic brain injury, are living at home, either independently or with family, and may be struggling to maintain employment or stay in school. And that is of the 110 polytrauma teams around the country, that is the vast majority of their work.

That care plan is then updated on a periodic basis. We don't have a -- there is not a set in stone time to review. We don't do it every three months. It is actually individualized, based on the Veteran's needs. The family and the caregivers are brought in to participate in that plan or reviewed the plan by phone or however the Veteran wants that done. And then that plan is individualized and is ongoing until the rehab needs are met.

There are a couple of slides coming up that talk about the kind of extended care services and that is also an emerging

issue and there has been multiple task forces but Dr. Beck is going to talk about that as well.

DR. BECK: Yes, and I think one of the good things that I think we have done is as you have looked at this continuum, what we know is we have got services throughout the country at 90 medical centers and 40 more medical centers. So, when a patient does come in and go through this process, the provider who is working with them on the team, knows that there is everything from sending them back to an inpatient center to putting them in a transitional to doing an individualized care plan, so that they get services at home. And that is what we mean by individualized, in terms of we are looking at that patient's needs.

Because I think the other thing that we have learned is that while there is fascinating work going on that is allowing us to look at the brain better and to image

better, and I think that is an important future for us, what we do know is we have to treat the patient, based on their symptoms and their needs and the problems, not necessarily on their diagnosis of mild or moderate or severe.

CO-CHAIR CROCKETT-JONES: I think the thing I remain a little unconvinced about is that the DoD is appropriately alerting you to those folks that are coming out of their transition units who probably need this kind of oversight. And really, the transition unit has been providing it through recovery care coordination and those things. And I am not sure that you all are getting necessarily the proper heads up in connection to the DoD from the transition units on those things. I am not sure what the protocol is for that alert.

This really isn't for you but I am just saying this so that our Task Force members can sort of go forward looking at that as we go to our installation visits.

EXECUTIVE DIRECTOR DAILEY: Yes, and let me just say the VA has mitigated that with their screening. So, if you can get them in the door, if you can get your veterans in the door --

CO-CHAIR CROCKETT-JONES: Yes, and get them to them.

EXECUTIVE DIRECTOR DAILEY: -- they have this. And it has been very effective. I saw it work very well. They screen for sexual assault, military sexual assault.

And so I think some of the nuances are, though, do you screen them for TBI every time they come in or are they only screened on that first interview? Or is there a periodic screen for TBI, once every three years, once every five years?

DR. CHANDLER: They are screened initially for TBI, however, they are also screened for depression, PTSD, military sexual trauma, substance use. And that

symptomatology is looked at by primary care providers on return visits and those kinds of things ongoing.

DR. BECK: So to address the issue, that is a concern that we have always had is how is that transitioning occurring. I think that Lisa can talk a little bit about it. It has been a major initiative in the Department, starting with Mr. Gingrich, our former Chief of Staff put a group together a couple of years ago, recognizing that managing that transition is a key part of what we need to do and there is a very comprehensive task force that has now been set up and has been studying this. And I think you are going to see or we are already seeing some outcomes from that task force to try to do a better job with this.

And to recognize that the coordination and the referral process is one that we have to honor because the way that the military does it, and even the Army versus the

Navy versus the Air Force is different, and that is one of the things we are managing, as we try to manage all of the services.

So, I know that that work is going on and I don't know if you want to say something about it, Lisa?

MS. PERLA: You did a lovely job of describing it. It is the Interagency Care Coordination Committee and polytrauma case managers, obviously, are a piece of that. But it is transitioning patients from DoD to VA and VA back to DoD and the idea being at any point in time the patient has one lead coordinator and that person transitions the Servicemember or Veteran in a warm handoff. It is in its infancy. We have rolled it out in an initiative on the East Coast and then in VISN 17 in San Antonio. So, we are learning a lot through that Interagency Care Coordination Committee and this Lead Coordinator Initiative.

DR. PHILLIPS: Let me ask --

EXECUTIVE DIRECTOR DAILEY: I just want to clarify one thing. Hold on, sir, just a minute.

It is, though, only for your very seriously wounded, at this point, the IC3's lead coordinator, checklists are for the very seriously wounded. It is for polytrauma.

MS. MALEBRANCHE: Actually, Denise, that is one of the things that we are writing and drafting the policy on right now because former Captain Evans and myself sit on that group. And we are trying to -- it is not for every single individual but right now we are looking for those that are seriously injured.

So, there has been some discussion on describing and defining Category 2. So, it wouldn't necessarily be only polytrauma. It could be a lesser level but not the walking wounded or that level of care just yet. So, defining the population is part of what the policy is doing right now.

EXECUTIVE DIRECTOR DAILEY: Great. Great, that is very helpful clarification.

DR. BECK: And I think one of the other things we have learned is that sometimes the Veterans don't know what kind of problems they are having. That is kind of the purpose of the screening and the referral. Sometimes it is not until they have lost a job or missed appointments or gotten in fights with various things or they can't -- I mean you have seen -- so, I think that our screening program is trying to work with that in identifying that once they are Veterans. But the transition piece, yes.

DR. PHILLIPS: Let me ask along those lines, a process question. Are the family caregivers required to attend? Are they involved or is it voluntary? I know on the DoD side it is different than the VA side, especially in the transition.

DR. BECK: I wouldn't say -- we encourage it and that is our goal. But for a

number of reasons, we have to honor what the Veteran and the family wishes to do. That is always our goal and we work towards that.

DR. PHILLIPS: If you could wave your magic wand, would you change that? I mean, understanding the patient's needs and understanding their dilemma, would you rather not be able to have someone there to support that, a caregiver?

DR. BECK: I think we would prefer to have someone there. We think that really successful rehabilitation is going to include the community, starting with the family.

DR. PHILLIPS: Because we all know there are certain exceptions but, in general, sometimes the Servicemember is not able to make an appropriate decision related to a family caregiver.

DR. BECK: Exactly. And I think one of the things we have had to navigate very carefully is situations where the family recognizes the need and the patient does not.

And it can be from things as simple as managing their money. And we see it a lot between mothers and sons; the 22-year-old who wants to be independent and doesn't want mom taking care of him.

DR. SCHOLTEN: Mothers and wives.

DR. BECK: And wives. Joel says the same thing with wives. I'm sticking to the mothers.

DR. PHILLIPS: I don't want to put words in your mouth but this is something that this Task Force can address in a more formal way, related to the role of family caregivers.

DR. SCHOLTEN: Well, and I think it is important to remember that the Veteran defines what -- we have to let the Veteran define what family means to them. Because there are often complex family dynamics and we have seen many kind of split families between parents and spouses. And so that is a challenge. But we would -- one of the roles of the team is to work on educating the

veteran and the family and, hopefully, we can work with the Veteran to kind of see the benefit of engaging the family and caregivers in their plan.

DR. PHILLIPS: Yes, we are aware of that and we know it can be a conundrum. But again, I think we have been more passive. Even though we are encouraging family caregivers to be involved as far as the regulatory aspects of it, we have been more passive than aggressive. You know, put on your seatbelt. I mean we don't care. You had better war your seatbelt. So, a little vague.

DR. BECK: Yes. Thank you for that comment.

So, I just want to finish up because I think I am over time here with letting you know some of the things we are doing is looking at the literature to see again the issue about long-term care needs, what needs, what can we expect to see. And so, we are doing some of that.

Looking at what we anticipate from the literature and from our own experience in terms of access to primary care or to mental health care; ongoing need for medical rehab; vocational rehabilitation; and again, I am putting a plug in for supported employment as being part of the continuum that happens during the medical rehab because that has been an area where we have had difficulty, even in talking about that as part of medical rehab; access to assisted living, which we have that pilot going on; and then our community center.

So, looking towards the future, addressing long-term care needs. And this goes beyond polytrauma. We are also looking at spinal cord injury and various other kinds of disabilities.

But we did have a big task force look at what the needs were going to be need and do an assessment of what our assets were. From that, we formed a number of groups that have been working in various areas. I talked

about assisted living. I talked about medical foster home. I have talked about providing care in the homes with primary care. I talked about Vet-directed care as some of the programs that we are currently using.

Last fall, we had a lifelong care summit. We had it in Tampa so that we could have families and Veterans and active duty Servicemembers talk to our group. And we brought our primary care providers, our extended care providers with our polytrauma providers because this is a partnership among all of us now. And we now have a group, a Steering Committee managed by our Deputy Chief of Patient Care Services that is developing and managing and tuning the programs that we have for the younger veterans.

In addition to that, VHA has an Advisory Committee on Care of Veterans. This is a legislatively-required committee. So, we have an overarching committee that is, each year, looking at our initiatives, looking at

our accomplishments, and directing us to think about the future and what our needs are. And that group is also working on this.

So, here are some of the things I think I have mentioned them but let me say them again. Our caregiver services and respite options, residential care options. I think you can read some of these. We are looking at what is the best way to continue with our restorative programs. When do we need to readmit people as inpatients and do evaluations? What is the family training need? How often do we see the patients? I think Dr. Scholten talked about some of that. How do we do a better job of getting the person home? I think we learned a lot in the early days, in terms of being sure that the family and the homes were ready to take care of the patients at home. And we have our teams that go into the homes. And then our ways with video telehealth, et cetera.

Lifetime care needs and thank you

again for bringing up the general medical providers in VA because we have had an ongoing initiative to train what we call our PACT Teams, Patient-Aligned Care Teams that our primary care providers and their teams to recognize and manage the medical care and the symptoms and work collaboratively with us. And we are doing a lot of work on that now and to integrate that more effectively particularly with our milder TBI, where there is an overlap with mental health and with traumatic brain injury and with pain management, in particular.

So, and then again, the vocational rehab; the return to work, the ability to work, the importance of that goal and ways in which we are teaching people how to be effective employees and to learn that skillset as part of their rehabilitation.

And then we recognize we will have needs for long-term institutional care for some of these patients. And the important

thing to do is to be sure that we have a Veteran-centric thriving system or capability for our Veterans to thrive in those systems by having the right type of long-term institutional care.

So, those are our forward-looking goals as we are managing and thinking about the future.

So, a couple of challenges for us. We are a little bit frustrated with TRICARE and I think you are fairly aware of the fact that TRICARE, like a lot of insurance plans, pays for some things and doesn't pay for others. And so, sometimes when we are referring a patient back for transitional care or various other kinds of care, we find that the waiver requirements are different from different regions of the country and sometimes they are just not paying for care that is needed and that is a challenge for us.

I think all of our teams have learned to work that insurance piece of it

with TRICARE but it is a challenge and it does, sometimes, delay and, in some cases, we are not able to always get the services that we need for the next stage of care.

And then I think an area that you have identified throughout this discussion is that we worry about those Servicemembers that never come to us. Right now about 52 percent of everyone that is discharged from the military, whether it is active duty or Reserves is coming to the VA and you know they have five years' of eligibility. But a lot of people don't because they have other insurance and that is fine, except for the fact if you have ongoing rehabilitative needs, the best place to be is in the VA because we are providing comprehensive care. We are not limited to ten PT visits a year. We can coordinate the care.

And so the worry that we have is exactly the one that you have identified, because we don't know about them if they are

not there. I think you will find that all of our groups are very connected with the private sector and we are able to identify and find patients very often but we recognize there is a gap.

And I don't know. You know the ongoing thing of communication, communication, communication is critical. That is why we have done the polytrauma website. That is why we have done the videos, to send the message that this care is available and it is available lifelong and it is pretty special, I think, the comprehensive nature of the kinds of rehabilitation we are able to provide.

I thank you for your time and your interest and your very good questions. If there is any more time for questions, we are happy to take those questions.

And I also want to tell you that we have a network of amazing providers in rehab. You go into one of those polytrauma centers and you see a lot of the same people

who were there in 2005 are there today doing the hard work of seeing the best and seeing all, but always being there to take care of these Veterans. And they are the ones that I work for every day as I work for Veterans. And I never forget that we wouldn't be able to do what we do if we didn't have this amazing group of providers out there.

So, thank you.

EXECUTIVE DIRECTOR DAILEY: And real quick. I'm not sure you know but we were going to follow up on this briefing, very comprehensive briefing. We do have three visits scheduled to your polytrauma centers.

DR. BECK: Oh, good.

EXECUTIVE DIRECTOR DAILEY: That is not quite the reaction I wanted. I was hoping, oh yes, we know you are coming. But now you do.

DR. BECK: He did know.

DR. CHANDLER: I did but I hadn't told her.

DR. BECK: We did know.

EXECUTIVE DIRECTOR DAILEY: Okay.

DR. BECK: He probably did tell me and I just didn't --

EXECUTIVE DIRECTOR DAILEY: Okay. So, that is good. We are hoping to get a briefing in San Antonio in December during our December briefing.

DR. BECK: Great. I'm so glad you are going there. It is really -- it is interesting. What I didn't tell you is that we have worked with our Facilities and Construction Group and we actually had a Design Group work for a year with our clinicians, working with the architects.

EXECUTIVE DIRECTOR DAILEY: Great.

DR. BECK: It is so interesting. And I think you will see in the polytrauma center, because we have meditative places, we have gardens, we have quiet spots. The lighting is organized a certain way. That is so important to the treatment and that is the

other piece that VA has really been working hard on.

EXECUTIVE DIRECTOR DAILEY: Good.

DR. BECK: So, I'm glad you will get to see it.

EXECUTIVE DIRECTOR DAILEY: We will be visiting Tampa also and Richmond.

DR. BECK: Good. Great.

EXECUTIVE DIRECTOR DAILEY: So, looking forward to following up this very good briefing with the fullness that you get at the centers themselves.

DR. BECK: Great.

EXECUTIVE DIRECTOR DAILEY: The other question was, we were in Chicago a year ago now. They had built a beautiful residential facility. They called it the Green Homes, the Green Communities. I get a head nod here. You know what I am talking about, it looks like.

MS. MALEBRANCHE: The Community Living Centers. The Green Health. We are

doing like an Eden sort of mix.

EXECUTIVE DIRECTOR DAILEY: Okay. And just you had mentioned that there were locations where our charter -- we care about all Veterans but our charter centers around the OEF/OIF. You had mentioned there are centers where this OEF/OIF population are living.

DR. BECK: There are a couple.

EXECUTIVE DIRECTOR DAILEY: There are a couple.

DR. BECK: There are a couple and I would like to be able to get you the exact locations because it changes. And so, the one that I have been most aware of has been in California, where we have had 40 or 50 younger Veterans with the diagnosis of TBI who have been in one of our community living centers.

EXECUTIVE DIRECTOR DAILEY: Okay.

DR. BECK: So happy to get more information about that. But it is really depending on patient need.

EXECUTIVE DIRECTOR DAILEY: Our travel is pretty locked at this point. We definitely probably won't make it out to California. But if there is something I could shift out of our current schedule, I would look at doing that.

DR. BECK: So, I don't know. We do have younger folks actually in the D.C. Polytrauma in the Community Living Center there, but they tend to be more shorter stay. They transition home more. But you can see there the ways the rooms have been reconfigured, the way the whole environment is, and the way they are managed to take care of and meet their needs. So, we do have some of that as well. That is more transitional, though. That is not really long-term.

EXECUTIVE DIRECTOR DAILEY: And we are not pressed for time, other than biological issues. I am the next briefer and I am happy to give my time up to you guys if there are any more questions here, please.

MS. MALEBRANCHE: Just, is there anything, Lu, I am not familiar with at Richmond? Because we are going to Richmond. Is there anything there?

DR. BECK: Richmond has a transitional unit. And actually, they have two transitional programs. The one is the one I talked about today, TBI polytrauma. But they also have another program which has been called STAR, which it was initially set up to manage amputees who needed transitional rehab but has now expanded to take other diagnoses as well. So, you can see those.

They do have a long-term care unit. I do not think at this point, though, there is any OEF/OIF younger patients in that center.

But and Richmond just opened a new polytrauma center which I haven't seen yet, which I am told is really wonderful.

So, you will be able to see the transitional center, the acute inpatient

center when you are there. And they are doing a lot with vocational support. Richmond, you may know, is a community that is very engaged in working in supportive employment for individuals who need to learn to return to work. And they have been very responsive to our polytrauma patients.

MR. DRACH: Do you know if that component is working with PBA's rehab program in Richmond?

DR. BECK: I do not know that but we can certainly get that question addressed. Yes, because we have a very active spinal cord injury unit and I think you will see when you are there that the physical medicine rehab service and spinal cord injury coordinate and collaborate on a lot of things.

MR. REHBEIN: As we start to think about Veteran-centric community living centers, the State Veterans homes come to mind. Are you working with any of them to begin to prepare them?

DR. BECK: Yes, I am not working directly with them right now but that is on our list with the Task Force that we talked about today and with the extended care leadership to work with the State Veterans homes, yes.

MR. REHBEIN: Because that really begins to address the closer to home aspect.

DR. BECK: Yes, really good point. Yes, thank you. That is a point well taken, which we will be sure gets incorporated.

DR. CHANDLER: Dr. Beck, I would just like to remind Task Force members perhaps as an orientation for you, we did provide folders for you that gives an overview of the Polytrauma System of Care. There is a DVD with a 28-minute video, which may give you a good orientation ahead of your visit, narrated by Gary Sinise and very well done. So, you saw the clip but that may be a nice orientation for you ahead of your visits.

DR. BECK: Yes, I would really

encourage you to watch that. I know you get a lot of CDs and things. Because it is told through the -- it is the story of three or four Veterans who have been there. And they really talk about the commitment that they make and their families make, which I think is an important perspective to have.

The folders are actually right behind you there and we will be sure they get handed out. And we also have a complete, it looks like you already have the briefing in your notebooks, but we brought that as well.

EXECUTIVE DIRECTOR DAILEY: We will get those passed out. Those are good materials for prep for our visits.

DR. BECK: So, I want to thank you very much for giving us the opportunity to present today and for your interest in our Polytrauma System of Care and for the work that you do on behalf of all Wounded Warriors and Recovering Warriors. We very much appreciate it. So, thank you.

CO-CHAIR NATHAN: Can I just say one thing, since I came in late, very, very late? And this may have been covered. But again, it is an amazing continuum of care. You don't know me but I used to Command Walter Reed Bethesda and went down to Richmond and Tampa on several occasions to follow up with the more complicated cases, just to make sure and see how the handoff was going.

There were lots of growing pains at first and I have an affection for the Tampa VA system. I did my internal medicine training at Haley Hospital USF. But I was impressed by the desire on both sides to try to figure out how to reduce the communications gaps that were occurring. We would send patients down there and there would be yow yowing that they were coming with things we hadn't discussed. Patients would go down there and have expectations that weren't being met because they had they had been given a different set of expectations before they got

there.

That feedback loop stayed robust and strong between there and between Palo Alto, Richmond, Minneapolis, and I think it really is a model system. The challenge for the VA is we look at it as how do you deal with the individual who receives the Buck Rogers prosthetics or TBI care at Tampa or Palo Alto or Richmond and then ends up in Des Moines or Kansas City, away from the major Meccas of the MTFs. And we are still working through those CONOPs now.

And then the last thing I would say is that one of the great problems we have now, and I call this a great problem, is we have much less need for the polytrauma in the MTFs because the wartime casualties are going down, thank God. So the robustness in our areas at C5 in San Diego, CFI in San Antonio and the MATC at Walter Reed now have to figure out how we are going to maintain that competence of care. And one of the ways we

are going to do it is we are going to partner more and more with the VA system in trying to share patients, admittedly, from different origins. Our patients tend to come to us from IEDs and yours tend to come from you from peripheral vascular disease and diabetes. But nonetheless, there is overlaps there. And I think we will see a lot more bang for the buck for the taxpayer as we combine our resources and our prosthetic experts, as well as our rehab and physical therapy and occupational therapy experts to do good stuff.

That's my commercial.

DR. BECK: And thanks for your comments. And thanks for your leadership at Walter Reed because we did talk extensively about the various things that we had done with embedding the A staff at Walter Reed and various other things to manage and really grow and develop and mature a good, coordinated, integrated system. And we did learn as we went.

But to your point about the future, I think one of the most valuable pieces of the Centers of Excellence are being stood up is that they give us a way to coordinate and integrate. And I was just at C5 last December, where C5 has taken, I think, about 150 of their Veterans retired amputees who have always been getting their services at C5 and move them to the VA. And the leadership of our San Diego VA with the C5 site has made that an extremely smooth transition. We have insured that the technology is equivalent and the expertise is equivalent and really made the veterans feel confident that the care that they are getting in San Diego now is the equivalent to the care they were getting at C5.

And we got the amputation physician from C5 when he retired now works for the VA, which is another thing we talked about. So, that is another way we are sharing the future, if you will and being sure.

But I appreciate your point. I think that is important. One of the things that we are faced with in the VA is maintaining the capability that we have built to take care of these seriously injured and to always be ready. And God willing, there won't be a next time, but if there is, we don't want to have to build a system again. We want to maintain that expertise, but also use our resources effectively.

So yes, thank you.

CO-CHAIR CROCKETT-JONES: Thank you, Dr. Beck. This has been terrific. And thank you to your whole team.

I think we are ready to take a bio break. So 15 minutes.

(Whereupon, the foregoing proceeding went off the record at 11:13 a.m. and went back on the record at 11:33 a.m.)

EXECUTIVE DIRECTOR DAILEY: Okay, I'm going to start. I want everyone to know

that this is a set of information that actually Dr. Phillips presented to myself and the staff in a number of papers that he gave us. One was handwritten. You could tell it was a thought process going in his head. And then one was an email, a very long email. And I took both of those documents and I combined them into this briefing so that we could get ideas that he has. But I know that these ideas have been resonating in some of the other members' minds for a while. And so I wanted to take this opportunity to put all these ideas in one place at one time. And so Dr. Phillips is going to be jumping and providing illustrative thoughts behind his concepts.

DR. PHILLIPS: I plead the Fifth.

EXECUTIVE DIRECTOR DAILEY: Okay, the Fifth. Well, I assure you I have no problem being up here all by myself.

So it has just been kind of a one-stop opportunity to here to pull all these

ideas together, figure out what we have accomplished really over these last three years, and then identify the gaps. This is a forward-thinking opportunity for us to, again, look at what we have accomplished, see the gaps, and then how can we work forward in 2014 for 2014 recommendations to fill those gaps.

So, we called this global. Your topic heads here and the topic leads on the slides are big topics. All right, essentially you all have a very tactical mission but we have kind of grouped these topics into global, overarching issues. And we are going to march down some of our recommendations against some of those global issues, see what we have done and see where the gaps are.

And again, this is kind of a thought process that Dr. Phillips is going through. It made for a great opportunity to kind of get it all in one place. And I do think it has been bubbling around in your minds also.

All right, so the task here is what we want to do is we want to look at some global areas that have not been addressed by the Task Force. And so once we can kind of hone in on those, maybe we can ensure that we include them in the 2014 report.

Okay, so first kind of broad kind of overarching are would be DoD and VA, very broad. And right now, and we worked through this a couple of times, the two big rocks, let's say, in the rock to use military language between DoD and VA is the electronic health record and IDES. So, we have got these two big, and I will use other analogies, you know muscle movements between the DoD and VA that we, as a Task Force has been making recommendations on for the last few years and we have been trying to watch DoD and VA kind of move down the road on these big issues.

Now, we have heard a little bit today about the technology transfer between DoD and VA. I have noted up here and Dr.

Phillips also pointed it out was we are not getting a lot of information about integrating civilian information into this electronic health record system. I don't know who to touch but the basic scenario right now is you PDF, you email, you fax any civilian consults into the MTF and into your provider.

And so you know when you are looking at gaps or you are looking at places that aren't being covered real well, that is one of them. We see a lot of movement on electronic health record. We see a lot of movement. We got some information today about how DoD is moving information back and forth. But this civilian piece might still be outside the lane.

In our IDES process, we have --

DR. PHILLIPS: Could I --

EXECUTIVE DIRECTOR DAILEY: Yes, please go ahead.

DR. PHILLIPS: I will keep my microphone on.

You know we all move -- I mean I know I move between all three systems. I am either at Walter Reed, I am in a civilian system, occasionally at the VA. It depends on where I am. And I think many of you have the same experience. And our co-chair has been saying forever we have one monetary system for the U.S., we should have one IT system.

I mean it is easy to say. It is very hard to do, related to the political environment and everybody's sandbox. But I think it is something that at least the Task Force should try to emphasize that we need to have the experts develop some way that health information transfer can somehow be harmonized between the three systems because that is a bottom line issue. We just heard that nearly 50 percent of the Veterans don't even go to the VA except occasionally.

So we really have functionally in the U.S. people working as one system but administratively, we have three different

systems. And that is an issue.

CO-CHAIR CROCKETT-JONES: Yes, it seems to me that if we have an enormous of providers receiving federal dollars in the form of TRICARE and Medicare that there should be some incentive to be able to talk, to have a single electronic system or at least compatible electronic systems that can talk to one another, even if what it did was facilitate better payment, something that would incentivize a system.

And it doesn't have to be one. To compare it to monetary, at least we know how to change money from one currency to another. I mean, that seems to escape us when it comes to the ability to exchange information throughout medical records.

EXECUTIVE DIRECTOR DAILEY: Okay. So, what work have we done in this area? So, you have some Recommendation 19 was an IDES recommendation. That was in your first year.

And then Recommendation 20 was an

electronic health record recommendation. It was a broad recommendation. You basically said in 2011 what you just said right here, which was come together, find an electronic health record system. And we know we have progressed since then. We had one single plan brought forward in 2012. And then in 2013, we had language in there that talked about -- we didn't make a recommendation but we made a recommendation that you still need to figure this out. So, you have done some work in this area.

DR. PHILLIPS: May I just add?

EXECUTIVE DIRECTOR DAILEY: Yes, go ahead.

DR. PHILLIPS: Just to be a little more specific, obviously, it would take a real magic wand to suddenly create a whole, an IT system that is harmonized across the U.S. But there are components of the existing IT systems that can be harmonized. For example, we heard about coding, ICD-9. I mean, I am

more familiar with that than perhaps you are but things like that can be emphasized. Terminology, if you have a thesaurus or some common terminology and I don't want to take too much time but there are components that subject matter experts can go into and help accomplish this.

EXECUTIVE DIRECTOR DAILEY: And I think what I am going to look to find is those points that Dr. Phillips just made about the coding, the harmonization, the data points and I am going to try and pull that in for a briefing, so that we can assess where they are on that piece that he is addressing. And then if we think we need to make a recommendation there, we will go forward with a recommendation on that type of information.

I believe we discussed this a couple of times in the summer. I believe I can get that information from the IPO briefing.

Okay, so you had two issues here,

EHR and IDES. We have made a lot of recommendations on IDES over the time period. And I think the gap here in your IDES, unless you want to kind of rejigger your current recommendations, the piece that hasn't been touched is the holistic approach to the IDES, is the change in benefits and disabilities which changes a way of thought, a more strategic thought process in your disabilities and benefits programs. And this is an unworked area. And we said yesterday when we talked with Congress, there isn't a lot of support. It has a lot of visibility. Everyone is talking about changing the disability system holistically but there isn't a lot of support for it.

All right. Looking at some other DoD/VA big rocks. So, we have a detailed policy to ensure the warm handoff. We got a great briefing here about the level of coordination between DoD and VA at the polytrauma centers and we have the warm

handoff process involved. We discussed it a little bit. Is it sufficient? Do we need to work down to Category 2s? Ms. Malebranche stated that the Category 2s, the seriously wounded are going to be, it is almost like a case-by-case management to find those who would need a lead coordinator. But it is starting to move down out of the very seriously wounded transfer, warm handoff requirement into maybe a top tier of your Category 2s. So, it is an area that still needs to develop.

Now, you all had a recommendation last year about warm handoff that didn't address very seriously wounded. I can re-resurrect that one this year but you all pitched it pretty quickly last time, when we looked at it in June. It was a warm handoff recommendation for the not very seriously wounded. We knew the VA Polytrauma System and the seriously wounded had a good handoff system. The recommendation centered around

emulating that for the Category 2s. And at the time, you all weren't that interested in it.

DR. PHILLIPS: Let me just add. Obviously, these aren't my ideas. I sit and listen, just as you do, to everybody else.

But the warm handoff, I mean in my mind and I think in your mind, and Suzanne has said this repeatedly, so much more can be accomplished and so many areas of difficulties can be eliminated if the family caregiver was actively almost required to be involved. I certainly understand there are nuances and there have to be exceptions based on their personal issues. But if somehow that could be part of the system, that is an individual or individuals who are seriously and very interested in the care and transition of their wounded Soldier and they will do above and beyond the call to make sure that things go smoothly.

So, it is something that this Task

Force can address in more detail.

EXECUTIVE DIRECTOR DAILEY: Now, we did split these out, a warm handoff transfer processes between DoD and VA and the caregiver process. We have -- you have made a lot of recommendations on caregivers, information for caregivers and I have listed three here. But if I went into other categories for WTUs, if I went into other categories like information exchange, there are more recommendations in those categories.

So, you have done a lot of work over the years on your caregiver emphasis and your attention to their needs. And I don't see any gaps there. You have touched it many times. And I'm not sure where we can take the caregiver issue over this year. Unless -- the only last place to take it, ladies and gentlemen, is the mandatory. That is the last place you can take it.

DR. PHILLIPS: Well, remember we discussed the fact of whether you can sign a

piece of paper to either approve information being transferred to your caregiver or sign the piece of paper in the opposite fashion saying I disapprove. It is assumed that they will be part of the process unless you disapprove it. Right now it is the other way. And I don't mean formally sign a piece of paper but your caregiver is part of the process unless you say absolutely not and these are the reasons why, as opposed to the way it is right now where we would like you to have your family member of caregiver be involved.

CO-CHAIR CROCKETT-JONES: From a personal standpoint, this is something that has improved enormously since we started looking. When we first started looking at caregiver information, we had a very different reaction. There was a lot of even hostility to the concept. And now, we see lots of programs and intentions in leadership to improve this.

And I am actually pretty happy on things as they have developed. I think cultural change takes time but it has started. And I think it will continue. I don't think this is one that has the potential to -- I think that since the waive has changed in some ways, I don't think it is going to quickly go back. I think that the policy changes that have happened are pretty good. But on the concept on the warm handoff, I think I am not convinced that our transition units adequately prepare or make that warm handoff. I think that the folks that are going to VA are not necessarily prepared for what they will encounter. And I am not super convinced that this warm handoff happens down to the level of folks who probably need it.

I think it is just like the drop off from inpatient to outpatient care within the DoD system. There is a site unseen aspect that once someone has been in a transition unit for an extended period of time during

that whole IDES system, it sort of by the time they are leaving, I think there is a lot of assumptions built into the well, now he understands the system. Now they are fine. Now they are ready.

And I am not sure that the reality matches what the assumptions are made about their ability to get fully integrated into the programs that would help them at the VA.

EXECUTIVE DIRECTOR DAILEY: Okay. We got the message. We will bring back that warm handoff recommendation that we had in 2012 -- 2013.

MR. REHBEIN: And I think as you look at that warm handoff recommendation area we have also heard that there is not even a particularly warm handoff between the WTU and the CBWTU.

EXECUTIVE DIRECTOR DAILEY: Well, we --

MR. REHBEIN: Specifically, remembering back to Arkansas where there was

talk that some of these folks aren't ready to be here but they are here.

EXECUTIVE DIRECTOR DAILEY: Correct.

MR. REHBEIN: And we didn't know they were coming.

EXECUTIVE DIRECTOR DAILEY: Correct. Correct.

Okay, let's talk a little bit about a big overarching concept of our military services, including the Guard and Reserve.

Integrating and aligning their services, integrating and aligning their policies, their regulations. And although it says policies and regulations, this is also Dr. Phillips, you were talking here, you were also concerned here about this is not necessarily defining Category 1 or Category 2. This is about defining elements of healthcare that need to be transferred between DoD and VA and the civilian environment. Correct.

So we have made recommendations for common terms. You made a recommendation for that in 2011. But this is about a technology transfer of what data elements are important when you are transferring between DoD, VA, and civilian healthcare providers.

You all have touched on Recommendation 1, which is the standardization of these processes. And then for our services, the same standards, the same outcomes for training, for tour of duties. This is your personnel management, skill management training. You have made a lot of recommendations in this area.

Am I still on track on here, Dr. Phillips with your thought process on this slide?

DR. PHILLIPS: Yes, ma'am.

EXECUTIVE DIRECTOR DAILEY: Okay, so you have been very -- you have done a lot of work in this area in making recommendations for alignment and synchronization of their

efforts.

Okay. So, here is a big concept about where to put these major healthcare providers for your units that you all have kind of touched on the edges of over the years. In the first year, I believe it is the first year, you had information and you did some work on where is the best place to put WTUs and Wounded Warrior Regiments. And your second recommendation talked about aligning it with the appropriate resources and aligning it with the needs of the families. You didn't talk geography about where. You know should you align these WTUs with the Mayo Clinic, with the Cleveland Clinic? Should you align them with polytrauma centers? Is there another way of thinking through putting them at the Campbells and the Stewarts and the Fort Hoods?

Now, in the first year, you didn't go in that direction but it might be something be worth rethinking as they start drawing

down.

LT COL KEANE: I guess I have a thought on that.

As the regiment is considering their footprint and they are possibly probably going to contract because of financial -- in the draw down, I don't think they have the money to relocate anything. So that is just kind of financial considerations.

If it was 2007 and we existed, moving a regiment is a thought not already in place, I don't think either the Army or the Marine Corps have the money to relocate.

DR. PHILLIPS: Let me just expand on that just a little bit. I certainly agree there are certain financial issues.

But thinking about, personally, if I were injured, where would I want to be? Well, I want to be home. I want to be near some loved ones, whatever. But primarily it is in my best interest in the best medical facility possible. Now, it is not realistic

to consider that the Army, Navy, Air Force, Marines, et cetera can create at every location the best medical care possible. I mean, it just can't happen. But if strategically we are able to create some alliances with major medical centers that are in specific locations around the country, the Harvards, the Stanfords, whatever and they may coincide with a medical facility in a VA or they may not coincide. Iowa is where we are from. The VA is in Des Moines but the University is in Iowa City, 120 miles away.

So, if there was a next time around there is a need for this from the starting gate, have some sort of relationship with the civilian sector or the university, the high quality care centers and say, listen, we think we should locate this at least for a temporary care needs. And then they could move on to the standard places. I mean, that is just a general concept. It is a strategy.

MR. REHBEIN: One of the other

things this brings to mind, too, and maybe this is something that we really could spend some time looking at is the CBWTU concept because it brings some advantages of being close to home and being with family. But it brings some disadvantages, too, because you have to deal with that TRICARE Network and you have to deal with access to care. And so maybe that is a legitimate area that we could really spend some time looking at is the CBWTU concept. Has it done what it was intended to do?

EXECUTIVE DIRECTOR DAILEY: But we will be bringing a briefing in on the remote care program. Keep in mind that piece is only addressing the Reserve component.

MR. REHBEIN: It is only addressing the Reserve component. But if we follow along with the line of thinking here that we locate a WTU near the high-class medical facilities, we are essentially replicating the CBWTU concept for the active

duty.

EXECUTIVE DIRECTOR DAILEY: Right.

DR. PHILLIPS: And I might say, this transcends physical issues as well. I mean behavioral health, which is a major issue I think would be very helpful. I mean just having, and we know this, having Servicemembers in a remote location with behavioral health issues and having to travel to a center of excellence for their care, that alone is detrimental.

CO-CHAIR CROCKETT-JONES: I just want to say that when we first started working on this, the population that we were -- it took a while for the transition units to really define who their population was going to be. And I think the entrance criteria has been more and more defined over time. Their policies have gotten hard and clear. And I don't think that they are taking in folks with the high end of medical needs.

So, the transition units, I think

it is less compelling now than it once was that we have transition units be at the most sophisticated medical services. But I would say that Mr. Rehbein's point is definitely true, that the CBWTUs shouldn't be off a cliff. Our expectation is that the reason why someone needs to be in a CBWTU is because they are still receiving care.

So, although I get Dr. Phillips' point, I think that the approach has to be more, as we look at this, it has to be more carefully aligned with entrance criteria and who the population has wound up being in transition units.

DR. PHILLIPS: Oh, I absolutely agree with you. I mean, I was talking in global terms. There is no question the percentage of Servicemembers that I am talking about are probably small. And they are probably small enough in a way that, depending on the location, that a university or medical center would accept them, even though

administratively they are part of a WTU or something for that transition. I think that is something that we could utilized, that they exist and that they will be more than willing to take care of our Servicemembers.

CO-CHAIR NATHAN: Just another it is a penny for your thoughts but everybody puts their two cents in. So somebody is making a penny somewhere.

One of the things that we have to reconcile is that there is some significant changes coming to the military health system. It is going to get smaller, not bigger. There is going to be contraction of resources across the board, maybe with consolidation of care into a few areas. But we are going to start seeing the decrement of some of our inpatient capability across the country. We are going to start seeing the decrement of some of our surgical care across the country as we look at consolidating our resources in certain key market areas.

What does all this mean? Also, there is going to be more pressure to divide the tasking that we perform in military and base facilities, compared to the VA.

DoD has sort of gotten into the rehab business. It wasn't our primary mission but if you go to San Diego, San Antonio, Portsmouth, Bethesda, Madigan, Travis, you will see a tremendous rehabilitation capability there, taking care of mostly patients who have been wounded but all the way from severe motor vehicle accidents to brain injury. Don't quote me on this in speaking for DoD, but my perception in looking at the tea leaves is that is going to start to subside as resources contract and we start giving more of the rehabilitation capability back to the VA system, where it was designed to be in the first place.

So, I think this is a very circuitous way of saying that I agree with you. We have to look at creating allegiances,

alliances, and affiliations early on with the civilian, private, academic VA sector in DoD because we are not going to have, two, three, four, eight years down the road, the footprint that we have today. Our hospitals, in some cases are going to get smaller, in some cases are going to go away and in some of our more robust facilities, we are going to contract some of those things. It doesn't mean we won't have superb capability in certain areas. It will just be more concentrated and fewer between.

So, I think that the Task Force has to recognize that as we deal with this, looking at how we spread out a recovering warrior and their family in the country, recognizing I believe we are going to have ask the private sector to do and the academic sectors to do more heavy lifting and be more incorporated in the care plan, which is going to require even more liaison and connecting the dots and continuity of care, so that

people don't get lost into the interstitial spaces.

This is what the Reservist has been living with for years. The Reserve Recovering Warrior comes back and basically says hey, Admiral Nathan, what you are saying ain't new to me. I have been sort of in the seams here in Iowa or Kansas or Arizona for years. But that hasn't been the predominance of forces from the active duty, the active component. So I think we need to recognize that as we look at a strategic change in the military health system.

DR. PHILLIPS: I agree. Thank you. And I am guessing it wouldn't be as difficult as we think because most of these major referral centers are already used to having patients not only coming from other parts of the country but internationally. And they have systems to manage families and medium term care and so forth. So they are already organized to accept people from

outside their medical service area.

EXECUTIVE DIRECTOR DAILEY: Okay, good. Next slide.

Big rock, behavioral health. How are we approaching behavioral health in utilization of the DCOEs for psychological health and traumatic brain injury?

What are centralization within these entities for research efforts for evaluation, for policy generation? In particular, the behavioral health for psychological health and TBI has policy making authorities. You have done, again, some work in this area. You have made recommendations in each year to strengthen, improve, utilize these resources to a better degree.

So, this has some traction. It had traction up on the Hill also. They also wanted to see greater empowerment of the DCoEs altogether.

DR. PHILLIPS: Can I jump in again?

EXECUTIVE DIRECTOR DAILEY: Sure.

DR. PHILLIPS: I just couldn't help thinking that when we had the draft and we needed people, if I showed up and said by the way, I have a substance abuse problem, chances are they would have said we don't need you. I mean, we have enough people coming through the pipeline.

Having said that, with a full volunteer Army it is wonderful. But when we needed to surge and I don't have any statistics and I don't want to be officially quoted, but I think we basically relaxed the rules a bit on who can come onboard. And if someone has a preexisting condition, it is not fair to that individual to put them into a vigorous military strict environment. And it doesn't do the armed services any good to have somebody they are suddenly burdened with that can't be a warfighter or carry out their assignments.

So, I know we haven't talked about

it a lot and I know probably it is not an issue at this point. But for future conflicts, I suggest that we perhaps think about recruitment standards in a way that will help reduce some of the issues that we have run into.

CO-CHAIR CROCKETT-JONES: I also want to say I would like us to find out if this DCoE has considered the approach that was made with TBI -- just to the VA, just talk to us about aligning ICD-9 codes and language. If that same approach, I mean it seemed to have better traction, TBI treatment changes in progression seems to have happened in a more smooth and predictable way over time, than we have seen in behavioral health, especially with post-traumatic stress. And I am wondering if we can ask if any work has been done with the same view of redefining and finding singular harmonized look see if the DCoE for post-traumatic health or behavioral health has done that work in diagnosing post-

traumatic stress.

EXECUTIVE DIRECTOR DAILEY: There are new codes out for PTSD. DSM5, is that correct? DSM5 expanded the definitions of PTSD. All agencies adopted it. That is how they do it. And there is an input and a buildup period allowing various agencies to provide input to changes to the DSM.

So, the answer to that question is yes. DCoE and VA worked on the clinical practice guidelines for PTSD and the evidence-based therapies that are now jointly used between both services and agencies. So, that is a yes.

So, --

CO-CHAIR CROCKETT-JONES: I'm trying to see how sort of the outside world of behavioral health is -- there just seems to be no real traction in this area. There seems to be no methodology for getting more clear on diagnosis.

You know I am wondering -- I know

what is happening inside a DoD and a VA but I am wondering if the sort of the larger community is being --

EXECUTIVE DIRECTOR DAILEY: Okay.

CO-CHAIR CROCKETT-JONES: Do you see that? That is why the coding and things is interesting to me.

EXECUTIVE DIRECTOR DAILEY: Okay.

DR. PHILLIPS: Well, I would say you are absolutely correct. I mean there are wonderful places and wonderful people working on this area and it is not easy. But in some respects you almost want to say we need a Manhattan Project. We need to get 500 of these people into a big room and not let them out until they come up with some recommendations.

People talk to each other. I know the Centers of Excellence and the civilian sector, they integrate. But from our point of view and I guess from the public's point of view it is not happening fast enough. And the

civilian population have similar issues, after hurricanes or disasters and mall shootings and all the things that are going on.

CO-CHAIR NATHAN: I think we are starting to see some congruence and alignment in TBI. It is happening because of the better awareness now in school sports injuries, the NFL, the NHL. And so I think we are starting to inject more science and less art into it across the spectrum.

You know if you have a heart attack, you pretty much get the same car everywhere. No question there is some avant-garde care in certain tertiary care centers. But pretty much you get the same care, whether you are in one area of the country or another. Not true with post-traumatic stress. Not true if you are being seen by a suburban office practice versus a tertiary care referral hospital.

If you happen to land at UCLA with Dave Hovda's group, you are getting the

latest, greatest stuff in the history of the planet. If you land at Walter Reed or San Antonio, you also are getting very good stuff.

We do a better job in the military, I think -- and we don't do a great job by the way, but we do a better job in the military of creating standardized care and diagnostic and therapeutics for post-traumatic stress and TBI mainly because of DCoE, NICoE, NICoE satellites, those kinds of things. The big challenge is, you don't know what you are getting in the private sector. And the problem with it, of course, is that the private sector is going to start bearing and more and more of the burden of people with PTS and TBI.

You have heard our quotes before. Up to this point in the war, about 1,600 Warriors have suffered amputations. That is 1,600 too many but it is 1,600. As you know, the figures in the military produced about 1,600 a month of people with mild-moderate-

severe TBI. Most of those are from garrison accidents, motor vehicle, falling off a pool deck or something; 20 percent were coming from the war. But nonetheless, that is a huge number of folks coming. And then you add the PTS to that and there is, I have used the term, tsunami. There is a tsunami of people, as the war ends, coming back from the Veterans and the Recovery Warriors that will be discharged as the Services downsize, as the Army goes down by pick your number, but down to maybe 330,000 to 350,000. So, they could lose 100,000 to 125,000. The Marines are going to lose about 30,000. The Navy is going to come down some. The Air Force is going to come down some. We are going to see all these people coming back, landing on the streets of our cities. And so how do we approach this as a community, as a consolidated community, linking arms with the military DoD, VA, private academic sectors.

So again, this is, I think, going

to be our great challenge, to avoid the post-Vietnam influx of people who were affected, either through TBI and/or mostly PTS that ended up somewhat caught between the seams. I think we have a better appreciation for it now.

But again, I think anything this Task Force can do to emphasize at the -- we have said before, Denise, this almost has to be at the Human Health and Services cabinet level to create some sort of congruent approach to post-traumatic stress that is put through in the nursing schools, the medical schools because we needed it yesterday.

EXECUTIVE DIRECTOR DAILEY: Good.

The concept of the Comprehensive Transition Plan, the need for one document to transition individuals from start of the injury to recovery, or into the VA, or into the community of care if they are injured.

Our Comprehensive Transition Plan has a number of iterations, so far. In the

DoD you have two dominant ones. One is the one developed by the DoDI, which is the Comprehensive Recovery Plan, the CRP and then the Army's CTP. Common elements in them, common intent: transition an individual through this care, period.

So, you have made a number of recommendations on it. We have received briefings on where this plan is going. It is in a transition phase also right now. Ma'am, do you think that the IC3 has got their arms around major changes to this? Do we think the IC3 is going to change this concept?

MS. MALEBRANCHE: There has been -- there is a whole group of DoD and VA folks working on this comprehensive plan. There has been a major, major effort. I don't know to say that they are going to have anything soon. It seems like the electronic health record and a lot of things have been influencing part of that. Perhaps we should have a briefing from the joint co-chairs of that group to give us

an update. I sit on one group there, actually this afternoon that are having a meeting and giving an update to the senior leadership. This is in Secretary of Defense Health Affairs and also our Chief of Staff. So, I don't know where that particular group is but they are moving in that direction, yes, having a great deal of I think difficulty because of all the other things that are going on, too.

So, I don't know if we are going to see something. I mean, certainly the intent was to have something at least started in this year. And also, to go along with this policy but I don't know the progress they have made. I have not been totally integrated in that piece.

EXECUTIVE DIRECTOR DAILEY: Okay. You all, as a Task Force, had put your stake in the ground in 2012. And you had a very robust discussion. Again, you weren't going to get in the details of it. You weren't going to try and tell them how to suck the

egg. Your 2012 Recommendation 11 said one plan. You put your stake in the ground for one plan.

DR. PHILLIPS: And I may add, I mean we all, I think, agree that having a comprehensive plan is intuitively a very good idea. But my questions -- but what has happened is, it is not achieving, at least from what we hear from the focus groups and feedback, it is not achieving what it was intended to do.

So, the questions I would ask, is there administrative and technical issues related to its function? Is it an administrative burden overall to the folks that have to proceed with the plan? Are the answers to the questions that have been asked perceived by the Servicemember as harmful to them? Like, I won't be able to go home for the weekend if I answer yes or no.

So, I mean, these are the things we want to know or are there not enough staff

to process the plans? I think the concept is a very good concept. I mean the planners and the people that we have been briefed by, the administrators say it is wonderful. And yet we hear from the Servicemembers that it really doesn't work. So, I think there are certain questions that perhaps we can ask them to try and see whether or not these are the logjams.

MS. MALEBRANCHE: I think Dr. Phillips is right. One of the things when he was talking earlier about the common elements, I think that piece is still working, but we have come to some agreements in the group about the common elements.

And now they are talking about automating this. However, I don't think automation should be the end-all be-all, which maybe we are getting a little bit, folks are a little bit hung up in. But it did seem like on our focus visits this past year, I was surprised that the actual Servicemembers and Veterans did not know of this plan. And so

the communication of that piece, I mean they were calling it by different names, maybe, but I was very surprised that the caregiver sometimes and the Servicemember did not know of it. And that, to me, was something that was kind of surprising.

EXECUTIVE DIRECTOR DAILEY: Yes, and you all have made recommendations in those areas.

For 11, the tactical level CTP/CRP issues, which you identified, ma'am, which you are still identifying as we go out, have been addressed. You have made recommendations that they have access to it. You have made recommendations that it be visible. You have touched the tactical level of the CTP/CRP several times in your recommendations.

Okay. So, into the easy slide. Dr. Phillips recommended we do a look at the other Task Forces that have done recommendations, that have provided recommendations in our field. I am not going

to get to it today. I am going to release you all here for lunch. I am going to get through a couple more slides, the base of his thought process but I will, sometime in the future, will talk about other Task Forces and what they have seen.

All right, big rock. Information -- one-stop information, education. We had a great discussion about this in 2013. You have made a lot of recommendations on it over the years. I have listed some of them. I have also talked about the lead coordinator's role and how there is some traction to try and have a one-stop shop, have one person ensure the handoffs are warm. Also, that is their function. So, you have done some work in this area. I have my bullet here. It says does not address Category 2, seriously wounded or ill. But we think it is going to reach down a little farther than Category 3.

It is difficult with the concepts of CTPs and the information delivery all

changing so rapidly now. It is difficult to get a hold on the answers to your questions because they are still be developed. It is policy. You put policy in place. You see how it works. And you can't always see how your policy is going to work before you have implemented it.

And you have had that concept well-grounded in the Task Force, which is you need to put your policies in place, ladies and gentlemen, before you can measure their effectiveness.

So, you all have been around the horn on this delivery of information to DoD to the Servicemember. You have made a lot of recommendations on it.

Okay, harmonization. We are going to bring this kind of back full circle. The next two slides talk about how we take all this information and we allow it to be synchronous between not only DoD and VA but the vision here and the vision also

articulated by Admiral Nathan is the civilian community, who will very possibly be absorbing a lot of these issues into their communities.

So, you bring another player into the mix, the Department of Health and Human Services. How do they interact at a strategic level, at a national level for delivering services or building a vision for delivering services?

DR. PHILLIPS: And I was just going to add we are all very close, from the VA to the DoD or the civilian sector. We may be too much in the weeds to look at the big picture.

Obviously, I think intuitively we would agree that if everybody could just work together it would be wonderful. But how do you do that? And so just a quick suggestion because there are intellectual bodies that address issues like this. National Academy of Science, Institute of Medicine, I mean I am on a variety of different programs and committees

with this. And they come out with a formal white paper recommendation and they have the ear of Congress and the people of the powers to be and often, that is very helpful. It is a long-term plan and we are all moving to that direction, Defense, Health, Agency, and so forth.

EXECUTIVE DIRECTOR DAILEY: And then the other bullet: what is the future of the Department of Defense Health System going to look like? We have received a briefing on the Defense Health System from General Robb last spring. We are going to look at several of the enhanced marketing system areas as we visit San Antonio, the Tide Water, and Hawaii. So we will get kind of a better look internally to DoD on where a large agency is going with creating efficiencies in its healthcare system.

DR. PHILLIPS: That's the theory.

EXECUTIVE DIRECTOR DAILEY: The theory, correct. So they were going there.

Whether they get there or not -- again, models to do this are tough. Modeling your policy is difficult. We go off and make a lot of money doing that. I think that they did that with the banks in 2008.

All right. So, if I pull kind of some gaps out of our recommendations and the briefing on the other major committee's recommendations throughout all the agencies, I am kind of -- I am seeing it kind of coalesce around these three bullets. We haven't done and don't have a lot of work done on very top level pulling together of various agencies. I mean one of our tasks is DoD/VA and other agency, what is the word, the language in the legislation? I can't remember the language in the legislation, interoperability, possibly.

So, we have touched on it as one of 15 topics. It might be worthy of a whole new Task Force all itself. And it might be worthy of your attention to make that as one

of your -- think about it over the rest of the years as moving forward after you have shut your operations down. And then so those first two bullets kind of talk about that.

And then one of the unworked areas again I use this third bullet. We talk about the Disability Evaluation System. It is changing it holistically and this is my last bullet has got visibility but it doesn't have a lot of support.

So, those appear to kind of be two of the areas that the gaps are coalescing around when it comes to our tactical. And we have made some global recommendations over the time period also. I think the first two bullets talk about harmonization among agencies, a national plan, essentially. And then a holistic look at the disability and benefit systems.

Okay, that is my conclusion.

DR. PHILLIPS: I just want to say a word. Ms. Dailey and the staff, I just

deeply appreciate you taking my rantings and scribbles and so forth and putting some logic and organization into it. And I thank you very much for doing it.

EXECUTIVE DIRECTOR DAILEY: It was a good think piece. I think it has been a good think piece for the members also.

The second part of this tab is the recommendations of major committees. I won't get to it today. But I wanted you to know that it I made a very interesting briefing. So, we will plug it in somewhere else.

And I am going to release my members for a half-hour lunch. It is set up in the same room that we were in yesterday. Correct? Okay, good. I'm hungry.

Thank you very much for giving me a half-hour of your lunch period.

(Whereupon, at 12:28 p.m., a lunch recess was taken.)

A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

(1:05 p.m.)

CO-CHAIR NATHAN: Okay, I think we've got a quorum. At this time, we are going to get a Physical Disability Board of Review update and we are going to welcome Mr. James Davis, who is the director of the PDBR. Mr. Davis will be providing an overview of the PDBR and updating the Task Force on information provided by Mr. Michael LoGrande in December of 2012. You can find the brief for Mr. Davis' information on Tab J.

Mr. Davis, the floor is yours.

MR. DAVIS: Thank you, sir and thanks for having me here today. I don't know who the scheduler was who put me after lunch but thanks a lot, I appreciate that. And apparently you have only had 30 minutes for lunch.

First of all, I am glad to be here to discuss this with you. I have had about 26 years in the Air Force and then recently

retired. And I would tell you out of the jobs that I have had, this is probably the most satisfying one that I have had, other than Command. It is a unique opportunity to help our Servicemembers in their time of need.

So, let me give you a quick overview. And I know some of you were here last year and others of you are new members. So, hopefully, I will not slow this down too much.

So, a little background on the PDBR. We were brought into being because of congressional concern about the way the services were handling disability for our members who are separating, that were wounded, ill, and injured. The solution to that was they established a DoD level board. And what they would look at is they would look at those disability ratings for Air Force, Navy, Army, Marine Corps and Coast Guard. That was made effective by the NDAA in January of 2008 and the Air Force was made the lead agent for that

and we operated, established ourselves as a joint organization under the review board agency at Andrews Air Force base.

So, why the Air Force? A couple of reasons. Number one, we have probably the smallest number of cases of potential applicants. So, we were seen as a disinterested party, to some extent. And we also had a Review Board Agency competency that was already in place that fit well into this particular requirement.

Again, I talked about functioning as a joint services agency and we fund this through a prorated basis to the services, based on the number of cases that they have outstanding that come to our direction and we are reimbursed on an annual basis.

What do we review? Well, DoD 6040.44 talks about a lot of things. But if you look in red here, that is kind of the nuts and bolts of what we do. If you have a combined disability rating of 20 percent or

less and you were not found eligible for retirement, you have the opportunity for the PDBR to review your record and recommend corrections if there are any discrepancies that existed in that rating.

The other thing that we do is that we use the VASRD, the VA Schedule of Ratings and Disabilities by the Service recommendations for when someone was separated. So, we use the VASRD that is in effect at the time of separation for the Servicemember, not the current one and not any service regulations.

So, that ensures that we have a consistency across all the services in our decisions. We will review these particular things, conditions that were found to be specifically unfitting for continued military service to see if the service made the right recommendation and then also conditions that were found to be not unfitting. If the Servicemember recommends that we look at that,

we will look at it and say was it still unfitting or not unfitting? Or if it was unfitting, what should have the rating have been?

Any questions on fitting and unfitting? Okay.

This is our process. And normally I wouldn't talk about this but it is important you understand how much work goes into one of these cases. We have an application unit down at Randolph Air Force Base in Texas and they act as a liaison with each one of the military departments and also with the Veterans Regional Offices. And they collect military records and files and the service treatment records and also the VA records from the member. And if the member submits an application with any accompanying data, that also goes in the file that comes to our unit here at Andrews Air Force Base, where we adjudicate that particular record. The member does not meet the board. It is just like

their record. Unlike the MEB or the PEB when you are in the service, it is just a records-only board.

So, comprising the Board we have one medical action officer and two other individuals that are either Lieutenant Colonel or Colonel or a civilian equivalent that meet the board. It is an administrative board. It is very similar to our BCMRs. And if the member is in the Reserve component, at least one member of that Board will have Reserve component time. Questions on that?

Some important things to note. We cannot lower a previous rating. We can either raise the rating that the member was given -- we cannot lower -- let me make sure I have made that clear. We cannot lower the overall rating. So, if a member had a 20 percent rating coming in, we might change one rating and lower it but there is another one that would go up and we would still have an end rating of 20 percent. We want to make sure

that the record is correct but we cannot lower the rating any more than it already is coming in.

And once you come to the PDBR in the military system, we are the final appeal. It can go through the legal system after their BCMR makes the adjudication.

So, once they are reviewed by the PDBR, we make a recommendation to the particular service, the Designated Decision Authority and most of those, like the Air Force Review Board Agency, SESs are senior, they will make the final decision. Our decision is not final. It is a recommendation to the Service. The Service still has the final say on what the individual gets.

Once they do that, they notify the applicant. They also notify the VA. And then, if there is a change to the monetary amount or the service rating, we will notify DFAS. And that does two things. That gets them back all of their retirement funds from

the initial date of separation and it gives them medical from that time. It can also, once that happens, if they are brought to retirement, they can also, if they have the paperwork, they can make a claim through TRICARE to have medical reimbursed. That may or may not happen but they can make the claim. Questions?

So, here is our outreach. The initial population was 77,000 personnel. We had planned five mailings. The first of those went out in May of '12, just over 17,000; 18 percent of those were returned because they had incorrect addresses. The VA is working to track those addresses to get correct ones. And to date, we have had an 8 percent application rate.

Our second VA mailing went out this September. It was 11,000 and that included some of those returned addresses from the first mailing. And that was delayed, due to a mental health review that we just began

last year. And I will talk more about that later on.

And then our last mailing was the third mailing on the 18th of October, almost 10,000 on that one. We expect future mailings about every eight weeks.

Now, you kind of see a gap between our first one, May of '12 to September of '13. Again, we were given a mental health review to do. And because of that and the uncertainty of the size of the mental review, we scaled back on our PDBR mailings.

These are our metrics. The numbers won't add up necessarily because we have some duplicates up there in the total. But about 6,800 total applications to date have been received. We have adjudicated 3,800. And 27 percent of those were re-characterized to retirement. So almost a third of those that submitted a package were brought to retirement, just under a third. And there is a split out by Service.

About 1,600 of them were administratively closed and those are just some of the reasons that we do that administrative closure.

We have 899 that in records collection. And again, I talked about that. That is probably the long pole in the tent is making sure we have a complete record for each one of these records. We don't want to move forward with adjudication without as complete a record as possible because this is their last shot without going to the legal system.

CO-CHAIR CROCKETT-JONES: Can I ask you a question on two items on this one?

MR. DAVIS: Sure.

CO-CHAIR CROCKETT-JONES: In the records collection, are you experiencing any issues where the VASRD rating requires testing that never appeared in the DoD medical, in the summary of DoD medical treatment? We have had an encounter where that was an issue someplace, that the VASRD rating described

test outcomes, a test that was not routinely done in the military. There was a disconnect under some diagnosis. And I was just wondering if that has come up that you know of.

MR. DAVIS: I don't that there is a trend to that effect. Not that -- Greg Johnson, my operations here with me. But I will tell you if the VA does attest and we look at the probative value of that test compared to and also how close was it to the member's separation date, we will use the VA information. Greg, have I got that right now? Yes, I will go with that.

CO-CHAIR CROCKETT-JONES: The other thing, on the administratively closed, I am wondering if any of those numbers going into retirement, I know there was a lawsuit that --

MR. DAVIS: The Sabo lawsuit.

CO-CHAIR CROCKETT-JONES: Yes.

MR. DAVIS: I think that was under

PTSD. We will talk about it later on in the mental health review. And those were all closed out as part of a legal settlement.

MR. JOHNSON: Some of those aren't included in that number.

CO-CHAIR CROCKETT-JONES: Thank you.

MR. DAVIS: Okay. And in our inventory -- ma'am anything else?

CO-CHAIR CROCKETT-JONES: No.

MR. DAVIS: Okay. In our inventory we have about 540 cases that we are adjudicating right now; 17 of those are in backlog at the -- they are in backlog with us, not with the intake unit. Because as our personnel went through the record and we are getting ready to adjudicate the record, they found that a piece of information was missing. So, we have gone back to the VA or to the service and say, you know sometimes you can tell when you are going through it will refer to another item. That item is missing. So,

we want to make sure we have as complete a record as possible before we move forward. So about 17 of those are waiting for that additional information. They have been there for about 105 days, which is our standard to try to get something through when we have it.

Questions on this?

EXECUTIVE DIRECTOR DAILEY: The administratively released, if you could go back, what is request by member for gathering of additional documents?

MR. DAVIS: Well, the member can submit whatever they would like. And what happens sometime is they remember an additional item. They say I don't want you to close my case out. I am going to go back and resubmit with additional information.

EXECUTIVE DIRECTOR DAILEY: Okay.

MR. DAVIS: And so we will do that at the request of the member.

EXECUTIVE DIRECTOR DAILEY: Okay.

MR. DAVIS: Okay, one of the

things you had asked for was a comparison of the last time that we were here to this year. So what I did is we took the exact chart that we briefed you last year and we put the '13 numbers in blue.

So, if you note, this is how many remain disability separation. This is how many were re-characterized to retirement compared to the last time. And we expected this to happen. The services got better at what they were doing, as time went on. And the ones that we are sending out is by year group and we are up to the 2005 year group. So, that was an expectation that we had all along as the services got better and did more of these. There is going to be a natural flow to decisions.

One thing I didn't say earlier was about 27 percent are brought to retirement. There is another 22 percent that we changed the rating but we don't get them to the 30 percent that is required for retirement

eligibility. So, we will find something in there that will maybe bring them from a 10 to a 20. And that doesn't affect the member monetarily at all. The amount of money they get is the same for separation. But it is making sure that we are going through and doing the right thing by the member. And they will know exactly, they will get that back in the letter that goes to them.

MR. REHBEIN: I want to be sure I understand your numbers. The black numbers are cases that were worked in 2012 and the blue were worked in 2013. These are not totals. They are each year's numbers.

MR. DAVIS: Right. They are totals, I'm sorry.

MR. JOHNSON: They are totals. They are totals.

EXECUTIVE DIRECTOR DAILEY: Yes, they are totals.

MR. DAVIS: Yes, but you can see the difference between the two.

EXECUTIVE DIRECTOR DAILEY: The black is what you had briefed a year ago.

MR. DAVIS: When we briefed last year, it is in the black.

MR. REHBEIN: Okay.

MR. DAVIS: And those are additionals.

EXECUTIVE DIRECTOR DAILEY: So that the numerators have changed. The denominators have changed.

MR. DAVIS: The other thing that we put down at the bottom was the adoption rates for the Services. That is a good news story for us. When you look at the Services probably were not too crazy about having their homework checked and that is what we do. And initially there may have been some pushback on that. But if you look at the adoption rates by the services, they are well in the 90 percentile. Remember I said, we make a decision. It goes over to the Service and the Service makes the final decision about whether

the individual has their disability rating changed. And they are in the 90s and two cases there, we are at the 100 percent mark. So, we have a good working relationship with the Services.

As a matter of fact, I was over at the Navy BCMR about three weeks ago talking to one of their doctors who is also a lawyer. I don't know who has that much time but he told us that they keep the PDBR cases that come to them, especially the minority cases where we write a minority opinion and we will do that. And he said we really don't have a law so much to look at. And you are the gold standard for when we are looking at an exceptionally difficult case we will look at the PDBR and say what did they decide in a similar case. So, good news about what we do.

MR. DRACH: Excuse me. Last year, you had a little over a third and this year, -- or 2012 you had a little over a third and 2013 you had a little less than a third.

MR. DAVIS: Right.

MR. DRACH: But you had a very high adoption rate. And I may be getting ahead of you but is there a trend? Do you see a trend in terms of what "error" is being made that is causing this?

MR. DAVIS: You are right, you are ahead of me. That's okay, though.

Again, we are going down but there is a slide -- let me see if it is the next slide. Well, there is two slides. The first one talks about through the years. This is re-characterization to disability retirement by year group. And I think we can, when you look at the conflict and the amount from 2004, it starts to go up and tapers down. It would be right in line with the conflicts that we have been in in the last few years. So, probably more injury during that time period, more severe injury to our personnel.

Those are the percentages by year group. And then in the column itself, those

are the raw numbers that go with those.

And then to your question earlier, these are by Service, the top three reason for re-characterization. So if you look over to the left, the Air Force asthma is number one, mental health is number two; and the back injuries are number three.

For the Army, it is mental health, then the back and then arthritis. And for the Navy and Marine Corps, the Department of Navy it is mental health, back, and leg and foot.

MR. DRACH: Mental health is a very big umbrella.

MR. DAVIS: It is all encompassing.

MR. DRACH: Have you broken it down any further into the types of mental health, PTSD, for example, depression?

MR. JOHNSON: We have not, but it is mostly PTSDs is what I am seeing. I have read every case that we have done since we have adjudicated before they get signed and it

is mostly PTSD that I have seen as the mental health condition.

MR. DAVIS: Questions on these slides?

So, I talked earlier -- go ahead ma'am.

CO-CHAIR CROCKETT-JONES: I actually have a question.

MR. DAVIS: Okay.

CO-CHAIR CROCKETT-JONES: So what percentage of those mental health re-characterization numbers were originally a temporary disability rating that did not -- I mean, how many people that you see would have gone through a TDRL before getting to your review? Do you have any numbers on that?

MR. JOHNSON: I don't have exact numbers, no. But those that should have been on the TDRL in accordance with 4.129, if they hadn't been, we will recommend that they change the records to show that they were put on the TDRL. And then we will try to

extrapolate and find what their condition would have rated at the 6-month point after the six months on the TDRL period.

So, if they hadn't gone, we will take care of it and make sure that they do get that time in the TDRL. We haven't been tracking whether or not the numbers, whether it is how many have been and have not been on the TDRL.

CO-CHAIR CROCKETT-JONES: Thank you.

MR. DAVIS: This brings me to our next project here and that is a mental health diagnosis review. We are a special review panel to the BCMRs. So, most of you probably know about the Madigan cases at Fort Lewis, Washington, where there was some issue about the mental health designations for personnel, that they may have been changed and lowered from the beginning of the process and to the end.

And so the Sec Def, in response to

that, has committed to a thorough review of that. We went to all the Services, that the Services looked at everyone from the period of 9/11 all the way up until 30 April of last year. And they came to us. They did, like I said, a thorough review, each one of the Services of Mental Health records of every individual. And then they brought all those records to us. And working with the VA, we sent out a mailing. About 10,000 personnel, I will show you that in a couple of minutes. And we are reviewing all of those, to make sure that those were properly adjudicated.

We have a term of reference. And I put that up here and I will talk about it here in just a second. But it is really important that we discuss that particular area there.

Again, here is the criteria for the terms of reference. They can be on the TDRL at this point for us to look at that. They have to have at least an MEB under their

belt. And these are folks that are referred into the DES and you noted I underlined that. They had PTSD previously and their diagnosis was either changed, downgraded, or eliminated completely. And they could have had anxiety or depressive disorder and that diagnosis was changed to adjustment disorder or eliminated.

Those are the criteria that we have to stay within on our terms of reference. And the folks down here are the ones that we excluded. Obviously, anybody that has 100 percent service disability rating, we are not going to be able to help that individual. We are already doing as much as we can. If it is already a case that is open, an appeal to the PDBR through another avenue, through the core PDBR process, we will continue to go through there and we will look at that mental health aspect. Or if the BCMR has it for a mental health condition, we won't look at it.

And then lastly, we talked about the Sabo case, the PTSD case and those are

already settled. So they are not eligible for this. So, that is the terms of reference. It is a document that we are given that says this is the box that you will stay in.

So, we sent this mailing out and identified again from the services about 9,100 individuals. We started getting those back in and very few of them met the terms of reference.

MR. DRACH: Could you go back to the previous slide, please?

MR. DAVIS: Sure. Yes, sir.

MR. DRACH: On your anxiety or depressive disorder, a diagnosis changed to adjustment disorder or eliminated. Adjustment disorder, is that under the 9400 diagnostic code, do you know?

MR. JOHNSON: I don't know.

MR. DAVIS: I don't know.

MR. DRACH: But it is part of the rating schedule.

MR. DAVIS: Someone in the back is

saying yes.

MR. DRACH: It is not determined to be preexisting or not a disability under the law.

MR. DAVIS: Right.

MR. DRACH: So, it is still a disability.

MR. DAVIS: The chronic disorder in April of this year was changed to a condition that we will look at.

MR. JOHNSON: Prior to this, adjustment disorder was not a condition that you would get compensated for and separated for under the DES program.

MR. DAVIS: And they just changed it to chronic adjustment disorder April of this year. And that is from that point forward, is the way we are looking at that now.

MR. DRACH: I guess where my confusion comes in, if you are using the VA's rating schedule, adjustment disorder, I am

going way, way back in time, but adjustment disorder was not something that would be considered service-connected under VA standards, under the 9400 diagnostic code series.

MR. JOHNSON: Yes, sir. What we are looking at is if their anxiety or depression was changed to adjustment disorder and we are to look at to see if that change was appropriate.

MR. DAVIS: If you are downgrading them out, we don't want the member to be disadvantaged. So the first things are what we are looking for, they had either PTSD, anxiety or depression or depressive disorder and we downgrade that. Then that is automatically within one of the arenas that we will look at.

MR. DRACH: Thank you.

MR. DAVIS: Sure. So, again, we had the Services identified individuals. The Army did quite a broad look and were very,

very thorough in getting us numbers. And I think it was one of those we would rather be safe than sorry things. We want to make sure that everyone that possibly could have been under this review is there. And that is what we have done. Again, almost 9,000 of those, 8,898 were Army members. And again, that is self-identified by the Army. They brought them to us.

So, initially when we got this we started looking through and we found that quite a few of them, or the vast majority of them did not fit within our terms of reference. And we just wanted to make sure we were doing the right thing. So, what we have done is we have made the decision in conjunction with the Service MNRAs that we will look at every single record that is brought to us by the Services, whether they meet the terms of reference or not. We want to make sure that we have done everything right by our Servicemembers.

So, we will mark, board, and adjudicate every single one of these that comes through with one of three decisions. Yes, they were within the terms of reference and something was changed to disadvantage the member. And we will make that recommendation as an SRP, Special Review Panel to the Service BCMR. Yes, they were within the terms of reference but there was no damage to the member. And that will go back. They were not within the terms of reference and we will just send the letter back that says didn't qualify. And there was nothing in here.

We have actually had some records where there was no mental health. And it is a very thorough, I mean thousands of pages in some of these. We go through every single one of those pages to identify. And it is not a computer check, either, it is an individual that walks through those records and checks.

And then lastly, if it is outside of the terms of reference and we find

something else in the mental health area, it is kind of like the good Samaritan; we don't drive by, see a wreck, and just keep going. If we find something in there that has a mental health aspect to it that is outside of our terms of reference, we will still bring that to the services attention and say you need to possibly look at this or contact the member. So, those are our actions right now in the mental health review and we are moving forward with that.

So, just like our other PDBR cases, these are records-only panels. The member does not have to come.

And I would tell you that when we looked earlier at the eight percent return rate, I was a marketing major in college, about 20 percent is usually what you look for when you do a survey. And we are only getting about eight percent. And I think part of that may be due, and we are working this on the PA side of the house. I just started working

that.

Most of these Servicemembers, this comes out of the blue to them, number one, when we contact them. Number two, they probably remember I had to go through the MEB process and the PEB process. They are painful for some of them and they go, I don't want to do this again. And they are thinking I have got to go stand in front of a Board again. So, we are going to try very hard to get the word out to the VSOs.

And one of the things we were talking about yesterday was hey, let's get out to the universities. These young men and women, they are not like us. They were in the service before our grandparents or our uncles. The VFW is not the place they all go hang out at. But there is quite a few of them that are doing their GI Bill right now and they are at universities. So what we are going to do is try to go through the universities which have Veterans offices and, if nothing else, have

something put up that says hey, did you know about this. If you were in the service between these two dates and you were not brought to retirement but you were separated for a disability, just hand in a sheet of paper. That is all you have to do. I think if we get that word out, we will get more folks to respond.

MR. DRACH: Is the Student Veterans of America on your radar and/or the American Council of Education where they have a very robust Veterans program?

MR. DAVIS: We can check with that. I know that we did change our second batch of letters. Our first batch that went out from the VA that told them about it just said here is the program, here is your opportunity. The batch that we just sent out in September of this year also included 26 VSOs. You can contact these Veterans Service organizations for help in filling out your application. But yes, just one of the things

we have been talking around is are we throwing the dart in the right direction to get these folks to, number one, aware of what is going on, and what it is that they have to do, which is in and of itself very little. It is one sheet of paper. It is a 294. All they have to do is say review my records and we will do that. They don't have to do anything else.

And when you think that one-third of the ones that we have looked at so far have been brought to retirement, we should push hard.

And that pretty much is my briefing, subject to your questions.

CO-CHAIR CROCKETT-JONES: Just a question on the mail outs from the VA. You noted the first one was an 18 percent return. Have you gotten any on the later ones?

MR. DAVIS: Yes.

CO-CHAIR CROCKETT-JONES: You have. And is the address they are using, is that from the defense manpower database? Is

that where it is coming from?

MR. DAVIS: Various sources but most of it is from the VA because they have probably the best address.

Many of these members when they leave the military, that is the last we see of them, unless they are connected to us somehow. But quite a few are still attached to the VA. And I think the Services, at least for the mental health review, I know the Services, I know the Army, they are looking everywhere, Facebook or wherever because they are getting addresses for us for those other ones. We are doing everything we can.

CO-CHAIR CROCKETT-JONES: I figured VBA probably had the best because usually you look at least where the check is going to.

MR. DAVIS: Yes, ma'am.

CO-CHAIR CROCKETT-JONES: But now they go to institutions, rather than addresses.

MR. DAVIS: Right.

CO-CHAIR CROCKETT-JONES: Thank you.

MR. DAVIS: You know the other thing about the mental health review is that is another tricky one to get people to answer. You know you get this out of the blue, this says hey, you may be eligible for this. Many of them have gone on to work for the government later on, gone to work for industry and the last thing they want is someone asking hey, do you want me to look into your records and see if you were mentally competent. That is hard thing. And most of them have moved on with their lives. They don't want to unearth that. There is a thought there.

MG MUSTION: I have a couple of questions.

MR. DAVIS: Yes, sir.

MG MUSTION: When the PDBR considers or conducts their review, do you consider a review material which was not

previously made available to the PEB or the MEB? For example, if the former Servicemember elected to provide additional information that was not made available or was not available for the Service to make their determination related to the PEB.

MR. DAVIS: If it is part of their medical record, yes, we will look at it.

MG MUSTION: I understand that. But what I am asking is if the former Servicemember elects to go gather additional information that was not made available and was not considered by the Service PEB in rendering their decision.

MR. JOHNSON: Yes, sir, we will consider that. We also go out to the VA and get copies of all of their post-service rating decisions and the exams that go along with those decisions and use those in our consideration as well.

And anything they provide as evidence, we will look at, whether it was

considered by the PEB or not.

MG MUSTION: Okay, so that kind of opens a Pandora's box, then, at least in my view that you are indicating you are overturning 27 percent of the determinations or recommending overturning 27 percent of the findings ratings rendered by Physical Evaluation Boards of the Services. But yet, you are doing that based on information that the PEB may not have had access to.

MR. JOHNSON: Yes, sir.

MR. DAVIS: Well, for some of those, if you think about it just from the VA portion, you know this is before IDES. So under IDES we look at the VA rating and that is it. That is the rating.

The PEB would give, okay, here is the unfitting condition. Here is the rating that we will give you. And the member goes after that and they get their VA exam. And we have always looked at the VA exam for probative value if it is the proximity of that

exam is close to the time and member separating. So, we will weigh the two. And again, I will tell you that is a very spirited -- I have listened to the vast majority of those cases ongoing. And it is not a flippant decision. Those goes on for a long period of time about whether that after the fact information is meritorious and should be brought in and used.

Greg, am I missing something? We Board Tuesdays, Wednesdays and Thursdays. And some of those are telephonic boards. I listen to pretty much every one of them.

MG MUSTION: I understand.

MR. DAVIS: And I will tell you there is not very many okay, this is --

MG MUSTION: So what insights had the Board provided back to the Services, as it relates to indicators, trends that the Services could do better at to get at that 27 or 28 percent, whatever the number happens to be?

MR. DAVIS: To get at or to lower it?

MG MUSTION: Well, if you are identifying, if your Board is identifying that 27 or 28 percent of the time you are finding the service was in error, that is basically what you are saying.

MR. DAVIS: Right.

MG MUSTION: Okay, why? What are the trends or indicators associated with that that can go back to Services? Is it an area of training? Is it an area of interpretation of specific elements in the disability process or specific elements related to particular types of conditions that the PEBs are not interpreting correctly or they are interpreting in a manner different from how you are interpreting it?

MR. DAVIS: Sir, number one, all the cases go to the Service to make the decision. So they have that data in front of them.

MG MUSTION: I understand that because they come to me.

MR. DAVIS: Sir?

MG MUSTION: I said I understand that because they come to me.

MR. DAVIS: Yes, sir.

MG MUSTION: So, I'm just trying to figure out what is the instructive loop here? You are saying you are recommending overturn in 28 percent of the time, there has got to be a reason. If a quarter percent of the cases you are finding in error, which would be my interpretation, why are you finding them in error? So, that the Service can begin to adjust that.

MR. DAVIS: One of the things we talked about is bundling and unbundling conditions. And we have passed a lot of this on to the Service, the trends themselves. I don't know what the channel that we use is.

Greg, do you have anything on that?

MR. JOHNSON: Well, the QAP program is coming up to address that.

MR. DAVIS: Right. Well, I didn't want to address that but I will.

EXECUTIVE DIRECTOR DAILEY: Last year when Mr. LoGrande was here, he said that the basic change is occurring because the Services had published addendums and additional guidance to the VASRD.

MR. DAVIS: Right.

EXECUTIVE DIRECTOR DAILEY: And when you strip those out, and you guys can beat me down here, I'm just trying to recall what Mr. LoGrande said, when you strip out the additional information that the Services added to adjudicate these cases, the change is the pure VASRD being applied to those records.

MR. DAVIS: So, I would tell you that those examples are the Army paying policy. That is one of those things where it is in the Army regulation we don't use that. That was in the first slide. We don't use

what the Services previously use. We use the VASRD that was in effect at the time. And that is what we make our decisions on.

So, the other one is bundling of different injuries into one disability rating. We will break those apart and look at each one of those and write it on its own merit. And that is where we probably get a difference in decision.

And I can talk to the QAP. Is anyone from the QAP here?

CO-CHAIR NATHAN: Well, I think the General's point is your roughly 25 to 30 percent revision rate has been fairly consistent over the last few years.

MR. DAVIS: It has actually gone down.

CO-CHAIR NATHAN: How much?

MR. DAVIS: It has actually gone down.

CO-CHAIR NATHAN: Thirty-six to twenty?

MR. DAVIS: Well, and before that it was even higher. When we first, initially, before '12 it was Greg?

MR. JOHNSON: It was 36 last year. Prior to that it was in the 60s. So it is coming down dramatically.

MR. DAVIS: The Services --

CO-CHAIR NATHAN: So you would attribute that then to the -- this is what he is asking about -- a feedback loop that the Services have become better and more adept at doing this?

MR. DAVIS: I think so, right.

MG MUSTION: And I think another point, sir, is that the cases that you are principally adjudicating in the earlier phases were prior to IDES.

CO-CHAIR NATHAN: Right.

MG MUSTION: And I think the closer you get to IDES, the more consistency in application you begin to find.

CO-CHAIR NATHAN: Do you have a

SWAG at what number of members are utilizing attorneys to correspond with you or to represent them?

MR. DAVIS: It's not a large number.

MR. JOHNSON: Two percent.

CO-CHAIR NATHAN: Not a large number.

MR. DAVIS: Not a large number at all.

MR. JOHNSON: Two percent, very few.

CO-CHAIR NATHAN: Have you noticed any particular predominance in that? Does that help? In other words if a young man or woman were asking I want to try to get beyond my 15 percent disability, would you say an attorney can help you?

MR. DAVIS: I would say no. I mean, it doesn't change the information that we have in front of us. They don't come to speak to the -- it is not like a PEB where you

can bring counsel with you.

CO-CHAIR NATHAN: They are not allowed to correspond with you?

MR. DAVIS: They can. They can send the 294, the form and then any other material that they would like to send it, that is up to the member to submit.

CO-CHAIR NATHAN: Right. You must occasionally get a letter from an attorney or some representative.

MR. DAVIS: We do. It is just we are not rife with packages with attorneys' signatures on them.

CO-CHAIR NATHAN: Okay.

EXECUTIVE DIRECTOR DAILEY: And you are only looking at the difference between a 20 percent separation and a 30 percent retirement.

MR. DAVIS: Anyone that is less than 30 percent and they were not -- if you were brought to retirement, you are not eligible to turn in -- for this Board. So

that is why it is 77,000.

It would be considerably higher if say you had a 30 percent and we brought you to retirement and you thought you needed a 70 percent. The whole reason behind these is we are concerned about these folks, their well-being. And that is the number one thing is how many of these need medical care for the rest of their lives or do that. So, I think the retirement pay is secondary. And it is not just for the member. Get them to 30 percent, now they have TRICARE, their family members have TRICARE.

EXECUTIVE DIRECTOR DAILEY: Let's hold your other topic for when it may be more mature.

MR. DAVIS: Yes.

EXECUTIVE DIRECTOR DAILEY: You can maybe send an information paper over sometime closer to the closure of our report.

MR. DAVIS: Sure. Sir, I can talk to you offline about that question you have,

give you some developments that we are working on.

Any other questions? Well, thanks for your time. I appreciate it.

CO-CHAIR CROCKETT-JONES: Thank you, Mr. Davis.

EXECUTIVE DIRECTOR DAILEY: And just a reminder you all made a recommendation in 2012. This is a good model for DoD to look at for a centralized PEB. After Mr. LoGrande's briefing in 2012, you were interested in learning more, understanding this process, and you did make a recommendation on it.

CO-CHAIR CROCKETT-JONES: Yes, I think the successful look and sort of the organized ways has been great. Thank you very much for your information.

Do we need a brief break?

EXECUTIVE DIRECTOR DAILEY: Yes, I think my briefers are here but you are not scheduled to start until 2:15. We could start

at two o'clock, if you would like, give everyone a ten-minute. Okay, two o'clock, please.

(Whereupon, the foregoing matter went off the record at 1:46 p.m. and went back on the record at 1:57 p.m.)

CO-CHAIR NATHAN: Okay, let's go ahead and get started.

CO-CHAIR CROCKETT-JONES: Okay, since we're all back, we now welcome Mr. Raymond Holdeman, the Deputy Division Chief for Personnel Army National Guard G-1 and Colonel Jill Faris, the Deputy Surgeon for the Army National Guard.

They have briefed the Task Force on both the National Guard Medical Management Processing System and the Reserve Component Managed Care. During this briefing, they will provide additional updates to these programs. We have information under Tab K.

I'm going to turn it over to you

all.

COL FARIS: Thank you. Ray, is it what, our third time here? Three times is the charm.

MR. HOLDEMAN: It is and it is always a pleasure to come back.

COL FARIS: It always is a pleasure to be here.

We are here to give you an update. Ms. Dailey asked us to come and give you an update on some of the initiatives we have done. I was raised by a military man so I will move around the room, because a moving target is a harder target to hit, I have been told.

In case you are wondering why I have a tennis shoe on, I am not trying to do mismatch with their shoes like my children do with their socks when they go to school every day. I had foot surgery. So, if you need to see my profile, I do have it with me.

(Laughter.)

COL FARIS: Okay, without ado, these are the things we are going to discuss today. And the way that Ray and I do this is we open it up if you have got a question. I know how it is if you have a question, it is burning, everyone tells you wait until the end to ask questions. Please raise your hand or shout out with any questions you might have. This is a free flowing discussion. We want you to understand the things that Ray and I deal with every day over at the Readiness Center.

So, we are going to talk about the Military Medical Processing System, people that have been a part of that process that we have had in the Guard now for over two and a half years, almost coming up onto three years. We are going to talk about some things that we have done with the Reserved Component Managed Care that we have talked to you previously about in a pilot phase. Now it is not in a pilot phase.

We are going to talk about some things that we have done with the Integrated Disability Evaluation System. Most specifically, the transition that the Guard is doing to go into an automated Medical Board process, something that we are very excited about and we wanted to share it with you. So, let's get going.

So, for those of you that weren't with us the last time that we were here, the National Guard has created back in 2005 a national contract to do case management. Because what we saw that was happening during the war is we would bring a formation forward to deploy. We would do a medical assessment. We would find deficiencies. We would take those Soldiers with deficiencies that we couldn't get fixed before deployment, put them to the side, cross-level other Soldiers to fill their places and move out smartly.

Well, what did we do with the people that we had left behind? Well, they

were left behind and we weren't doing a very good job of figuring out how we could fix them or determine whether or not they were fixable and needed to permit profile. So, we created a formalized process called MMPS, which is our formalized case management process.

And so that has really, that coupled with the periodic health assessments is really what has brought our readiness at the time of 2006, 41 percent Medical Readiness Categories 1 and 2 to 85 percent, effective 1 October. And that was something we are very excited about but I have put a lot of what we have done into the management of Soldiers.

And remember in the Guard and Reserve we have the haves and the have nots. The haves are people that have a medical situation that is tied to being in a duty status, so they have a line of duty and then get their care. And the have nots are those people that have hurt themselves on their non-military time and it is impacting what they

can do in their military vocation.

So, some of the key folks that make up this organization of processing for case management is a forcing function called our Medical Readiness NCO. These are positions that we brought onboard to the Guard back in 2010.

Something that is really exciting is the fact that we have a limited number of full-time active Guard Reserve positions and we were able to take some of those positions and actually put funding behind the positions. And so, we were able to fill to 80 percent to the battalion level a Medical Readiness NCO, E6 and to the brigade level, E7.

Now, once it gets to the state, the state can decide what they want to do with that force pool. And so we saw some states have them be helicopter repair people or whatever and then eventually they saw the error of their ways because we used it and we said this is a key component with the

Commander and First Sergeant and without having this position, you are going to struggle. And they did. And many states, over the course of time, have now transitioned to put people, 68 whiskeys into these positions to help those Commanders and First Sergeants manage their Soldiers with medical challenges, either duty or non-duty related. And so that is their sole functionality. That is their sole functionality. That is their primary mission in life and most of them do do that.

We have training that we give to these folks at our Professional Education Center and they focus on all those touch points, so line of duties, someone gets injured, they are the go-to person to collect medical documentation and assist at the state headquarters in getting those line of duties completed. They are the ones that do roll-up reports to the Commander and First Sergeant of those people that need to have dental exams,

periodic health assessments. Those are the people that track anybody that has any medical deficiency. And they really are the touch point for the first 90 days in this process.

So, I talked to you about a contract that we brought up in 2005 that we expanded again about a year and a half ago. And I have close to just right under 500 either Nurse Case Managers or Care Coordinators in the state. The ratio that we were look at to try to fill is not the most appropriate ratio but it is what we could be funded for. So, for every person that works on the case management team, either a Nurse Case Manager or a Care Coordinator, we have one of those people for every 150 Soldiers in the National Guard. So we had to do an adjustment. Some states had less. Some had more. And so we made it equitable for everybody to have that kind of structure to assist in the case management.

These people are nurses, for the

most part. We do have some that are social workers because states can opt to get a social worker to fill the position because we do have struggles and challenges with behavioral health things and they feel like having a social worker there to help assist with behavioral health. Touch points is important. And they are the go-between between the state surgeon and that unit and they are the ones that are working and consolidating. And once they feel a Soldier is very close to getting to their medical retention decision point, Mr. DP, then they provide the packet of information for the state surgeon or his or her designee to make a determination on where we need to go forward with the Soldier.

Care Coordinators are the conduit between the Nurse Case Manager and the Medical Readiness NCO. They are the ones that do all the great work behind the curtain. They are the ones that consolidates all the paperwork. They reach out to the Soldier, the Medical

Readiness NCO and they foster getting all the things together that they know are required to make a decision and what is happening with the solider in regards to their care.

We have wonderful people that work within the one community, much like my friend Ray Holdeman, that we partner with. And in the state that full-time presence was the only presence up until 2001 that did anything medical in the state, and that is the Health System Specialist. The Health System Specialist works all those touch points in the state, as it overlaps into the medical community. So, they do line of duties. They do incapacitation pay, they do the medical board process, MAR2s. So, the HSS is also part of the team that makes up MMPS in the state.

So for those of you who are visual, because I am, I like to draw pictures, I did kind of a time line. It is a little bit busy. It doesn't meet the standard of so many

words per slide but at least you can print one slide and it conveys everything that we do in MMPS. And it has all the different touch point people. So, we have the Medical Readiness NCO, Case Manager, Care Coordinators as they work.

So, if you look in the Army, we have this magical thing called Mr. DP, the Medical Retention Decision Point. So, once we identify a medical deficiency, the clock starts.

Now, it is not a science, in that at 365 days you are going to turn into a pumpkin if we don't make a determination on what is happening with you medically, but we would have a really good idea. And there are some circumstances that we will waive beyond 12 months for Mr. DP, if we feel like a Soldier is still making process, let's say in physical therapy for a rotator cuff or a bad knee or something like that.

So, the whole idea of case

management in MMPS is that we are having touch points, not only with the Soldier but with the Command. A representation in this meeting, because Commanders are normally part-time Commanders, as are First Sergeants, is the Medical Readiness NCO, which is a full-time person. They are representing Command at the table and they are having a discussion on what is going on. So, it could be something like you know Sergeant Faris. We have been working with her and she has been on a profile, she is on her second profile and now getting ready to go on her third profile and she really hasn't been very compliant. I have asked her to provide some documentation with her appointments with her physical therapist and she really hasn't been compliant. So, Sergeant Holdeman, Medical Readiness NCO, can you please work with your Soldier to ensure that she understands the importance of getting that documentation together? So, that is kind of like sometimes what the conversations go

like.

Or we may find out we get a definitive diagnosis and we don't have to wait 12 months. We know that for whatever the diagnosis is, we found out they are a Type II diabetic. That means they don't meet medical retention standards and they are at their medical retention decision point and an action needs to happen as such.

So, this is a constant dialogue that is going on, which has worked very effectively.

Understand that there are many different touch points when a person can be introduced into case management. Obviously, it happens when we have a periodic health assessment. It could happen when you have post-deployment health assessment or post-deployment reassessment during a Yellow Ribbon event, post-mobilization. It also can happen when a Soldier just self-identifies themself with an issue and they come forward to their

first line leader who would direct them to the Medical Readiness NCO.

This is another chart, in case you didn't like the other one. This is a different thing, kind of tells you the same thing but it shows you -- someone is trying to call us on Skype.

It shows you all the actions that are happening as far as case management. We have a module within our suite of applications in MED-CHART, which is how we manage our medical readiness that is called eCase. And that is the system of case management where we track with all of our touch points with the Soldier. So, the Medical Readiness NCO, the Care Coordinator and the Case Manager can all go into that and every time they have a touch point with a Soldier, they can make a comment, chart it, and then another person who has access to the system can go in and take a look at it.

And so, during this time frame, it

may be determined that they are going to have some comprehensive care that needs to happen. They have got a couple of different things going on, a bad knee, a torn rotator cuff, plantar fasciitis and it is all duty-related. So, a determination may be made with the Health System Specialist that an MRP2 order needs to happen or active duty medical extension order needs to happen. And those are the dialogues that happen during these touch points when we are talking about our Soldiers who are being case managed.

Ray, it is yours now.

MR. HOLDEMAN: Thanks, Colonel Faris.

As Colonel Faris indicated, the G-1 and the medical community across the National Guard work very closely together because this is ultimately a G-1 function managing people with a medical component. And that medical component is what drives all the actions that relate to pay benefits and

entitlements and, ultimately for some folks, Medical Evaluation Board of Physical Evaluation Board, PEB and MEB.

A lot of the longstanding policies and practices that have been in place since the beginning that relate to pay, benefits, and entitlements for the Reserve Component member are listed here on this slide.

Line of Duty determination for a Reserve Component member is what determines access to benefits, care, pay, and entitlements. Without the Reserve Component member having been determined to be in a Line of Duty status, some duty status, they are not entitled to or have access to care.

So, the practical application of Line of Duty investigations turns on or denies benefits for Reserve Component members who are injured or become ill and it is not duty-related. That protects the interest of the government and it also ensures that when a Soldier is entitled, they receive their full

benefits and entitlements.

Incapacitation Pay, as some of you may know, is that pay benefit or entitlement in two distinct tiers that a Soldier may receive if they are incapacitated. They can't work. They can't perform their duties of their civilian job or their military duties, depending on the severity of the injury or illness. And it is determined to have been in the line of duty, so they have a LODS. They may be entitled to INCAP pay.

Now one of the things that we very quickly recognize as we participated in this long fight overseas was that there was a gap in program policy and procedure with regard to care or pay benefits and entitlements for certain populations of Soldiers. We starting using Incapacitation Pay at the direction of DoD and the Department of the Army for some things that it was never really intended to support. We over executed Incapacitation Pay for many years and it was a bill that we

pretty much took out of hide. One thing that we found out very quickly, and that is on the next slide, is that we needed some strategy, some process that we could manage that would provide a bridge over these gaps in current program policy and procedure.

PDHRA, Post-Deployment Health Reassessment is a funded program. It ensures that Soldiers who identify issues post-deployment have the funds available, the states have the funds available to ensure the Soldier can get to the medical appointments, receive care or treatment up to seven appointments, while we are trying to determine and sort out exactly what the cause, modality of the injury is and the medical practice and plan for care and treatment is.

Those things that are not in the Line of Duty, Soldiers have access, currently, based on expansion of the TRICARE program under TRICARE Reserve Select and TRICARE Retired Reserve to purchase healthcare

coverage. That is a pretty important thing, given the discussion today about healthcare and healthcare reform.

Our Soldiers have access to TRICARE Reserve Select and I have to make one change to this slide. The current premium for the member is not $53. It is only -- I had to look it up this morning because it changes every year and, unfortunately, I didn't catch that edit. But the current premium of $51.62 per month for members only and the family premium for coverage is $195.81 per month. Extremely affordable insurance, given the amount of coverage and the benefit product. It does a pretty good job of covering just about everything, comparable probably to some of the more notable civilian products that are out there, Blue Cross/Blue Shield. TRICARE Reserve Select is actually rated very highly in the insurance industry.

COL FARIS: And the nice thing about TRICARE Reserve Select is that they

don't exclude you from preexisting conditions. You get it by the nature of being a member of the Selected Reserve.

MR. HOLDEMAN: Yes, great benefit.

COL FARIS: Are you ready for the next slide?

MR. HOLDEMAN: Yes, please. Thanks.

So, I spoke earlier about a gap in program policy and procedures. What we recognized was there were certain Soldiers that couldn't get a benefit, no matter the determination with regard to how they were injured or became ill because the antiquated policies and programs just couldn't keep up with the rate at which we were changing and using Reserve Component forces. The paradigm was shifting faster than the programs could keep up.

What we developed in the Army National Guard was the Reserve Component Managed Care Program. And we addressed both

issues for the training, the folks who were injured or became ill during training in preparation for mobilization or deployment. And those Soldiers who were mobilized and deployed came back and, for whatever reason, didn't receive the attention, the quality of care, or the treatment that they needed at the mobilization station before they rushed home to see their family post-deployment.

So, we developed this program. We got approval from the Secretary of the Army, the Department of the Army, and the Army G-1. We were fully supported. And to our benefit, we launched a pilot. That was back in 2011, February of 2011. We ran that for about a year. We got an extension. We ran that for another six months. And what I want to point out about this program is it is somewhat limited in scope because we didn't want to get into the business of handling extremely complex medical cases. It is limited to those low-risk, low acute cases that are determined

to be repairable to some degree. We depend on the Surgeon, the State Surgeon and our Surgeon's office to assist us in defining the modality, the plan, and how quickly we can get these Soldiers back in formation, ready to fight again.

COL FARIS: For the most part, what this program helps us with is the number one issue that we have with Soldier, because we do have a job of rating them, is ortho. And so 99 percent of the people that have been through the program because of ortho issues and everyone, except for I think two Soldiers during the pilot, were able to get resolved in less than 179 days. And I think, Ray, we averaged about 88 days of Soldiers being on 12301(h) orders.

MR. HOLDEMAN: I have the averages. They are coming up.

But another thing I want to point out is the historical policy for the army with regard to managing a portion of this

population was always the WTU consolidated guidance and you probably heard about that or will hear about that here. But the Active Duty Medical Extension Authority and the Medical Retention Processing, Version 2, Authority or the programs that I indicated had some gaps in them, that didn't allow us to take care of every Soldier who had an injury or illness. So, we came up with the RCMC.

The Army liked the RCMC concept so well that they are now revising the regulation related to WTU, ADME, MRP2, to mirror more closely the RCMC program that the Army Guard has stood up. Unfortunately for me, they named it RCMC also but it is Reserve Component Medical Care and we are working through some of the confusion.

COL FARIS: I think we have copyright rights on the title first.

MR. HOLDEMAN: I didn't get the copyright on the name, the mnemonic but the acronym was plagiarized. We helped them use

it in the rewrite to the regulation. Next slide please.

Again, some assumptions. The Soldier injured or became ill in preparation for or during mobilization. And we have the authority to publish 12301(h) orders. The specific statutory authority provides for medical care, examination, and treatment in an active duty status for a Reserve Component member who is injured or becomes ill.

We publish these for up to 179 days. This kind of lays out the pilot program, where we are today. We have authority today and we are executing a roll out to all 54 states and territories. The pilot, initially, only included 14 states, limited a number of packets. And you will see the numbers in just a minute but the program provided enough management controls, transparency on publishing of orders and expenditures, and execution of the funds made available that we were given authority to go

ahead and roll it out to all 54 states and territories under the limited criteria, the initial pilot policy.

COL FARIS: And Ray, we have that for two years?

MR. HOLDEMAN: Through December '15, correct, 31 December '15.

Again, statutory authority, it resolves low-risk, low acute medical issues for Soldiers and gets them back in the formations. The average number of day, like Jill said is coming up on one of the next few slides.

And more importantly, it helps us better manage and mitigate the over execution of Incapacitation Pay for the Reserve Components. So, if we are managing that pot of money better, it allows us to -- well, obviously, we demonstrate better fiscal responsibility and we also focus the resources where they were intended to be utilized and executed.

COL FARIS: And if you look at that second bullet, low risk and low acuity are not things that get approved to go on to Active Duty Medical Extension Orders. So, we were bridging a gap of people that didn't qualify to go back on to active duty because they didn't have comprehensive care greater than six months. But nonetheless, that group of people were using INCAP pay because they couldn't work. And so now, by having this program, we are able to afford them the opportunity to focus all their attention on getting well while they are in a duty status.

MR. HOLDEMAN: And that is why the G-1 and the surgeon work so well together because she knows the medical terminology and lexicon and I know systems and data management.

Here we have a brief overview of the population. First from the pilot and then what we have today.

I have noticed that -- do we have

one more slide, Jill? Oh, okay, go back. I'm sorry.

Right. So, the numbers are still significantly low. The total number from both mobilization and training is right at I want to say a little over -- right around 200. And the reason, again, is we originally only had 14 states that participated in this. It is a small population to begin with because of low-risk low acute criteria. And our roll out to the 54 states and territories was somewhat delayed early on in '14 by sequestration, training issues associated with funding. We overcame most of that. We had to push some of our training to the right. And we just started really rolling this out to all the states and territories back in September. Well, we know what happened 1 October.

So, we had to push a couple of classes to the right again but we are back on track for the end of November, December, January. We should have this pushed out to an

additional 20 or so states before the end of the second quarter '14. That is our current plan.

We had, as I said 183 orders, including amendments; 110 of those Soldiers have been released from active duty and are back in the formations as traditional drilling Guardsmen, medically ready.

And then we have about 89 days on orders. The orders are initially published, depending on the treatment plan for 179 days. We have published orders for as short as 60 days. It depends on the plan.

COL FARIS: Plan of care.

MR. HOLDEMAN: Plan of care.

COL FARIS: But notice bullet number four, which I am really proud about, 96 percent of those Soldiers that participate in the program go back, after getting off the program, and they are fully medically ready to do Homeland Defense, OCONUS, whatever we need for them to do.

MR. HOLDEMAN: Correct.

COL FARIS: To the tune of a $2 million savings to INCAP Pay.

MR. HOLDEMAN: Right.

MR. REHBEIN: If I may, may I interrupt for just a moment?

COL FARIS: Yes.

MR. REHBEIN: The 179-day limit, it sounds like most of your people don't come to that.

COL FARIS: Correct.

MR. REHBEIN: But that tells me that there are a few that do and may need to go beyond that.

COL FARIS: And we have done that twice.

MR. REHBEIN: Okay, so you don't have any problem?

COL FARIS: No, we don't, if it is medically prudent. Because what happens is the doctor says we are going to go on and fix that torn meniscus and they go in to the torn

meniscus and they go, oh, now there is something else we have discovered. And so when we medically discover something, then it sort of changes the playing field and so, we understand.

But why we have that hard limit is we really want to define what low-risk, low acuity is to the states.

MR. HOLDEMAN: The criteria for managing this program is extremely intense. The management controls are many and the counseling requirements and documentation requirements are somewhat burdensome. I wouldn't say over burdensome but they are because we wanted to ensure two things. The Army had confidence in our ability to manage this, be prudent fiscally in the publishing of the orders, because you have to understand this is the first time the Director of the Army National Guard has ever been delegated by the Secretary of the Army the authority to place a Guard member in an Active Duty Title

10 status.

COL FARIS: Less mobilization.

MR. HOLDEMAN: Yes, outside of mobilizations. It is directly related to medical care. So, it was precedent-setting in that regard. And we wanted to make sure the Army had full confidence that we were going to be good stewards and we have been.

Real quick, I just want to touch on a new program that we have partnered with the Army on. You will hear more about this. But on the tail end of medical management is the MEB PEB process, the Medical Evaluation Board's Physical Disability Evaluation Boards for those Soldiers that unfortunately most often leave the service, due to a disability, that was incurred or aggravated by the Line of Duty.

IDES Dashboard, what this program does and you will hear more about is gives us better visibility and the ability to track and manage that MEB/PEB process for the Reserve

Component Soldiers. You have to understand, there is only one process for the Army, that is IDES. And all Reserve Component members, active duty members, go through the same MEB/PEB process.

But what we didn't have on the Reserve Component side was visibility. Any clarity on where the application was, where the packet was in the process of adjudication. So, it kind of went into this dark hole and we couldn't see it again until it came out. And part of the problem there that was generated for the Army National Guard in particular is when a Guard Soldier is all through with the process and USAPDA publishes an order for them transferring to the Retired Reserve with benefits, we can't see that until sometime after the fact. And what was happening was the Soldiers would come out the other end and nobody in the state really knew what to do with them and they didn't really have Soldiers as Soldiers often do that are early retirees

from the military. They didn't have a good idea of what to do next to get their pay started, to ensure their benefits were received in a timely manner.

And there was one final piece because of the Army National Guard being a distinct organization under separate U.S. Code, they had to be separated from the Army National Guard of the U.S. before they could receive their pay and allowances from the Retired Reserve because it is actually an active duty retirement.

So, this helps us immensely. IDES Dashboard is a great innovative program. It is a great process and it provides clarity all the way down to the Soldier and Commander level.

COL FARIS: And I think Colonel Johnson is going to talk to this after us.

MR. HOLDEMAN: Yes, great partners over at USAPDA and the Department of the Army. We have rolled this out. We have access at

all 54 states and territories to the system. They are very diligently pushing this access to this web-based automated system down to the lowest level, Unit Commander, First Sergeant Soldier. There is different authorities at those levels. So the Soldier can only read their file. The Commander can only see Soldiers in their organization.

But this gives us some clarity, allows us to be proactive, rather than reactive and help the Soldier transition when they need it most.

COL FARIS: All right, so now I am going to talk to about what the Army National Guard is doing to try to bring some more transparency to the Medical Board Process.

So one of the things that happened is that a few years ago, about three years ago, there was this retired general by the name of General Franks who did a study and said hey, there is disparaging going on between the Active Component and Reserve

Component, when it comes to the Integrated Disability Evaluation System, or at that time, it was just the Disability Evaluation System.

And so, we stood up an organization down in Florida, and I believe that they have come and spoke to your organization here, at Pinellas Park, the Soldier Reserve Component Medical Support Center. And so they helped us get Reserve packets validated before they went into the process.

And so there was some great things that we learned out of standing up Pinellas Park. And so on the left side, we identified some of the friction points and problems that we had. We had lack of standardization and MEDCOM freely admits it. So, if you were in the great State of Texas and there was five or six MTFs there, there were five or six different standards for packets to go into the Medical Board process. So, it just depended on where you were going as to what your

checklist looked like.

So one of the efficiencies that we got right away was a standardized 17-item checklist. So that has helped facilitate success enormously. If that were the only thing that we got out of the experiment, it would have been a win but we got some other things out of it as well.

So, there was a lack of standardization of looking and validating the records. And so what we looked at are some of the ways that we could mitigate that. So a lot of it is about education and training. And one thing about the Army, is it is in a constant state of change. People are always coming and going from different positions. And so some of the things we did from the Guard is we mandated the use of eProfile Training because we went to the electronic solution for having all profiles. And so that has really helped us a lot because you have got to do the training before you have access

to be able to use this system.

We did some mandatory basic profile training when we get together as a Guard entity in our Medical Team Conference. We have developed some sources, working through the folks down in Crystal City, a PDES course, and we have done, I believe, three of them that are Reserve-component focused. It is always, I have learned, that if you know what you need to study for on a test you do better on a test. So, if we can understand what the end process looks like in the Medical Board Process, then it helps the people in the front understand why it is important that they do it this way. And so that course has been very, very beneficial to State Surgeons, understanding what the end process looks like.

And we have also worked on developing, and what I am going to show you a couple of screen shots of a process called MEB Prep, which is an electronic solution; instead of doing a paper Medical Board process, doing

an electronic one.

And Ray talked about the fact that having transparency. So, if you have a process and you don't have transparency, what happens to that poor PEBLO? They are on the phone all the time answering calls. Where is my packet? Where is it at? Where is it at? So, when they are on the phone, they are not actually doing their work or the work that gets things through the process.

So, we are like we want to create a solution because the Guard has always been about how we can create solutions to be a win-win for everybody. So, we created this system that is called MEB Prep.

So, I think Mr. Scott has been here before to talk about the electronic LOD module. MEB Prep is very similar to that. So, it is role-based. You initiate a case. It gets assigned a number. And what you do, is there is a 17-item checklist and you scan and upload all the information into the 17-

item checklist.

Once all 17 items have been uploaded, all the information that is in the Health Readiness Record, which is our electronic repository for all of our medical information. Everything is scanned, indexed, and uploaded in that because you have to understand the Guard doesn't do treatment. We don't have treatment facilities. So, therefore, we don't use AHLTA. So, we have created our own version of AHLTA for the Guard and Reserve. And so, everything in HRR gets scanned, indexed, and is also zipped and compressed into this.

Now, what we did on the other side is that MEDCOM now has access to this. PEBLOs now have access to this. We did a beta test with his last year with the Indiana Guard and we did a beta test between Indiana and Pinellas Park. So, Pinellas Park would receive and we got information back and forth about how things went, how they didn't go,

what we needed to change, and all those kinds of things. So, it has now evolved from a beta test.

We did a pilot with the first six states. And so now it goes from the state to the MEBTO. Those are the folks I call them like the head cashier. Like at Target, if a line gets too long, Bill, I need you on 14.

So what the MEBTO does is they regulate the cases. We got a backlog at Fort Gordon. We have got to move some to the MEBTO at Fort Carson and they regulate to make sure that we are getting Soldiers at the shortest line so we can get them more timely through the process. So, we created roles for them.

So, now what happens is the state does an electronic MEB record, no paperwork whatsoever. Once they are done, it has been validated, it goes across the berm from the State of Ohio, down to the MEBTO office. They receive it electronically. They get an email that says Colonel Faris, you have an

electronic case from the great State of Ohio. And I go in, log into the system, and I start checking and validating that I have all of the required information that is needed for this packet to go forward.

If there is something delinquent, Colonel Faris, I need your most recent PHA, there is a tool within the tracking tab here, where they can write a message and say Ohio, I need the most recent PHA and you forward it back electronically. It doesn't get mailed. You don't have to -- so, it goes back.

And then there is ding, Mr. Holdeman, you forgot Faris' PHA. So Holdeman goes in and gets the most recent PHA, uploads it into the system, sends it back to MEBTO. They validate it, then they discern where it goes to.

Right now there is two locations that these electronic cases go to, Fort Gordon and the MEBTO at Fort Carson. And right now, they are able to keep up with it because we

have started implementing the full transition away from Pinellas Park, which will be sunsetting September 14. And we have got 14 states that have already transitioned over to this electronic process. And the MEBTO is able to regulate to those two locations. And we do monthly IPRs with our friends at MEDCON. And we have a new revision that is going out. The Guard likes to build things while we drive it and fly it. We don't wait until we have the Cadillac. We get a Yugo and we go. And then we add the other options, like a sunroof and electronic steering and stuff like that.

So, this is our time line here. We fully expect these folks that have been at it actually got trained last week, Friday, so I can change them into trained. So, you can see by the end of June, the Guard will be fully transitioned.

Now, the USAR is also transitioning and I believe their transition they are starting in January. They have four

regions that they are doing and they are going to do their process a little bit differently because they are organized and structured differently than us. But this has been hugely successful.

So someone will ask me, well, Colonel Faris, what are the efficiencies that are gained from this process? The efficiencies are just in the first step, the first step of sending a packet down to Pinellas Park to validate it, to get it to the MEBTO and regulate it to an MTF takes on average, it was averaging about 30 days. This process takes about three days, which is great.

It doesn't help the end where the backlog is piling up but what it provides it transparency because now the Medical Readiness NCO can go into the system and say where is Faris' packet and can look at the tracking tab and see that the PEBLO from Fort Gordon has had it for three days and they are getting the

appointment scheduled to do the COMP and PEN at the VA in Dayton, Ohio, closest to my home. And now I am not calling the PEBLO and I can go into the system.

And oh, if I have got a question, in the system when you hover your mouse over in the tracking over the person's name, it has got all their contact information. So, you can send them an email, call them on the phone, do all those kinds of things. So, we are very excited about it.

So, because of all these efficiencies, Faris is all about readiness. Readiness is my game.

This is what we looked like November 28th of 2012. We were at 77.4 percent MRC 1 and 2. And today, this is what the Guard looks like or we did. We are at 84.8 because we had this government shutdown thing that kind of impacted our readiness for a few weeks.

And oh, by the way, the standard

changed. The DoDI says all Services will be at 85 percent ready, effective December of '14. So, that is our measurement pole that we changed effective 1 October. And the Guard is the only Service -- the Guard is the highest Service to all the other two Services in the Army. And we are very excited about these efficiencies that we have taught you about with case management, MMPS, Reserve Component Managed Care Orders, the things that we are doing to try to automate IDES to make it better and more efficient for our Soldiers to go through are all things that build to this overall medical readiness that you see at 85 percent.

MR. HOLDEMAN: Yes, Jill is absolutely right. The EMMPS is the base and all the other things that we piled on top contributed significantly to this.

The last little piece, and it is not insignificant is better data management and that is part of what my team has done in

coordination with the State Surgeons and the Surgeon's Office at NGB, is manage the data better. And we put a great deal of effort into more accuracy in our reporting and qualifying and quantifying what we call medical ready.

COL FARIS: So that is my last slide and Ray's last slide. Does anyone have any questions of us?

CO-CHAIR NATHAN: Going once, going twice. Thank you. This was a very comprehensive review and, clearly, you understand your business model and you are on the right trajectory.

So, thank you Mr. Holdeman and Colonel Faris. We appreciate it.

MR. HOLDEMAN: Thank you all. Ms. Dailey, thank you.

EXECUTIVE DIRECTOR DAILEY: A pleasure to see you all again. I have had Colonel Faris up here three times, I think, Mr. Holdeman two. It might be good news to

know we probably won't get you up here again.

You, as a Task Force have made a number or at least one recommendation talking about RCMC as being a model for other Reserve Components, low acuity, low-risk individuals being in their home community on Title 10, managed by their units, receiving care in their community. It keeps them out of the WTUs. It keeps them from being separated from their families. You have identified that in previous recommendations as a model for managing our Reserve Component.

So, thank you, Colonel Faris and Mr. Holdeman.

COL FARIS: It was a pleasure.

MR. HOLDEMAN: Thank you.

EXECUTIVE DIRECTOR DAILEY: We are way ahead, ladies and gentlemen. I'm not sure how we did that. I have a quarter 'til three. Our next briefer is starting at 3:30 but he is here. Would you all like a break or would you like to roll into your last briefing?

CO-CHAIR CROCKETT-JONES: If we have time, we might get a cup of coffee.

EXECUTIVE DIRECTOR DAILEY: Cup of coffee, five minutes.

CO-CHAIR NATHAN: Cup of coffee, five minutes.

EXECUTIVE DIRECTOR DAILEY: Five minutes, yes, yes.

CO-CHAIR NATHAN: Army time, five minutes; Navy time, six minutes.

(Whereupon, the foregoing matter went off the record at 2:42 p.m. and went back on the record at 2:53 p.m.)

CO-CHAIR NATHAN: Okay, Colonel Johnson?

COL JOHNSON: Yes, sir.

CO-CHAIR NATHAN: Great. So, we have Colonel Johnson who is from the IDES Transition Office. He is the Director of the Army Physical Disability Agency. Colonel Johnson is going to be briefing us about the

overall improvements being made to address the timeliness, the efficiency, and the effectiveness of the challenges that are specific to the Army.

You can find Colonel Johnson's information in Tab L. Sir, the floor is yours.

COL JOHNSON: Thank you, Admiral.

All right, ladies and gentlemen, I have been duly informed that I am the last person standing between you and leaving. So, we will move through this and we will move through it as quickly as you would like.

CO-CHAIR NATHAN: For the record, this is important stuff. So, we will take as long as you think is necessary.

COL JOHNSON: Very well, sir.

I was asked a series of questions but they all kind of boiled down to two things. One was how did you improve performance between FY12 and FY13 in the Army. And then the second major question was what

about your timeliness for informals.

So, what I did was get a pat on the back and then a kick in the tail about, hey, you have improved performance over all this stuff but now your formal rate stinks and what are you doing about it. So, that is what we are going to talk about here today.

As we look at the improvement of performance, I kind of tried to break that out into three subcategories, just a snapshot in time of where we were and where we are now, the progress, and then how did we get there.

Here were the specific questions. And I tried to provide some very basic short answers first and then we will look at the metrics that support my answers because I have learned, been in the Army long enough to know that you don't just give an answer if you don't have the background or the information or details behind it to make it stand the test.

So, give examples of process

improvements, et cetera. And I think was a desire to say okay, Lean Six Sigma, Lean Enterprise, any other Baldridge programs, et cetera. What did you do to get after this?

We had the IDES system in the Army over the course between about 2009 and 2012 was the most studied process in the Army. Multiple Lean Six Sigma programs, multiple Lean Six Sigma reviews, multiple process improvement teams coming in, IG inspections, IG assistance visits, Army Audit Agency, you name it. So, everything, except I think Baldridge. I don't remember Baldridge. Rand Corporation studies, et cetera.

So, we did a lot of studies. The challenge was had was we were doing so much studying, we weren't doing a lot of improvement. And we could see it coming but we didn't get out ahead of it. So, we started to have a problem in '12 or '11. It really became acute in '12 and then we got after it. So, we had a lot of studies.

Active Army IDES days are below the goal -- are above the goal of 295. What are we doing? Essentially, the Army is meeting standards, actually exceeding standards in everything we control. Every single step that we control we are exceeding the standards.

Our VA partners, as we moved the backlog that we had and we moved it to them, some call it the pig and the python, the rat and the snake, it moved to them and that is where it is at. So, they are dealing with that now.

CO-CHAIR NATHAN: What is your current MEB average?

COL JOHNSON: Below 100 days, sir. It is, I think, across the enterprise the whole MEB phase is approximately 79 days, the entire MEB phase. That is all the sub-stages within it.

The VA has had a challenge recently within the MEB phase on the medical

exam part, where they have started to miss goals here recently in the medical exam portion. They are working that and they are driving that back down. So, they are back within tolerance. So, we are still well-below the standard across the MEB piece.

We noted drastic improvement. What did we do and did we share it? Absolutely. We have multiple forums that we meet with our counterparts from the other Services with the other Service MNRAs and their representatives, their IDES leads, the other Service PEB leadership, the other MTF leadership. And we share constantly.

Some of the things that we did to improve our performance were actually based on discussions we had had with the other Services. How do you do better here? What can we adopt? And we adopted those things. So everywhere we could mimic them, copy them, we did. So, the two-member Board that the Air Force had gone to well in advance of us, we

said okay, we requested permission using their model, their template, we received permission from OSD to do that and then we executed it and that helped us. So, a lot of sharing.

Where were we? What did we do? The blue bars are where we were in '12 and it is a snapshot end of '12. And then '13, a snapshot end of '13. So, where was the work?

So, if you look here in particular, these areas that are highlighted, this is the benefits phase here, the preliminary rating phase here. This is done at the DRAS. This is done at the DRAS. This is where the Army's workload is now, almost 9,000 cases. And this is information a little dated based on the most current data at the end of September and then 4,150 here.

The VA has started to make some progress against this backlog, which was much higher. It has started to come down. This backlog remains relatively stagnant. It has gotten a little worse each month. Last month

they added 39 to it. The month before 400 and something. The month before, 50 some-odd.

CO-CHAIR NATHAN: So Colonel, let me ask you a question because not much more than a year ago the Army sort of went on record saying it needed -- because what I see here is if this is true, and I have no reason to believe it isn't, you pretty much controlled the processes that you had to change and amp up to control your piece of it.

COL JOHNSON: Yes, sir.

CO-CHAIR NATHAN: But a little over a year ago, the Army came in and said we need a thousand FTEs at something like 150 million -- please don't quote me on the figures. It was a pretty large number, chunk of people for a large chunk of change to throw at IDES to get it under control. You never got that. So, what happened?

COL JOHNSON: Sir, we did get some increase in resourcing. We did get a number of folks. We didn't get the number that we

had originally requested. We used internal Army resources.

The senior leadership of the Army, frankly, the Vice Chief of Staff was quoted in front of the Congress at that time as saying the Disability Evaluation System in IDES is the single greatest threat to readiness in the Army. At that point, that is what it was.

And so, when you have the Vice Chief of Staff of the Army making that statement and then executing things like monthly meetings with every senior mission commander in the United States Army, with the Chief of Staff of the Veterans Administration sitting to his left every month, that gets leadership attention. That gets leadership action.

So, I would tell you that that is the single greatest factor in our improvement is this leadership attention. And I will go through some other specifics we did. But that was the first thing we did.

What we also did, and this was equally important to that, was establish measures of performance. You, doctor, when you come in, are going to produce X number of NARSUMs every day. Absent that, we are going to take action to dismiss you or something else. You, PEB adjudicator, are required to do X number of cases a day. And that is what we did.

MG MUSTION: Sir, --

COL JOHNSON: In addition to that, sir, it was just plain old hard work.

CO-CHAIR NATHAN: Right, I applaud that. Admittedly I don't walk in your shoes but I was concerned when the Army came in and said if you can just throw thousands of more people at this and millions of more dollars, we can get this fixed. And it seems like necessity here was the mother of invention. The leadership of the Army sort of got engaged. And you made some process changes.

My next question is -- and let me

say this. If it ever seems like I am picking on the Army, I tell everybody that will listen that your numbers alone make it difficult for the other Services to comprehend. I mean the Marine Corps has got a chunk of people, too, but the Army is dealing with tremendous numbers of individuals and that is almost an unwieldy number to deal with. So, you have all our respect for that.

That said, the other Services also are dependent on the VA and certain choke points but they are coming in under the 295. Is it sheer numbers that is preventing the Army from doing that? What is it about the VA hold up in the Army that is not congruent with the Navy or the Marine Corps?

CO-CHAIR NATHAN: I believe that is the single greatest factor, sheer numbers, sir. I think that is the single greatest factor.

And just for clarity, we did put additional resources at this problem. My

organization, the Physical Disability Agency, which includes, we are organized with three PEBs and the headquarters, my organization more than doubled in size for a time. But what we also did was everyone who was wearing a uniform worked six days a week. Everyone who was wearing a uniform worked a minimum of 12 hours a day. Everyone who was wearing a uniform got one day off for Thanksgiving and got two days off for Christmas. We got no four-day weekends and half the federal holidays because we knew that we had to take care of our fellow Soldiers.

And I had to go around as the Director -- Deputy Director, at the time, and kick people out of the office. You have done enough. Because they understood the severity and the importance of the issue and they just kept coming back for more. I couldn't be more proud of them.

MG MUSTION: Thank you, sir. I think there are two things that Carl didn't

mention, in addition to the Vice's partnership with the VA in driving things through is there an investment. The Army has put assets on the ground at the DRAS, 31 Soldiers that help with the administrative work, which allows the DRAS to try to focus on the benefits, stuff that they need to accomplish making some progress.

The second is, in the past year we have really matured to eMEB and ePEB electronic systems. So much of what Colonel Johnson's team used to do. If you walked into the PEB before, it was just mounds of paper. Now, when you walk into the PEB, it is all electronic and stuff is moving in a much more efficient matter.

CO-CHAIR NATHAN: I mean the classic photo was you walk in, the desks. You cannot see anybody at a desk because the records that are stacked up.

MG MUSTION: Absolutely, sir.

Sir, a year ago, I went to visit the PEB in San Antonio and it was exactly that

in the main adjudicator. And I was there three weeks ago on a visit and you could actually see people in the room actually doing work, which was freaking amazing.

COL JOHNSON: Our storage area, sir, just at the Agency level held 14 tons, that is no exaggeration, it was weighed because we moved in a BRAC move, 14 tons of paper. It has now one filing cabinet that goes along the wall that is about 15 feet. That is how much it reduced.

Where is our problem? When you look back here, to look at this and start to peel this out into its fundamental parts, this is where we are at. This is where we went over the course of those years.

So, our rating, what the Physical Evaluation Board is, our standard is 15 days, we were upwards of 25 days a year ago. We are not down to about ten. So, we more than -- we increased that by more than 100 percent.

The time of disposition, which is

all of that administrative action that get the Soldier's Counsel, get the election back, the processing that was done at the physical disability agency to issue orders on behalf of the Secretary of the Army separation to ensure that his DoD benefits started, that we were taking upwards of 90 days. We are not consistently below 50.

This, I own. That is mine. So, if it is good, it is my fault. If it is bad, it is my fault. This is mine. If it is good, it is ours. If it is not, it is mine.

And this is where we are at with the DRAS. This number, when we talk to the DRAS, we work with them, et cetera, that number is going to get worse between now and January of 2014. What we should see about February 2014 is that number should start to come down. The time limit should start to improve and the VA is confident that by the end of the fiscal year, they will be back to standards.

So, they are going to go from their confidence that they can go from about 146 days, which I think is what they averaged so far this month, to 15 days by the end of the FY.

So, how did we improve it? Again, no silver bullets. It is just leadership, proper resourcing, right sizing organizations, and then hard work. Just do it.

What did we do? You asked for specific improvements that we made based on studies and Task Forces, et cetera. You can see there is a plethora of improvements that we put into the process. And Admiral, I think that goes to your point. We had to do this simultaneously. We couldn't just throw resources at it because we didn't have enough resources to throw at it, if we didn't improve our efficiencies. One of the most significant efficiencies we gained is within two months of fielding the new electronic Physical Evaluation Board System, within two months we

gained 31 percent efficiency in every admin process in the organization. We sat down and we did internally without Lean Six Sigma, we stop watched people without them knowing, so you can get an honest assessment how long was it taking them to move a case through the process. How long did it take them to do something?

We then put those into metrics, built the algorithms that gave us what the measures of performance should be for each position, fed that to the employee, fed to that to the supervisor, the established standards and moved the cases through the process.

And we did this, we did not have an increase in the rate of formals, as an indicator of did we just do the bum rush through. Our rate of formals remained generally the same throughout this process.

One of the things that the Guard talked about, standardized checklist. That

was an initiative that the Agency took to make everybody's case a standard case. That increased efficiency across the board, Reserve Component, Guard, Army Reserve Guard, and regular Army.

I will tell you that this action here, which we borrowed from the Air Force, was a positive action. Two-person boards allowed us to move cases through rapidly and efficiently, without a loss in quality because we put some restrictions on that. Example: any case of a Soldier who suffered both from a behavioral health and a TBI had to have three members because it is just a more complex case. It is harder to figure out.

Other key improvements and these are not based on studies. These are just us kind of getting through and talking to our other stakeholders within the Army, putting the Reserve Component Soldier Medical Support Center underneath the G-1. The number of cases that they produced, validated and pushed

up doubled when they came under the leadership of the G-1.

Again, established standards. This is what you are going to do. If you can't do that, there is always Saturdays and Sundays. And so, we got it done.

Other key improvements, training, centralized training, really put under the G-1 in the Agency to do training across to all of the MEB providers and PEBLOs, lead PEBLOs, et cetera. They came to us. We trained. In those training environments, what we did often say they would share with us their challenges. And what those training opportunities turned into, actually process improvement opportunities because what we would do is get the feedback from them and they said well, you wanted us to do it this way. It is impossible. If you ask us to do that, we are going to fail. So, let's do this. We take that, change the process, disseminate it back out and then start training the new standard

so we could do rapid changes.

We implemented a program with our adjudicators so that when they first come into the organization, the first thing they did was they were assigned a mentor, a senior adjudicator who had been there, done that. Sat them down, talked them through, walked them through the building, give them their points of contact, all that kind of stuff.

They would then go through a lesson outline with them. I think Colonel Faris said it when she was up here. If you know that the test is going to be, you generally do better at it. And so, they would understand what they were going to be tested on to be certified as adjudicators. You then stick them in that adjudicator training and their mentor sits there with them.

Well, like I said, we were identifying process improvement things, pushing it right into the training. So what happens? That mentor, who is a senior

representative in the PEB hears those process improvements, hears those changes. They then go back and train the rest of the adjudicators back in the PEB. And so that is what the model we use to get through that.

Information technology, you know I have talked there, 31 percent standardized also how adjudication was done. When you standardize how adjudication is done, it is easier to train it because I only have to train it one way. It is easier for me to check it IEDQA because if you don't follow this, I know.

Additionally, you have visibility of the leadership at both PEBs and the Agency. So, I can look down and see how individual adjudicators vote. And if I see that one adjudicator is off the norm, I can pull them out, retrain them, pull them back in, and maintain momentum. And then I don't have the formal percentages going up because I have someone who is out of whack.

And then the other thing that we have done is a lot of work with the MEB and the Surgeon General's Office to share system access, AHLTA, assorted other things. We are working a lot of initiatives now to improve system access for the Veterans Administration, which will make us even more efficient. I would expect that we could probably again about 20 percent more efficiency if we can get access to all their systems. And they have agreed to give us those and we are working those agreements right now.

Questions on formals. Before I go there, is there any questions on where we were, where we are now, and how we got there?

Okay. All right, we will push through on formals. We are not doing well recently. Well, we have been improving recently but we had some problems with the timeliness of our formals and we will talk about why here in a moment.

Have we improved in most recent

months? Yes. I measured it again today. Based on where we were today, we were at 46 days so far this month. That is an improvement over last.

What have we done? One of the things we did, we hired more government docs because DoD policy requires three people on a formal. One of those has to be a doc. Well, if you have limited doctors, you can only do so many formals a day. Having sat on a number of formals, they will wear you out. You do about three a day and then you are drooling on yourself because you are listening to all of the motion that that Soldier is bringing in. Oh, by the way, you have already had to review the case in detail with the Board before the Soldier ever came in to see if there was an obvious error and to help focus the questioning that you are going to do during the formal to try and get at the Soldier's contention.

So, it is an intensive process.

So, about three a day. And when you only have a couple of docs in the PEB, that limits you.

What have we done to further improve? We are trying to recruit and retain MDs. That is a challenge. That is a challenge. The Army doesn't pay MDs very much. MDs that work for us aren't touching patients. As such, they are at a lower pay scale.

The VA, where they are doing the same job kind of in adjudication or advisement, pays a lot better. So they come to us, get familiar and then say hey, I have got experience at an Army PEB or an Army MEB and they walk across the street to VA. We are kind of eating each other's young.

What are the factors that contribute? Critical shortage of MDs at JBLM first. That was the biggest challenge they had. Then we had a shortage at JBSA. And what that was was people walking across the fence to go work somewhere else or people --

we had two deaths, tragically. I mean you can't predict those losses of doctors and it is just what happened.

And then just the sheer case volume. The sheer case volume.

And then RC cases as a percentage of the volume. RC Soldiers generally tend to appeal more often and we will talk about why.

What do we do? Why do they? I think these are the reasons, we believe. And I talked to the Office of Soldier's Counsel and a number of the Warriors there. I think they agree. The biggest, probably initial challenges are incomplete record. The second challenge is the RC Soldier who is given the same briefing as an AC Soldier as they enter the process, simply just doesn't avail themselves of the lawyers, who are available, who are there, et cetera. So, we are taking some more aggressive actions here in the near future. Here is a flyer. Here is the better phone number. If you can't reach them here,

do this. Trying to get them to reach out to those lawyers earlier.

You asked for statistics; 47.4 percent of the cases that we had a formal for, there was no change. The Soldier came in, presented additional evidence. The PEB reviewed that evidence and the formal PEB made the same decision.

Then 38.7 percent of the cases that were brought in resulted in an increased rating. That goes back to, I think, some of what General Mustion was asking before. How does it change? Well, the Soldier comes into a formal and he brings in new evidence, evidence that was presented to the MEB or the PEB before. So, I get a whole stack of new evidence. It is going to likely change the decision. And that is, generally, what happens.

And 10.3 percent went from a finding of unfit to fit. That is a good thing; 10.3 percent of the formals. This

still translates to a number less than 3 percent across the Army found fit after going through IDES. But this is a Soldier coming in and fighting to stay in the Army. We love to see those kind of Soldiers.

Then 2.5 percent resulted in change to a combat code. For example, a Soldier comes in and nowhere in his record does it say that injury happened while he was deployed in Kuwait, which is a combat theater. He comes in and says well, here is the theater treatment record I kept. Okay, you got hurt there? You get 10(d).

And 0.71 percent resulted in a decreased rating; 0.35 went from fit to unfit. Because generally, a Soldier who comes in is trying to be found fit, most frequently.

And how many resulted in appeals to the our level? Well, 17 percent of all of those then request another appeal to the Agency; 17 percent of all of those.

Okay, this is designed to be busy.

It talks to all of those key things; what happened. So, if you look at it, most of these factors hit every time we had a spike. It just hit somewhere else. So you had an MD die here, you had one quit there, had another one that was asked to leave because they failed to perform, et cetera, et cetera. So, it has effects at different spots.

As you start to come farther over here, we start to do a little better. Why did we have a spike here? Well, you look back, we lost two MDs in this PEB for this entire month. We hired two here but they are not ready to execute until here because we are training them.

So here, when I just checked their data, they are down to 36 days because in October all those cases that were backlogged, they were doing five and six formals a day, if they had to, to get caught up because they had multiple boards running.

So, that is where we are at and

you can see the numbers are starting to come down. JBLM, horrible; now much better. JBSA got a little worse last month; that was the loss of those two docs, like I said. And then NCR was not doing very well; they are doing better.

So, I would like to point out the primary reason. December and January, IDES cases, when did they hit? We produced more cases in January 2013 than we did in some four years combined, four-year periods combined before in one month.

As the Soldier goes through the election process, meets with his attorney, gathers additional information, has a formal schedule and then shows up, it is a month or two later. So, that is where you see the delay. There is a delayed impact of that Soldier hitting. And so, that is going to delay the sheer number of cases.

Your rate stayed the same but it is simple mathematics. If I do five times as

many cases and my rate stays the same, I am going to have five times as many formals.

So what is our average? This is the other thing we look at that I worry about. Across the Agency, less than 12 percent or about 12 percent request a formal. So, 12 percent request a formal. We only execute 3.5 percent. So, 3.5 percent of the cases that we do end up going to a formal.

The challenge is when a Soldier requests a formal, we re-adjudicate their case automatically because we assume the Soldier is right. We assume that the Soldier found something that we missed. And so we assume the are right and start to re-adjudicate that case.

What we have done recently is start meeting with the Office of Soldier's Counsel before we execute a formal to say hey, what is your contention. You know, if the Office of Soldier's Counsel provides evidence we didn't see before, there is no sense

holding a formal. We will just change the finding, provide an amendment to the Soldier and move on.

What is the difference between the Reserve Component and Active? If you ask me, Active is here, Reserve Component here, about twice as high. And the reason is down here. One, they don't take advantage of the lawyers. Two, many RC Soldiers, particularly RC Soldiers who are not in an active duty status, don't understand how we can find them unfit. I can go to drill. I don't have any issues going to drill. I can do two days a month. That is not what we are finding them fit or unfit for. We are finding them fit to be able to execute their mission in a full-time environment, mobilized, ready to fight. And some Soldiers, particularly younger Soldiers, just don't get that. And so they ask for a formal and then little changes.

What are the rates? They are about, they are fairly similar in the

percentages we execute between JBLM and NCR.

The percentage executed down in San Antonio is a bit lower. We attribute that to a couple of things. One, they had more docs out here to look at it for a while. The other thing I will tell you is they are our busiest PEB. They are our highest volume PEB. They have mostly the southern United States that goes into there. And a lot of their cases were Reserve Component cases here earlier in the year where information was stale. Rather than hold a formal, they would send the case back to the MEB, redo, re-workup the medical information, give us the most updated stuff. We have the most updated stuff and the Soldier would say okay, you have got the most updated stuff, I am satisfied with your decision. And that is what you got.

Army formal dispositions, you asked me where formals were held, what happened. Of all the formals requests we get, we only actually execute about 30 percent of

them; 60 some-odd percent waive. And this data is skewed here. September data is lagging. August data is lagging. And the reason it lags is because the data is not measured by VTA until the case closes. Those cases aren't closed yet. So, the data lags.

And then this is how many are still pending results. Well, you look at this one way back here and you say wait a minute, you did a formal? Ten percent of the formals you did way back in February are still pending? Yes.

Generally, that is because the PEB said you know what, we agree with you. That condition should be found unfitting. The VA did not provide a rating because they deferred their rating. We had to send it back to the VA. And the VA time line, as we showed was about six or seven months. So, that is where you are at.

Additionally, when a Soldier comes through, they can get all the way through

their formal here and then request okay, I have got my formal result and now I want the VA to reconsider the percentages they gave me. So they can put themselves back in that loop and, again, VA is backlogged there. There is another two or three months. I think they are down to about a month and a half now. So, they have made a significant improvement there recently.

But there it is relative to the PEBs again, fairly similar between JBLM and NCR. A little bit different but not alarmingly different anywhere that I saw there.

Subject to your questions, that completes what I think you asked me to talk to you about.

MR. REHBEIN: If I may, Colonel?

COL JOHNSON: Sir.

MR. REHBEIN: When a Soldier requests a formal, do they specify what part of the decision they disagree with?

And then to follow-up with that, it sounds to me like though the formal looks back at everything, not just what the Soldier disagrees with. Am I correct in that?

COL JOHNSON: Yes, sir, the statute requires us to do a complete review. So, when a Soldier requests a formal, and this doesn't happen often, you saw the statistics, but when you come in and request a formal, your rating can go down, up, stay the same.

MR. REHBEIN: And I was just thinking about the look I would have had on my face when I opened that letter with the results of my formal that told me that not only did they disagree with me but they had lowered my rating, too.

COL JOHNSON: Yes, sir. And the thing with the formal, what we do in the Army, we tell the Soldier. We do not send it to them in writing. We give them the finding face-to-face because that is an emotional moment for them and us.

MR. REHBEIN: But they are aware that that is a possibility when they go into the formal?

COL JOHNSON: They are. We have a standard script that we read at the start of every formal that reviews that, sir. And I will tell you Soldier's Counsel does a very good job with their Soldiers to review that. We talk to Soldier's Counsel. We make them acknowledge with the Soldier there present. Do you understand what can happen here, before we proceed? We haven't started to proceed yet. Once I pull that trigger that says the formal is called to order, everything is on the table.

But then you ask, do they tell us? The Soldiers are provided in their election the opportunity to provide information for the PEB to consider and still request a formal. If they do or whether they do that or not, the PEB re-adjudicates the case.

If they provide us new

information, that is great. Because normally what we will do is we will look at that new information and we will contact the Office of Soldier's Counsel and say hey, we agree with you or Counsel, that doesn't cut it because there is the evidence that is in the medical file; you have got to overcome that. And what it does, it provides Counsel an opportunity to understand what the target is. And so, we find that to be useful.

DR. PHILLIPS: Colonel, can non-DoD medical personnel see these folks and write an opinion? And if so and that disagrees with the DoD medical personnel, how do you resolve that?

COL JOHNSON: It's the weight of the evidence, sir. It is the weight of the evidence. So, yes.

Now, if you think about it, if the Soldier is in DES and you heard the National Guard Team talk about different methods we have to pay for that Soldier to get another

evaluation, et cetera, if suddenly the guy goes out and gets three or four other opinions from an outside person when I have got a track record that says this, you are going to weigh those differently.

The other thing is you get some people, some doctors in some communities where you start to know what they are doing. If you pay $500, you get an opinion. Tell me what your opinion is. It's sad. It's rare but it does happen. But what we do is we weigh the evidence and look at the totality of it.

EXECUTIVE DIRECTOR DAILEY: Colonel Johnson, we were up at Fort Lewis and did have a chance to talk to your PEB up at Fort Lewis. He and the Counsel up there also talked about the opportunity to engage with the PEB when the formal is requested. Because as you noted, if they can hand the PEB a piece of paper right there and say look, this is why we are requesting this formal. How about if we resolve it right now and then we will pull

this formal out now, instead of in three months when we come up on the docket.

COL JOHNSON: Right.

EXECUTIVE DIRECTOR DAILEY: So, you described that process. You said some of that is being done.

COL JOHNSON: It is being done at all three PEBs. It is done less at JBLM. It is done less at JBLM because, frankly, and you are going to get my side of the story, and I think this is partly because of the tyranny of geography out West. The JBLM is representing Soldiers that are up in Montana, Wyoming, et cetera. That Soldier's ability to go get a new test result or whatever, new evidence, is limited. And so, they don't get new evidence before the Board is scheduled.

The lawyer comes in and tells the PEB, hey, believe me, this is what is happening. And the PEB says okay, that is not evidence. So, I can believe your client if he comes and testifies at the Board but I can't

just have you just tell me trust me, this is what is going on. I have to see evidence to make a decision because we are making a decision for the Service, for the Secretary of the Army that has to take care of the Soldier but, at the same time, we have a fiduciary responsibility to the government.

EXECUTIVE DIRECTOR DAILEY: So, that early touch with your Counsel, when the formal Board is requested, can be -- it is not like just walking across the street with a new piece of paper to talk to the PEB guy/girl, XO, deputy and saying look, we really don't need to go formal, if you will address this right now. It is not that easy.

COL JOHNSON: It is almost that easy. It really is.

EXECUTIVE DIRECTOR DAILEY: Yes, if they could come together.

COL JOHNSON: If they could bring the information to the Soldier's Counsel. And what we have done is locate Soldier's Counsel

right near the PEB.

EXECUTIVE DIRECTOR DAILEY: Right.

COL JOHNSON: We have done that on purpose, so that it is easy to coordinate and synchronize efforts. But, if it is that Reserve Component Soldier in Montana, no.

EXECUTIVE DIRECTOR DAILEY: Okay. Okay and then I do want to, as I call it, connect some dots here. Mr. Tierny in San Antonio's Air Force -- Tillery, excuse me.

COL JOHNSON: Tillery.

EXECUTIVE DIRECTOR DAILEY: Tillery. You have both echoed one of the same comments, which was the doctor situation and docs for the Board, for the PE Board is very difficult to manage. It takes creative hiring practices, creative hours. It is tough to find that balance between pay and quality of life that they are looking for. It is drudgery, it can be.

And so, I found that interesting that both you and he kind of made that same

comment about creating an environment where you are bringing in quality doctors and able to help them find -- what was the word that our SOCOM talked about as job satisfaction yesterday? Relevance and meaning.

COL JOHNSON: Yes.

EXECUTIVE DIRECTOR DAILEY: How do you find relevance and meaning for your PEB doctors when they come into this job? Which is very not a lot about the Soldier but more about the paperwork. So, relevance and meaning.

COL JOHNSON: Absolutely. And General Mustion can tell you how many times I go to him begging him, sir, I need to increase bonuses. I need to increase retention. I think we have got them at about as high as we can reasonably do it. There is only so much money.

Oh, one last thing, Admiral, before I sit down, we did put together a Dashboard info paper here. The picture on the

back is what it looks like. We are very proud of that.

Yesterday, we sent an email to the over 20,000 Soldiers who are in the DES process and said you have access. This is how you access it. Gave them a link, et cetera. We have gotten hundreds and hundreds of emails already back within the first 24 hours, discussing it. A lot of good feedback.

The vast majority has been very positive. Thank God, I finally know where I am and I can see how I went there. We did get one email, in particular, that they sent to me immediately, where the Soldier says it is about damn time. And why couldn't you tell me this X amount of time ago. And look at my time line. Look at how long I have been in this process.

So, but that is okay because what the Soldier didn't go on to say is he had cancer. We delayed him on purpose so he could get more treatment with the same doctor, at

his request. So, when we go back in and start to look at it, that's okay. He is frustrated and he is dealing with something that God, I hope I don't ever have to deal with. So, we will take that hit.

EXECUTIVE DIRECTOR DAILEY: So, we will incorporate this into our findings. But this, ladies and gentlemen, your recommendations over the past year have been to one of them was to increase accessibility to the VTA, so that there was more visibility in the DRAS and at the CBWTUs and at the lawyer's offices.

This is the individual goes online. They sign on to what you call a CMS. You call it signing into a system called the CMS and they can see their current status. And I would be interested to see, as we go out on this next round, how many more black hole discussions we get. Obviously, it needs roll out time. It needs time to get traction and get into the lexicon. But, thank you.

I think this black hole discussion dominated last year's Task Force discussions. Before that, it had been it takes too long. It takes too long. The dialogue changed last year to I am moving through much faster now but I have no idea where I am or how long, or where I am going next or when it is going to resolve itself. It is in the black hole, the black hole. So there was an interesting change in dialogue out there.

COL JOHNSON: And I think this obviates the need for individual access to many IDES stakeholders to VTA data because that Dashboard is based on VTA data poll. It is a once a week data poll, so it is a little dated but it is once a week. In a 295-day process, that is probably often enough.

CO-CHAIR NATHAN: So, Colonel let me close with the last question.

COL JOHNSON: Sir?

CO-CHAIR NATHAN: So obviously, you have leaned into this. You have cleared a lot

of the backlog out. So, now you are at the point where you can sort of bail the water at the same rate it is coming over the side, Navy term.

COL JOHNSON: Yes, sir.

CO-CHAIR NATHAN: Now, I am going to ask you a question, sort of in Army metaphor. You have approached the 50-meter target. You are really at the 300-meter target. The 1,000 or 5,000-meter target is the people coming off active duty roles over the next few years. And the choke point more at the VA and at the IDES system, what does your gut tell you about that? Where are we positioned, especially in the Army, which is going to bear the brunt of people coming off the roles at a faster than normal evolution?

COL JOHNSON: Sir, here is what I told the G-1, sir, General Bromberg, my boss. I said all right, sir, where is where we are at now. That is one of our concerns. It is an unknown target because we have looked back

at it historically after the second World War. We looked at it after the Korean War, after the Vietnam War. We looked at it during the '91 draw down. We tried to see could we pull lessons learned from that, the '91-'92 draw down. And what we found is that there is no direct correlation for the number of Soldiers that are going into DES. And the DES has been here for decades.

The most common thing, or the thing that appears to be a driver is the economy. So, if the economy is not good and there is not an alternative for that Soldier to take the skills that learned in the Service, limited however much by the disability they have, and then just go out, they are going to seek another means.

They have to take care of their families. They are going to have to take care of themselves. If the economy stays bad, you ask my personal opinion, that is my personal opinion, if the economy stays bad, more and

more folks will go into the DES because it is the only alternative they have. A former G-3 of the Army said, used the term, that is normal economic behavior. What do you expect them to do? And that is what I think. That is my personal opinion. Others disagree but I think it is tied to the economy.

What I will also tell you is that the next big thing that we are after, what we are trying to do within the Agency and across the enterprise, is to ensure we have the capacity to do upwards of 3,000 cases a month. We don't expect to have, and recent data does not show, 3,000 cases a month coming into IDES. But what we also have to remember is we have TDRL, we have non-duty-related cases, et cetera.

When we executed all of these cases, we built a backlog on TDRL. We have got to get after that monster. If we don't, Soldiers lose their benefits after five years. So, my goal is to reduce that figure by about

35 percent in the next year, reduce the backlog by 35 percent, and then eliminate it within the next year, year and a half after that. Because if we don't, that is going to be our next crisis. So, rather than have a crisis, let's get it after it now while we have capacity in place, we have experienced people in place before there is a change in mobilization authorities or whatever. Get after it now. Get her done and then leave the system in its place in a couple of years where it is a steady state and you are not having to react to crisis.

So, that is the Army's plan within the DES, larger than just the IDES. That is what we are after. And so, that is what MEDCOM is focused on now and that is the cases they are pushing to us.

As you know, sir, that drill to reevaluate all those troopers coming in, contacting them, getting them in, getting their evals done, getting it to the PEB. So,

that is what we are focused on now.

CO-CHAIR NATHAN: All right, thank you. Good answer. I think that will do it. Thank you, sir.

COL JOHNSON: All right, Admiral, thank you.

EXECUTIVE DIRECTOR DAILEY: Ladies and gentlemen, that wraps it up for today. We will be heading down to -- a small group of us will be heading down to Quantico tomorrow and Thursday. And we will see you again then possibly if you are going to Utah with us but if not, our next meeting is in December. It is in San Antonio.

So, ladies and gentlemen, thank you very much for your time today.

(Whereupon, at 3:46 p.m., the foregoing proceeding was adjourned.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Recovering Warriors Task Force
October Business Meeting

Before: US DoD

Date: 10-29-13

Place: Arlington, VA

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter