

UNITED STATES DEPARTMENT OF DEFENSE

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

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JANUARY BUSINESS MEETING

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TUESDAY

JANUARY 28, 2014

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The Task Force met in the  
Washington Ball Room of the DoubleTree Hotel  
Washington D.C.-Crystal City, located at 300  
Army Navy Drive, Arlington, Virginia, at 8:30  
a.m., Suzanne Crockett-Jones and Matthew L.  
Nathan, Co-Chairs, presiding.

PRESENT

SUZANNE CROCKETT-JONES, Non-DoD Co-Chair  
VADM MATTHEW L. NATHAN, DoD Co-Chair  
CSM STEVEN D. DeJONG  
RONALD DRACH  
TSGT ALEX J. EUDY  
LT COL SEAN P.K. KEANE  
KAREN T. MALEBRANCHE  
MG RICHARD P. MUSTION  
STEVEN J. PHILLIPS  
DAVID K. REHBEIN

ALSO PRESENT

DENISE DAILEY, Task Force Executive Director  
BRANDI BARNETTE  
MARION CAIN  
FRANK C. DIGIOVANNI  
SHARI ERICKSON \*  
KEN FALKE  
JOHN HANSON  
YVONNE HARRINGTON \*  
DARCY HOTCHKISS  
JIM LORRAINE  
DERENDA LOVELACE  
CHRISTOPHER MILLER  
MICHAEL PARKER  
TERESA PIERCE \*  
GINNEAN QUISENBERRY  
PATRICIA REILLY \*  
JOHN RICHARDSON  
CAPTAIN STEPHEN SEARS  
RICHARD WILLIS

\* Present via telephone

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

8:31 a.m.

CO-CHAIR CROCKETT-JONES: Welcome,  
everybody.

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 H.

Good morning, Mr. Parker. I'm  
turning it over to you.

MR. PARKER: Good morning and  
thank you.

At the October 2013 business  
meeting, the Recovering Warrior Task Force  
received a brief from Mr. Jim Davis of the  
Physical Disability Board of Review. Part of  
that brief covered the PBR Special Review  
Panel, which reviews past mental-health-based

1 DES cases to ensure they were properly  
2 adjudicated.

3 I recently received the results of  
4 an SRP review. The contents demonstrate that  
5 the SRP process is fatally flawed and will do  
6 little to ensure proper compensation of  
7 wounded warriors with mental health issues.

8 Troy Balke is an Iraq war veteran  
9 with over 10 years of service who underwent a  
10 MEB and a PEB for both physical and mental  
11 health issues. Despite being diagnosed for  
12 PTSD while on active duty, his MEB and his PEB  
13 changed his PTSD to a non-compensable  
14 diagnosis of adjustment disorder with anxiety  
15 and depression.

16 The outcome of the SRP process is  
17 an advisory opinion to the Board for the  
18 Correction of Military Records. Troy Balke's  
19 SRP advisory opinion is arbitrary, capricious,  
20 and very much one-sided. It leaves out  
21 critical information that clearly demonstrates  
22 that Troy Balke suffers from severe PTSD which

1 is unfitting.

2 The SRP admitted that Troy Balke  
3 was diagnosed with PTSD while on active duty.  
4 However, the SRP stated that, since both his  
5 MEB and PEB classified the mental health issue  
6 as adjustment disorder, Troy Balke was not  
7 disadvantaged by the process. In other words,  
8 as long as the MEB and the PEB are  
9 consistently wrong, there is no problem, and  
10 this is absolute BS.

11 In addition, the SRP opined that  
12 Troy Balke's mental health issue was not  
13 unfitting. Nothing could be further from the  
14 truth. Two key elements that the SRP  
15 conveniently left out of their advisory  
16 opinion is Troy Balke's VA and Social Security  
17 determinations.

18 The VA rated him 100-percent  
19 disabled, permanent and total, for PTSD,  
20 effective the date of separation. The VA  
21 based this rating on an extensive list of  
22 issues, to include total occupational and

1 social impairment, disorientation to time and  
2 place, persistent hallucinations and suicidal  
3 ideations.

4 The Social Security Administration  
5 deemed Troy Balke totally disabled due to  
6 physical and mental conditions, with an  
7 effective date 15 months prior to his  
8 separation from active duty.

9 Troy Balke's 100-percent PTSD  
10 rating decision specifically mentions his  
11 Social Security determinations, but the SRP  
12 made no mention of these facts in their  
13 advisory opinion. This leads me to conclude  
14 that the SRP structure, procedures, and  
15 culture will not honestly evaluate mental  
16 health issues. Rather, the SRP is designed to  
17 do the least amount possible, and they will be  
18 a part of a chain that cheats Wounded Warriors  
19 out of proper DoD disability benefits.

20 Time limitations prevent me from  
21 sharing other concerns and issues with the  
22 SRP. To that end, I have attached an

1 information paper to this statement  
2 summarizing these concerns and issues.

3 I have also attached key documents  
4 from Troy Balke's case for your review, and  
5 this includes his 100-percent VA PTSD rating  
6 and his Social Security determination.

7 I'll be happy to entertain any  
8 questions or issues you may have.

9 CO-CHAIR CROCKETT-JONES:

10 Actually, I have a question. Did this happen  
11 in the legacy DES or in the IDES?

12 MR. PARKER: His initial PEB was a  
13 legacy case. So, the VA was involved, but not  
14 -- as a parallel process, he applied for  
15 benefits delivery at discharge and was  
16 actively getting his VA rating while he was  
17 still on active duty, but it wasn't as part of  
18 the IDES. It was a separate action.

19 CO-CHAIR NATHAN: Mr. Parker, when  
20 you and/or Mr. Balke went to lengths to try to  
21 reconcile this with the PEB, did you get any  
22 kind of answer for them? In other words, if

1 the PEB were here or the cogent  
2 representatives of that, and we asked them,  
3 "Why the discrepancy between what he was  
4 diagnosed with before he came to you and your  
5 change to an adjustment disorder?", what would  
6 they say?

7 MR. PARKER: Well, I was not  
8 involved in this case at that time. His case  
9 was adjudicated in 2010, and he just recently  
10 reached out and touched me about two months  
11 ago.

12 And that was because the PDBR sent  
13 him a letter saying, "You're eligible for this  
14 review," which was part of the whole issue of  
15 adjustment disorder and personality disorder  
16 being used in lieu of PTSD. So, he got  
17 flagged for that.

18 The SRP grabbed all his records  
19 and, again, the output was to do this advisory  
20 opinion. So, all I am basing this on was the  
21 record. I have never met Troy. I have talked  
22 to him on the phone several times. I wasn't

1 part of his case back then. But I have looked  
2 at his VA, his Social Security, and the other  
3 documentation that he has, to include the SRP.  
4 The SRP was the one that confirmed that he, in  
5 fact, was diagnosed with PTSD while on active  
6 duty, which triggered a MEB.

7 CO-CHAIR NATHAN: Was he one of  
8 the individuals who came through the Ft.  
9 Lewis-McChord group?

10 MR. PARKER: No, he was not at Ft.  
11 Lewis-McChord. He was in the Kentucky area,  
12 if I remember right.

13 CO-CHAIR NATHAN: Okay.

14 MR. PARKER: But it was a similar  
15 thing, and his SRP, which puts an advisory  
16 opinion out to ABCMR, and the ABCMR, he gets  
17 a letter saying, "You now have 30 days to  
18 rebut it," and we're in the middle of  
19 rebutting it right now, as to why the SRP  
20 didn't do everything they should have done.  
21 But that's the records we have.

22 The SRP, if you look at it, it

1 says, "We have a case file, and our decisions  
2 are based on that case file," well, Troy  
3 doesn't have that case file yet. We have  
4 requested it, so that we can make an  
5 appropriate rebuttal. We can't really rebut  
6 it in full without knowing exactly what the  
7 SRP looked at. Because they mention it and  
8 say, hey, based on the information in the SRP,  
9 this, or on the case file, but we're blind to  
10 the case file at this point.

11 CO-CHAIR NATHAN: So, if I can  
12 infer from what you're saying, two main  
13 points. One is that, from a tactical  
14 perspective, you believe that his ultimate  
15 finding of disability by the Social Security  
16 Administration and by the VA lends weight to  
17 the fact that he does have a disability, a  
18 Disabling Post Traumatic Stress, that was not  
19 captured by the MEB and the PEB process? So,  
20 that, one, they just simply got it wrong in  
21 your opinion.

22 No. 2 is that, even if they got it

1 wrong, you don't believe there is a viable  
2 mechanism that exists for him to go back and  
3 get that corrected?

4 MR. PARKER: Well, I would couch  
5 it as there is an array of evidence out there.  
6 And the SRP based their advisory opinion on  
7 the evidence that supported what they wanted,  
8 which was not to have a change in decision.  
9 And for them to leave out his VA ratings in  
10 that advisory opinion and to leave out the  
11 Social Security determination in that advisory  
12 opinion is the foul ball. They can't go  
13 through this review process and then to give  
14 a one-sided story with only the evidence that  
15 supports the position they wish to make.

16 CO-CHAIR NATHAN: Any other  
17 questions or concerns?

18 (No response.)

19 Thank you, Mr. Parker.

20 MR. PARKER: Thank you.

21 CO-CHAIR CROCKETT-JONES: We now  
22 welcome Mr. John Richardson, a Navy Reservist

1 and Wounded Warrior, to provide his statement  
2 to the Task Force. Members can find Mr.  
3 Richardson's information behind Mr. Parker's  
4 information in tab H.

5 I'm turning it over to you, Mr.  
6 Richardson.

7 MR. RICHARDSON: Thank you. Good  
8 morning.

9 My circumstances are the same as  
10 stated when I appeared before you in October  
11 of last year. Therefore, I would like the  
12 same information submitted for the record  
13 again.

14 There is one exception, however.  
15 The Social Security Administration,  
16 specifically the Disability Department, has  
17 reviewed my military and civilian medical  
18 records and also determined that I should be  
19 retired on disability.

20 This is the third government  
21 agency, the first being the Navy and the  
22 Veterans Administration, to review my injury,

1 medical condition, and confer my original  
2 diagnosis as well as documentation from  
3 numerous medical professionals.

4 For your information, the Social  
5 Security Administration has a higher standard  
6 of proof than the Department of Labor and the  
7 Office of Personnel Management.

8 Again, I am entering my third year  
9 of limbo. I am unable to completely and  
10 permanently retire and begin the next phase of  
11 my life. I know that Mr. Jeh Johnson is now  
12 Secretary of DHS.

13 There were five things that I  
14 asked for when I appeared before you before.  
15 And again, permanent military retirement at  
16 the appropriate rating, restoration of the  
17 promotion that I lost. I was selected for  
18 promotion to Commander, but because I ended up  
19 on the TDRL list, a designation that this Task  
20 Force has asked Congress to eliminate, my  
21 promotion was taken from me. So, that's  
22 rubbing salt in the injury that I suffered on

1 active duty.

2 And any sort of email or letter of  
3 support asking DHS to simply allow me to  
4 retire.

5 Oh, and then, also, again, the way  
6 my injury occurred, as described in several  
7 statements, was via wearing the body armor in  
8 pre-deployment combat training. Again, I  
9 injured myself, did not know the extent of my  
10 injury, completed my deployment, and followed  
11 my doctor's recommendation to retire. I'm on  
12 this road because my doctors told me, "It's in  
13 your best interest to retire."

14 And then, finally, I would like to  
15 have a retirement ceremony. After 30 years,  
16 I think I have earned it.

17 Again, if I have some time, I need  
18 you to know that my father is buried at  
19 Quantico National Cemetery. He was a World  
20 War II veteran, Pacific Theater Ribbon. He  
21 was one of the first African-American Seabees.  
22 My father-in-law was one of the first African-

1 American hospital men, corpsmen. My  
2 grandfather was a medical doctor. My family  
3 has contributed to this country.

4 And I would like to be able to go  
5 back and tell the neighbors that have written  
6 emails of support to you, I would like to be  
7 able to tell my mother, I would like to be  
8 able to tell my children that I'm not going to  
9 be lost, that I'm not going to be another  
10 statistic.

11 I cannot imagine being on active  
12 duty and having a junior person come to me and  
13 ask me for help, and several months later that  
14 person has to come back to me again and tell  
15 me the same story. I cannot imagine in the  
16 duties that I have performed telling someone  
17 that I would facilitate something to get them  
18 out of trouble, and then not do it.

19 My story is real. I'm a real  
20 person. What has been done to me, the effects  
21 are cross-generational. I support not just my  
22 elderly mother, but I have nieces and nephews

1 who depend on me for book money, for car  
2 money. So, I really need you to understand  
3 that I need your help. I'm a real person and  
4 I have real problems.

5 And again, I submitted for the  
6 record a letter from Congresswoman Duckworth,  
7 whom I have reached out to, and even from her  
8 military liaison, it is very clear that there  
9 is still confusion as to what my status is.

10 So, I am here again asking for  
11 your help. Thank you.

12 CO-CHAIR NATHAN: So, Commander  
13 Richardson, no one questions that your family  
14 has been very dedicated in a heritage of  
15 service to the country.

16 You currently are in your third  
17 year of TDRL status?

18 MR. RICHARDSON: I am, yes, I am  
19 in -- this is, when I came back, my deployment  
20 was from September of 2010 to 2011, Admiral.  
21 And so, I began that process of becoming a  
22 disabled veteran, but coming back and

1 reporting to my civilian job and having every  
2 single federal disability, USERRA, every  
3 violation in the book being done to me. That,  
4 again, adds to the same problem.

5 So, basically, for me, this is my  
6 third year of just limbo. I'm not able to  
7 work. I am not able to even volunteer. I  
8 can't go to training. Anything that I do  
9 right now in the limbo that I am in puts me in  
10 some sort of jeopardy.

11 And I need to talk with you and  
12 Ms. Crockett-Jones off the record.

13 And I can tell you, DHS, which is  
14 part of, in my opinion, our defense, what I am  
15 dealing with at DHS is nothing more than  
16 corruption and cronyism. That's what is  
17 keeping me from retiring.

18 CO-CHAIR NATHAN: I'm trying to  
19 understand a little bit about the difference  
20 in your situation. And you're correct, the  
21 Task Force has gone on the record as saying  
22 that the TDRL system probably creates more

1       bureaucracy than it solves. That said, it is  
2       still in existence.

3                       What do you see at the endpoint?  
4       What are you being told by the people who are  
5       following you and doing your periodic physical  
6       examinations that are required under the TDRL  
7       process? At the five-year point, when you  
8       reach the term limit of the TDRL, what do they  
9       anticipate will happen?

10                      MR. RICHARDSON: Well, I did talk  
11       with one of the TDRL lawyers. He discouraged  
12       me from actually asking to go to the Board  
13       early.

14                      My doctors, every single person  
15       that the Navy referred me to, including Dr.  
16       Steven Hughes, who is a renowned back surgeon  
17       in the D.C. area, have all unconditionally  
18       said, "This gentleman's injury, he should  
19       retire."

20                      So, my concern is I am supposed to  
21       go back for the TDRL Board this spring. And  
22       everything that I have been told about that,

1 it is anecdotal information, but all of the  
2 professionals that I have talked to, they say  
3 that is a business decision. "Your medical  
4 condition is going to be secondary to the  
5 business decisions of that TDRL Board."

6 And quite frankly, I fear going  
7 before them in this status where I have asked  
8 people in Congress, I've asked this Task Force  
9 for help. My fear is going before them, and  
10 they reduce my benefits right now, at a time  
11 that I just cannot afford that to happen to  
12 me.

13 CO-CHAIR NATHAN: So, if someone  
14 were to say to you, "Look, we're just going to  
15 kind of flip all the cards over now at the  
16 three-year point, instead of the five-year  
17 point, and put your MEB through to the PEB for  
18 medical retirement," that's what I heard you  
19 say initially. But now I hear you saying you  
20 worry about that because you might receive a  
21 lower disability rating than you deserve.

22 MR. RICHARDSON: Well, my concern

1 is based on what I have been told. To be  
2 honest with you, there are so many things that  
3 I am dealing with, including the effect that  
4 my injury has on me in terms of just  
5 concentration in pain as I am standing before  
6 you right now.

7 I don't know what to do. I cannot  
8 adequately answer your question right now  
9 because I would only be parroting back to you  
10 the things that I have been told by others.  
11 And I don't know how accurate or inaccurate  
12 what I have been told actually is.

13 I know that the documentation that  
14 I currently have on hand from a number of  
15 medical professionals that span my original  
16 diagnosis in July of 2011 up until now are  
17 exact same, with the exception of my condition  
18 has worsened. But the original diagnosis from  
19 the doctor that I saw at Camp Lemonier, it has  
20 been consistent.

21 Everything that the medical  
22 professionals have written about me has been

1 consistent. So, my condition, as documented,  
2 is still the same. I just don't know what  
3 else I can do to show that I need to be  
4 permanently retired. I'm willing to do  
5 whatever this Task Force or whatever someone  
6 that I am given to to act as an advocate, I am  
7 willing to do whatever they want me to do.  
8 But, as of right now, the phone calls and the  
9 emails that I have sent out to various  
10 individuals whom I was told to contact, it  
11 just seems as though I have fallen through the  
12 cracks again.

13 CO-CHAIR NATHAN: Okay. Well, I  
14 understand the bureaucracy can be very  
15 confounding. What I hear you saying is that  
16 you suffered an injury. The injury was such  
17 that it was not consistent to leave you on  
18 active duty. You were not sent for a PEB at  
19 that time. You were put in a temporary  
20 disability limited-duty status, a TDRL, which  
21 is designed, whether it is the right way to do  
22 it or not, is designed to monitor the status

1 of your injury or illness, determine if it  
2 improves or deteriorates over time. If it  
3 does not improve to the point where you can  
4 return to active duty, then at the end of the  
5 TDRL period, you are to be retired medically.  
6 And you will go through a disability  
7 evaluation, and if there is compensation based  
8 on that from the VA system, you'll get it.

9           What I hear you saying is, "Look,  
10 I had this condition three years ago. They  
11 put me on TDRL. There's medical documentation  
12 that I'm no better now than I was then; in  
13 fact, worse. I just wish they would fish  
14 instead of cutting bait all the time and put  
15 me through the disability system."

16           But, then, I hear something a  
17 little confusing from you. "But I fear doing  
18 that now because I'm worried they won't give  
19 me the compensation to which I am due."

20           MR. RICHARDSON: Understood. That  
21 fear is based on appearing before the TDRL  
22 Board again. I think the TDRL process was the

1 most expedient process to getting me out of  
2 the system, to getting me out of Norfolk  
3 MEDHOLD East, to be honest with you. I think  
4 that was the path of least resistance.

5 Had I known then what I know now,  
6 and even going back and remembering what one  
7 of my PEBLOs or what one of the VA reps said  
8 to me, I said, "Well, how is my condition  
9 going to improve?" And she said, "Well,  
10 you're right, very rarely do back injuries  
11 improve. So, this is what we're going to do  
12 for you right now. Later on down the line,  
13 you'll be permanently retired."

14 But, again, having gone through  
15 this process right now, I know more than I  
16 knew then, but, ultimately, my concern is  
17 this: if I was a younger, less mature, less  
18 experienced, less trained person, I can tell  
19 you right now, Admiral, I would have checked  
20 out by now. I would have become another  
21 statistic. I would have been a member who has  
22 taken their life because they could not stand

1 the circumstances they're in.

2 In my case, I have a good spouse  
3 who was with me here last time. I have a very  
4 supportive spouse. I have a supportive  
5 family. But not everyone is that fortunate  
6 who finds themselves in these circumstances.

7 But I can tell you what I have  
8 gone through right now, I'm glad it's me. I'm  
9 glad it's me. I would hate for this to be a  
10 young person with kids with a mortgage, with  
11 additional pressures that I do not have. I  
12 can tell you emphatically they would not have  
13 made it to this point.

14 CO-CHAIR NATHAN: Well, I  
15 appreciate your frustration, and I recognize  
16 that sometimes the uncertainty of a decision  
17 is worse than the decision itself because it  
18 is hard to get on with your life when you're  
19 in, using your terminology, "limbo".

20 You're being followed where for  
21 your TDRL? Where do you go back for your  
22 periodic examinations?

1                   MR. RICHARDSON: I do not know. I  
2 guess the questions -- I've been referred to  
3 civilian healthcare providers.

4                   CO-CHAIR NATHAN: Okay.

5                   MR. RICHARDSON: National Spine  
6 and Pain Center is one of them. And then, as  
7 I mentioned, Dr. Steven Hughes from  
8 Commonwealth Orthopedics is the other  
9 doctor --

10                  CO-CHAIR NATHAN: What facility  
11 processed you for your TDRL? What military  
12 facility processed you for your TDRL?

13                  MR. RICHARDSON: This was in  
14 Norfolk. This was at MEDHOLD East, I guess.

15                  CO-CHAIR NATHAN: Were you seen by  
16 providers at Portsmouth Medical Center?

17                  MR. RICHARDSON: Yes. Yes,  
18 Admiral.

19                  CO-CHAIR NATHAN: Okay. All  
20 right. Well, I'm going to pull the string on  
21 it because you were in the Navy, right?

22                  MR. RICHARDSON: Yes.

1 CO-CHAIR NATHAN: Okay.

2 MR. RICHARDSON: Still.

3 CO-CHAIR NATHAN: So, I'm going to  
4 pull the string on it, and I'm going to see  
5 where your TDRL status is. I'm going to see  
6 what the last results of your periodic  
7 examination was. And then, if it's warranted  
8 and it's cricket, we'll see if we can expedite  
9 decision on -- if your MEB/PEB warrants it,  
10 we'll try to get you into a definitive status  
11 of retirement.

12 MR. RICHARDSON: Yes, sir.

13 CO-CHAIR NATHAN: Now that system  
14 is that system, and that system can vary  
15 depending on the degree of your injury and  
16 what the findings are and how the VA rates it.  
17 You can have a compensatory rating from zero  
18 percent to 100 percent.

19 But I think what you're saying is,  
20 "Please let me get on with my life. The TDRL  
21 status has allowed me to either return to  
22 training and be on active duty and pursue my

1 military career, nor has it allowed me to  
2 really put a stake in the ground in the  
3 civilian sector and get on with a job and do  
4 other things. And I'm still having pain and  
5 issues, and they have me one foot in the  
6 military and one foot out of the military.  
7 And I'm still in pain, and I can't really  
8 function well. And I need to be an ultimate  
9 dispensation of my disability status."

10 MR. RICHARDSON: Yes.

11 CO-CHAIR NATHAN: Okay.

12 MR. RICHARDSON: Yes.

13 CO-CHAIR NATHAN: Got it. Thank  
14 you.

15 CO-CHAIR CROCKETT-JONES: Now we  
16 welcome Ms. Darcy Hotchkiss, a veteran and  
17 practitioner of bioenergy therapy for those  
18 diagnosed with PTSD, to provide her statement  
19 to the Task Force. Members can find Ms.  
20 Hotchkiss' information behind Mr. Parker's  
21 information in tab H.

22 MS. HOTCHKISS: Good morning.

1                   I'm Darcy Hotchkiss. I'm an Army  
2 veteran, a GS-14 cyber-security analyst, and  
3 an accidental practitioner of the Domancic  
4 Method of bioenergy therapy.

5                   In my free time, I provide  
6 donation-based healing events, group events,  
7 for civilians, military, and veterans with a  
8 diagnosis of PTSD and more. A common theme I  
9 am hearing from veterans coming to our clinics  
10 is that they've gone through the traditional  
11 treatments with the medicine and the  
12 counseling and the talk therapy, and they  
13 don't want to continue to relive the pain over  
14 and over again that they do in the talk  
15 therapy.

16                   One veteran said he feels worse  
17 after attending the counseling, and another  
18 veteran said that the medication makes him  
19 feel disconnected, groggy, and destroys his  
20 ability to be intimate with his wife.

21                   So, what we're seeing going really  
22 well with this therapy is we're experiencing

1 and seeing positive effects of bioenergy  
2 therapy in a group environment. In some cases  
3 we are seeing the PTSD symptoms completely  
4 managed to where they don't need medication.  
5 In a lot of the other instances, we are  
6 actually seeing the symptoms of PTSD  
7 completely reversed.

8 I'm in no way suggesting that  
9 bioenergy therapy is a replacement for  
10 conventional medicine. We don't see ourselves  
11 in competition with medicine because what  
12 we're doing is not medicine.

13 As an alternative to what is being  
14 done and might not be completely working with  
15 veterans, we would like to see bioenergy  
16 therapy offered on a larger scale in a group  
17 environment to those who would like to try  
18 something different. We see ourselves  
19 alongside medicine or in collaboration with  
20 medicine, as an alternative to the traditional  
21 methods that do not resonate with everyone.

22 We're getting amazing results with

1 bioenergy therapy, and we believe the proof is  
2 in the results. Because why else would you do  
3 it if you don't get results?

4 We think everyone should have  
5 access to this method. And that's why I spend  
6 all my time doing it.

7 If there are no questions, that  
8 concludes --

9 CO-CHAIR NATHAN: So, there is no  
10 question that alternative complementary  
11 medicine or therapy has become much more  
12 integrated into the holistic approach to  
13 emotional health, especially that of Post  
14 Traumatic Stress, which ranges from the  
15 chiropractic to the acupuncture, to the  
16 biofeedback, to the art therapy, to massage,  
17 to a variety of things. We are now starting  
18 to see more and more types of therapies that  
19 are designed based on imagery, based on  
20 supplanting the thoughts, the traumatic  
21 thoughts of PTS.

22 If you could -- and this is maybe

1 challenging -- but if you could, in a  
2 nutshell, what is the center of gravity of the  
3 bioenergy therapy? How does it differ from  
4 talk therapy? How does it differ from therapy  
5 of imagery replacement?

6 MS. HOTCHKISS: Bioenergy therapy,  
7 the way that it is done I think is something  
8 that sets it apart from all the other  
9 alternative therapies, in that it is a little  
10 bit more palatable. It is done in a room  
11 similar to this in chairs similar to this.  
12 People are sitting or standing. They get  
13 individual sessions. We can do 60 to 100  
14 people at a time in the group events. And  
15 you're sitting or you're standing. It takes  
16 about 15 minutes.

17 There are a few specific movements  
18 that we work in the bioenergy field, the  
19 energy field. If that term is not known to  
20 you, the Chinese call it Chi; the Japanese  
21 call it Qi; the Indians call it Prana. It is  
22 a bioplasmic energy field.

1                   So, we work in that bioplasmic  
2                   energy field. What that does is it optimizes  
3                   the immune system, and it starts reversing  
4                   major diseases.

5                   We have done Life projects in LA,  
6                   where we have done with Parkinson's and MS.  
7                   We have that documented. And there is a  
8                   documentary done called "Think About It,"  
9                   where we have documented all of this. It has  
10                  been 40 years going, Eastern Europe and just  
11                  now kind of getting to the U.S.

12                  CO-CHAIR NATHAN: And there's a  
13                  long history of East versus West, you know, as  
14                  far as adoption of medical practice and those  
15                  sorts of things. Do you know of any -- this  
16                  is not an endorsement for or against it -- but  
17                  do you know of any major marquis institutions  
18                  of care that have adopted it as part of their  
19                  pain therapy and/or healing therapy, in the  
20                  Mayo or Hopkins or Stanford or Duke?

21                  MS. HOTCHKISS: Not yet, sir.  
22                  It's fairly new to the United States. There's

1       only six of us that are actually at my level  
2       that we can actually host groups and things  
3       like that.

4                   I would love to get that. I would  
5       love to get this in front of anybody who would  
6       give me 200 of your worst. You just give me  
7       200 of your worst and I'll show you 200  
8       miracles.

9                   And I stand behind that. I have a  
10      team of therapists that also stand behind  
11      that. We have videoed it. We've documented  
12      it.

13                  And we get amazing results. I  
14      think results are why we get up every day and  
15      do what we do. We want to see results.

16                  I'm an engineer. I didn't mean to  
17      do this. This is not where I saw my career  
18      path going.

19                  CO-CHAIR NATHAN: Yes.

20                  MS. HOTCHKISS: But I can't not  
21      tell you about it because it is something so  
22      amazing that it shouldn't be kept a secret.

1 CO-CHAIR NATHAN: Well, thank you.

2 Do you have questions?

3 (No response.)

4 Thank you for your passion and for  
5 your presence here today.

6 MS. HOTCHKISS: Thank you for the  
7 opportunity.

8 DIRECTOR DAILEY: Ladies and  
9 gentlemen, in addition to the oral statements,  
10 there are two written statements in tab H.

11 The first statement is from Mr.  
12 Bertram Jenkins, a Naval Reservist who  
13 provides a case demonstrating the hardships of  
14 trying to appeal a discharge through the PDBR.

15 The second statement is from Mr.  
16 Paul Rieker regarding alternative therapy  
17 methods for those diagnosed with TBI.

18 CO-CHAIR CROCKETT-JONES: And now,  
19 from the Population Health Medical Management  
20 and Patient-Centered Medical Home Division  
21 under TRICARE Management Activity, we welcome  
22 Ms. Ginnean Quisenberry, the Division

1 Director, and Ms. Derenda Lovelace, the  
2 Division's Case Management Nurse Consultant.  
3 Ms. Quisenberry and Ms. Lovelace will update  
4 us on medical care case management information  
5 provided in 2013 and on the status of the  
6 publication and implementation of DODI  
7 6025.20. Please refer to tab I for their  
8 information.

9 Glad to see you back. Ms.  
10 Quisenberry, I'm going to turn it over to you.

11 MS. QUISENBERRY: Thank you.

12 Good morning, Ms. Dailey and  
13 Members of the Recovering Warrior Task Force.  
14 We appreciate the opportunity to be able to  
15 come back and give you an update on the  
16 publication and ultimate rollout of our  
17 Medical Management Department of Defense  
18 Instruction.

19 So, I am going to manage two  
20 things. So, please bear with me.

21 So, the primary questions that I  
22 was asked to address today involve the

1 service-level publication as a result of the  
2 Department of Defense Instruction publication  
3 that recently came out in the April timeframe.  
4 In addition, the impact of the delivery of  
5 those medical care case managers and how this  
6 is being rolled out within the care management  
7 teams; our coordination and participation with  
8 the Interagency Complex Care Collaboration  
9 that is currently going on with DoD/VA  
10 members, as well as the results of our  
11 Wounded, Ill, and Injured Survey that we had  
12 the opportunity to get some questions in and  
13 get feedback from those injured service  
14 members, family members, and such. So, we had  
15 an idea of if what we were doing was the  
16 correct approach and where we were going and  
17 where we needed to right the ship, so to  
18 speak.

19 So, in starting out, I think it is  
20 important to note, with the implementation of  
21 our Department of Defense Instruction, that no  
22 longer are our Services really looking at

1 medical management in its purest sense of what  
2 it entails. We have become and matured a  
3 little more, and are starting to look at  
4 across the Services with the implementation of  
5 their policy, what it means to be a care  
6 management team, as opposed to just simply  
7 medical management and the benefits of what  
8 each program under medical management, that  
9 being disease case utilization with the  
10 linchpin of referral management, means.

11 We are now going along with the  
12 Services. We are getting much more mature in  
13 our approach and a holistic, patient-centered  
14 type of approach. That is being implemented  
15 within the policies that we see across the  
16 Services, of which we can look at:

17 Starting out with the Navy  
18 medicine, they currently have their BUMED  
19 posted policy and, again, looking at that  
20 holistic patient-centered care management type  
21 of approach, and what that means for each  
22 member of that care team and how they interact

1 not only within that primary care setting, but  
2 those supporting settings that might be beyond  
3 that primary care setting, and how that  
4 collaboration and discussion is going on  
5 between those teams.

6 Air Force is taking on an approach  
7 of rescinding, actually, their clinical  
8 medical management program and rolling that  
9 into the population health, making it a  
10 population health medical management type of  
11 umbrella, which is, then, considering another  
12 arm of medical management of our chronic care  
13 conditions, because they are certainly going  
14 to impact our wounded, ill, and injured and  
15 the healing and what they're going through  
16 with their injuries. So, they are rolling in  
17 both into one policy and recognizing the care  
18 management team patient-centered approach  
19 across the medical management umbrella.

20 Also looking at Army, they are  
21 putting out and their new OP Order came out  
22 where they are looking top-to-bottom and

1 they're making sure that they're looking  
2 exactly how they're implementing medical  
3 management, how they're looking at the  
4 approach and making sure they're reducing the  
5 variance of what each team member is doing,  
6 and how they're applying those medical  
7 management applications.

8           So, top-to-bottom, it is really  
9 looking for all Services as we get more mature  
10 with a care management type of team approach  
11 as opposed to a simple what are we doing in  
12 utilization management; what are we doing in  
13 disease management. How are they interacting  
14 with each other, and how are we applying that  
15 where we're talking to those members of the  
16 team that need to collaborate and be able to  
17 approach the care needed for those members?

18           Are there any questions with that?

19           (No response.)

20           So, I wanted to give you some  
21 examples, now that we have an idea of how the  
22 care management teams are coming into play and

1 give you some examples of the impact of that.

2 One thing that we have started  
3 across the military health system -- and I  
4 understand you had a presentation on that --  
5 was our Patient-Centered Medical Homes. So,  
6 how are our medical management teams becoming  
7 part of this?

8 Well, as the Patient-Centered  
9 Medical Home team concept has matured, they  
10 are now rolling in not only our primary care  
11 settings, but they are rolling in those case  
12 managers. They're rolling in those care  
13 management teams as part of that patient-  
14 centered team.

15 They are looking at care  
16 coordination through a real-time approach.  
17 Therefore, if our case managers are embedded  
18 in those primary care team settings, where  
19 they're coming in for their appointments, they  
20 have the opportunity with those case managers  
21 right there to touch them real time, to be  
22 able to follow up with them in phone

1       conversations or be looking at what their  
2       needs are before they come in, and getting  
3       with that primary care physician, making those  
4       appointments much more robust for that member  
5       coming in to be able to address their needs.

6               In addition, they are looking at  
7       the secure messaging, where we are able to  
8       reach out and talk with our members beyond  
9       just those primary care setting walls. So,  
10       that is now being, the secure messaging tool  
11       is being rolled out, and in some cases the  
12       case managers are having the opportunity to  
13       roll that out and be working right with those  
14       members.

15               So, the priority in doing so also,  
16       then, helps our patient-centered approach  
17       because they are NCQA-certified homes, and  
18       they are being able to recognize the NCQA  
19       requirement certification, which is No. 3 for  
20       them, that talks about that care coordination  
21       and the care management, allowing our medical  
22       homes to become much more mature, recognizing

1 the support that they provide and allowing  
2 that care entire type of approach.

3 In addition, we are rolling out  
4 and looking at a Tri-Service Work Flow Form.  
5 In the past, much like medical management,  
6 where we approached the concept of it, we are  
7 now expanding that concept and looking at  
8 where is the documentation.

9 I know something that you have  
10 heard a lot about is, where do we document;  
11 how do we find that information for our  
12 members that need that care? Well, we are  
13 working on and trying to roll out a brand-new  
14 Tri-Service Work Flow Form, which will help,  
15 much like a care plan, helps identify those  
16 elements of needs for those members in one  
17 standardized fashion in which all of our  
18 Services, recognizing the care management  
19 approach, holistic care, have come together  
20 and built and identified what elements of care  
21 need to be involved in those.

22 Right now, we are working on the

1 rollout of them. It has been through a beta  
2 test. It is moving into a pilot and rollout,  
3 where inclusive of that will be the education  
4 and training that will include all of our case  
5 managers with our Service partners at the  
6 table with us.

7 MEMBER KEANE: I have a quick  
8 question.

9 MS. QUISENBERRY: Yes.

10 MEMBER KEANE: Ma'am, is that  
11 going to replace the CRP?

12 MS. QUISENBERRY: I'm sorry?

13 MEMBER KEANE: Is that plan that  
14 you mentioned, is that going to replace the  
15 CRP?

16 MS. QUISENBERRY: What is the CRB?  
17 I'm sorry.

18 MEMBER KEANE: CRP.

19 MS. QUISENBERRY: CRP? No, no.  
20 No, this is where we're in our primary care  
21 settings. And so, when we have the  
22 opportunity to address those elements, this

1 will not be replacing the entire plan,  
2 recovery care plan.

3 This is when, if you are my  
4 provider, I'm coming in, and that case manager  
5 embedded in there, I'll be able to have a  
6 documentation site where I will be able to put  
7 your needs or you will be able to identify my  
8 needs. So, that care management team would be  
9 able to see that.

10 Elements of that, though, are  
11 included within the recovering plan because  
12 they are the same type of element type of  
13 approach. This is helping our Patient-  
14 Centered Medical Home in looking at the care  
15 coordination embedded case management needs,  
16 and they are similar in nature. But, when we  
17 are looking at the recovery care plan and  
18 where that will be housed, and possibly moving  
19 to one type of system where that could be,  
20 that is not being replaced, but it has certain  
21 elements that support that.

22 MEMBER KEANE: It does seem like a

1 duplication of effort. And if we are trying  
2 to get the Services to all get online with the  
3 CRP, your creation of a new thing, which maybe  
4 only you have access to, seems like a  
5 duplication of effort in a stovepipe.

6 MS. QUISENBERRY: It actually  
7 allows the opportunity for those primary care  
8 providers, though, to be able to have that in  
9 that medical record for them. So, that team  
10 and that provider would be able to see that as  
11 one of his tabs on the treatment within the  
12 medical record specifically, that that case  
13 manager embedded in that primary care setting.

14 So, this is not so much looking at  
15 the care plan, you know, across the treatment  
16 settings that we are looking to, but more of  
17 in that primary care setting how that team  
18 would address those needs, allowing the  
19 primary care provider to have visibility on  
20 that. He would be able to click over and  
21 identify, hey, we have a plan, and what do we  
22 need to be working on. If it is chronic care

1 conditioning, what meds; how are the wounds  
2 healing, things like that.

3 So, our primary care providers are  
4 not having to go to a separate place, but are  
5 remaining with the string of having all the  
6 documented or the care needs in one place for  
7 that primary care team and provider.

8 MEMBER MALEBRANCHE: Ms.  
9 Quisenberry, in light of -- I know you're  
10 working with the Interagency Care Coordination  
11 piece, as is Derenda, closely in doing this.  
12 When you are doing this, and knowing what's  
13 coming aboard, was this done in concert with  
14 knowing how it's going to roll into the IC2 or  
15 IC3 effort?

16 MS. QUISENBERRY: It was done in  
17 recognizing that the elements would be the  
18 same and trying to drive the care at the point  
19 of care for our providers. So, it's not  
20 something that would be not visible for our  
21 providers.

22 MEMBER MALEBRANCHE: So, with the

1 IC3 coming onboard and for the more complex  
2 patients and those that are not perhaps, this  
3 will be still part of the plan and the care  
4 and the documentation because it will be part  
5 of the medical home, if you will?

6 MS. QUISENBERRY: Yes, and those  
7 direct-care members, those members in the  
8 direct-care system would be able to readily  
9 see this form.

10 MEMBER MALEBRANCHE: All see it?

11 MS. QUISENBERRY: And it would be  
12 a standardized type of approach, instead of us  
13 trying to find pieces and parts of  
14 documentation in records where you literally  
15 have to go through each chart to be able to  
16 find. It would be a standardized format that  
17 the Services have come together, that we will  
18 use and recognize.

19 MEMBER MALEBRANCHE: Then, I guess  
20 I am still a little bit, with what Colonel  
21 Keane was saying, with the comprehensive plan,  
22 where does that fit as part of this? It is

1 part of this?

2 MS. QUISENBERRY: It can be part  
3 of it. It will be part of the elements of it.  
4 But, as we are developing that comprehensive  
5 plan, we needed something to be able to be now  
6 and supporting our Patient-Centered Medical  
7 Home approach in having a holistic way to be  
8 able to treat these members.

9 And it will be elements of it that  
10 can be part of that plan, but it will be  
11 something that our providers would be able to  
12 go to and readily see the needs. As opposed  
13 to the Recovering Coordinator Plan, it is  
14 going to have, when we are looking at the time  
15 that our providers have with our patients,  
16 trying to go to a separate place might be  
17 difficult for that primary care provider.

18 CO-CHAIR CROCKETT-JONES: So, this  
19 is basically only a medical documentation, and  
20 it can be included into the larger recovery  
21 plan?

22 MS. QUISENBERRY: Right. When you

1 look at the elements of it, they are similar,  
2 but it helps identify the primary care  
3 provider's ability to help in what needs. If  
4 we have, say, for instance, the need for some  
5 type of durable medical equipment or some type  
6 of supporting services, such as occupational  
7 physical therapy, they would be able to  
8 readily identify and see that at the point of  
9 care, as opposed to going to a separate place.  
10 But the elements within it are similar to care  
11 plans that would be able to be part of the  
12 Recovering Coordination Plan.

13 We needed to have something where  
14 we did a standardized approach within the  
15 documentation for our providers, much like the  
16 Patient-Centered Medical Home has their CORE  
17 form.

18 MEMBER REHBEIN: So, if I'm  
19 understanding correctly, it sounds to me like  
20 the same information might be resident in two  
21 different places. How do you go about  
22 coordinating those two different places to

1       make sure that it really is the same  
2       information?

3                   MS. QUISENBERRY: We would need to  
4       be making sure that we're working with that  
5       ongoing development of that overarching plan  
6       and making sure that we're fitting in with  
7       that.

8                   MEMBER MALEBRANCHE: So, I guess  
9       the other piece -- and again, Derenda has, I  
10      know, worked on this, as you have, Ginnean.  
11      But for this DODI that is out there, when the  
12      IC3 piece comes and this overarching piece  
13      comes, this will, then, line up and be in  
14      concert with the IC3, so that we don't have  
15      anything in competition with.

16                   But I guess the concern here --  
17      and I think I'm kind of hearing that -- is  
18      that there's potential for duplication of some  
19      things, but I guess that kind of remains to be  
20      seen until we get the overarching guidance out  
21      there.

22                   MS. QUISENBERRY: Yes, and what I

1 think you need to remember is, also, it's  
2 driving to the point of care, for our primary  
3 care providers to be able to see it and act on  
4 it with those embedded care managers, as  
5 opposed to where the recovering overarching  
6 plan in that system will be in a separate  
7 place, when we are having patients coming in  
8 and those providers having the ability to see  
9 that, readily see it and act on the needs  
10 then.

11 What is in that, certainly, will  
12 help drive to the point of care where our  
13 providers are, so we can get that care  
14 coordination much quicker and get the  
15 identified needs for our patients. Get it  
16 ordered, get it set up, making contact,  
17 getting those referrals, whatever is needed at  
18 the point of care.

19 CO-CHAIR CROCKETT-JONES: I guess  
20 my question is, would, then, the lead case  
21 manager have access to this and be able to  
22 import it to the larger CRP? I mean, that

1 would make sense to me.

2 MS. QUISENBERRY: This would be  
3 standardized --

4 CO-CHAIR CROCKETT-JONES: Is that  
5 the plan?

6 MS. QUISENBERRY: This would be  
7 standardized across in the direct-care system.  
8 What we need to do is make sure that the same  
9 type of information, as it is developed for  
10 this lead coordinator and final plans are in  
11 place, and how that's going to look like and  
12 where that's going to be housed, will be  
13 similar in nature. But that will, again, be  
14 at a separate place that our primary care  
15 providers doing the care, needing to make the  
16 orders, will not have to go to a separate  
17 place. It will be encompassed in the home  
18 where they are enrolled and receiving care.  
19 So, all members of the team will be able to  
20 see that.

21 DIRECTOR DAILEY: And one more  
22 time for me, please. This is going to be in

1 AHLTA, is that correct?

2 MS. QUISENBERRY: Right.

3 DIRECTOR DAILEY: All right. And,  
4 currently, across the Services there is  
5 nothing that standardizes delivery of these  
6 elements that you're going to identify?  
7 Nothing standardizes its delivery to a Marine,  
8 to a Navy sailor, to an Army Service member,  
9 to an Air Force --

10 MS. QUISENBERRY: Who are  
11 enrolled --

12 DIRECTOR DAILEY: Who are  
13 enrolled.

14 MS. QUISENBERRY: -- within that  
15 direct-care system to a patient-centered home,  
16 where our case managers now will be embedded  
17 within.

18 DIRECTOR DAILEY: Okay.

19 MS. QUISENBERRY: So, we have come  
20 together to try to resolve.

21 DIRECTOR DAILEY: Okay.

22 MS. QUISENBERRY: Because, right

1 now, until we have these overarching plans and  
2 guidance in place, we have this documentation  
3 in different parts of the chart.

4 DIRECTOR DAILEY: Okay. Just  
5 short soundbites here. This is going to  
6 standardize the common elements for taking  
7 care of Service members enrolled with case  
8 managers across all the Services? They are  
9 going to be looking at the same standard  
10 elements for a Marine under case management,  
11 an Army/sailor under case management, an Air  
12 Force Service member under case management?  
13 The nurse case managers will be looking at the  
14 same element across all te Services?

15 MS. QUISENBERRY: It's the same  
16 form built by all the Services together.

17 DIRECTOR DAILEY: In AHLTA? In  
18 the medical piece? So, right now, that's not  
19 how it's managed. A nurse case manager in the  
20 Marines, a nurse case manager in the Navy, Air  
21 Force may be including in the AHLTA case  
22 management different elements. Okay.

1                   So, now CRP currently, ladies and  
2 gentlemen, is a non-medical plan, all right?  
3 So, you really don't have any -- you are not  
4 going in a direction where the non-medical  
5 piece is going to be included in AHLTA, is  
6 that correct, in your overall work?

7                   MS. QUISENBERRY: It will not, but  
8 it has elements such as the financial support,  
9 you know, that somebody may need or something  
10 like that. Just asking the question in the  
11 basic care plan, but --

12                  DIRECTOR DAILEY: Okay. Wait a  
13 minute. Wait a minute. Wait a minute.

14                  So, the answer to my question is,  
15 yes, this element, the gathering of these  
16 elements and standardizing them across case  
17 management --

18                  MS. QUISENBERRY: Yes.

19                  DIRECTOR DAILEY: -- across the  
20 Services is going to include some non-medical  
21 information in AHLTA?

22                  MS. QUISENBERRY: It will such as

1 -- yes.

2 DIRECTOR DAILEY: Okay. Good.  
3 Yes. So, it will include some non-medical  
4 elements in AHLTA for the medical guys who are  
5 now going to be able to see some non-medical  
6 elements in AHLTA? So, some of it is going to  
7 be imported into a medical setting, into the  
8 medical home setting?

9 MS. QUISENBERRY: Yes, yes.

10 DIRECTOR DAILEY: Okay. And  
11 that's what this is going to do, assist in  
12 doing? All right.

13 Now is it going to be, is the VA  
14 setting up a similar system for their medical  
15 home?

16 (No audible response.)

17 Okay. Good answer.

18 MS. QUISENBERRY: I would have to  
19 make sure. I mean, I would have to go with  
20 our medical home team, but, currently, the  
21 efforts are underway within our direct-care  
22 system.

1                   DIRECTOR DAILEY:   Okay.

2                   MS. QUISENBERRY:   Certainly, our  
3   medical home team speaks and works with our VA  
4   partners, but they have rolled out with our  
5   NCQA-required Patient-Centered Medical Home  
6   approach within the direct-care system.

7                   DIRECTOR DAILEY:   Okay.  So, last  
8   year when we were talking with the Navy nurse  
9   case managers out at Camp Pendleton and they  
10   were saying they have to print out a CRP for  
11   me, I don't know what's going on in the CRP.

12                   This, having it embedded at the  
13   point care -- she keeps using all this  
14   language, point of care, blah, blah, blah --  
15   having it in AHLTA, so that the nurse case  
16   manager can look at it solves that problem or  
17   helps solve that problem?  Is that a correct  
18   assumption, a correct visual for nurse case  
19   managers?

20                   MEMBER KEANE:   Unless you're in  
21   Iowa, because Iowa they don't have enough  
22   access to AHLTA, right?

1                   DIRECTOR DAILEY: All nurse case  
2 managers have access to AHLTA.

3                   CO-CHAIR CROCKETT-JONES: Just so  
4 I get a picture of this, who qualifies for  
5 Patient-Centered Medical Home? What puts you  
6 in that system?

7                   MS. QUISENBERRY: Okay. So, for  
8 myself, I'm a spouse of an active-duty Service  
9 member. So, right now, I am enrolled in the  
10 direct-care system to a site that has a  
11 Patient-Centered Medical Home. So, I am  
12 enrolled into -- if they have a Patient-  
13 Centered Medical Home which they are rolling  
14 out, you know, they continue to roll those  
15 out, then I would have that.

16                   And so, for example, if I had a  
17 chronic condition, I now have the ability to  
18 speak directly. I don't even have to go -- I  
19 have the secure messaging ability to speak to  
20 you as my provider and say, if I have asthma  
21 and it's severe, I would be able to say, "Hey,  
22 listen, I'm starting to have some type of

1 wheezing. I feel like I'm possibly getting  
2 worse. I'm escalating my -- I'm having a  
3 chronic, you know, an acute episode," I would  
4 have the ability to speak with you. And then,  
5 you may be able to put me with my case manager  
6 and help me address that and get into an  
7 appointment before I wind up in an urgent or  
8 emergent care setting that is not going to  
9 give me the continuity that I get from my  
10 primary care provider. Therefore, I am  
11 reducing episodic care and improving the  
12 ability for my primary care provider to be  
13 able to keep me in a stable way moving  
14 forward.

15                   Simply put, Patient-Centered  
16 Medical Homes are rolling out. They continue  
17 to roll out. They continue to be mature. I  
18 have the ability to enroll that into one, if  
19 it's available and if they have room, the  
20 availability, if the MTF is not full,  
21 capacity, basically.

22                   CO-CHAIR CROCKETT-JONES: So,

1 basically, this would mean that before folks  
2 have -- before a Service member becomes  
3 wounded or injured, if they were already  
4 enrolled in a Patient-Centered Medical Home,  
5 this form would, then, be generated, so  
6 that --

7 MS. QUISENBERRY: It can apply not  
8 only to a wounded, ill --

9 CO-CHAIR CROCKETT-JONES: So,  
10 then, they can be pushed into -- okay, I get  
11 it.

12 MS. QUISENBERRY: Yes.

13 CO-CHAIR CROCKETT-JONES: I'm  
14 getting a clearer picture.

15 MS. QUISENBERRY: This can apply  
16 to anybody. So, it expands beyond our  
17 wounded, ill, and injured. This is a form  
18 that will help address the care of our  
19 beneficiary population as a whole enrolled to  
20 our direct-care system. So, it has value in  
21 two ways.

22 Any other questions? Do you have

1 any other?

2 CO-CHAIR NATHAN: Just a comment  
3 about it. So, this is, ideally, the new  
4 panacea for trying to reduce cost and increase  
5 health in the military health system. It is  
6 designed, really the tenets of the Patient-  
7 Centered Medical Home is to be built upon one  
8 leveraging technology, which is leveraging  
9 communication to the patient through  
10 asynchronous web communication, like  
11 RelayHealth, email, telephone, smoke signal,  
12 carrier pigeon, whatever?

13 Older patients prefer telephone.  
14 Younger patients prefer an iPhone app that  
15 they can use that is web-based.

16 The other tenet of it is  
17 leveraging preventative health. It is  
18 designed to track through electronic databases  
19 much more aggressively healthcare screening,  
20 colonoscopy, mammography, cholesterol,  
21 diabetes, asthma, smoking cessation, all those  
22 things.

1                   And then, what it is designed to  
2 do, ideally -- and this is what you are  
3 bringing into it -- is, basically, help manage  
4 the care of the patient, case management,  
5 clinical case management, so that things don't  
6 fall through the cracks.

7                   So, old system, you go to see your  
8 family practice doctor, your pediatrician,  
9 your internist, and they tell you, "You need  
10 to see the urologist because you have  
11 something going on with your urinary system.  
12 Go get an appointment." And you disappear,  
13 and whether you get it or not is up to you.  
14 Whether we know you have it or not is up to  
15 you.

16                   New system, there is a care  
17 manager/case manager in that primary center  
18 medical home who, then, facilitates that  
19 appointment for you, checks, has a database.  
20 If you haven't made the appointment, then we  
21 find out. And then, we call you back and say,  
22 "Go get the appointment or we'll make it for

1       you."

2                       The other major thing -- I can't  
3       remember if you discussed it or not -- about  
4       Patient-Centered Medical Home is the other  
5       tenet is it embeds primary care emotional  
6       health within the patient's medical.

7                       The old system, you come to your  
8       primary care doctor and you start weeping or  
9       crying during the blood pressure visit and  
10      they say, "Oh, my goodness, what's wrong with  
11      you?"

12                      "I'm just not doing well. I'm  
13      losing sleep. I have issues at home with my  
14      children" or my PTS or my spouse, or whatever.

15                      "Oh, my goodness, let me put in a  
16      consult for you to go see one of our mental  
17      health providers, and give me a call if you  
18      have trouble making that appointment or can't  
19      get one."

20                      And you don't hear anything from  
21      the patient. So, you assume things must be  
22      okay.

1                   When Patient-Centered Medical Home  
2                   is working very well -- and this is key to the  
3                   Recovering Warriors -- when it's working well  
4                   and it's staffed correctly, you, then, are  
5                   sent from that primary care doctor or  
6                   provider, nurse practitioner, PA, down the  
7                   hall to the primary care mental health  
8                   provider, a psychologist and/or psychiatrist  
9                   and/or social worker who sees you then. It  
10                  may be for five minutes to just get you in the  
11                  door and say, "How are you doing? Let me take  
12                  a quick look at you, make sure you're okay.  
13                  I'm going to see you back in three days." But  
14                  it's all continuity.

15                  And then, the last thing is it's  
16                  based on the pod concept. It is based on the  
17                  fact that you are enrolled to a pod of people,  
18                  usually which is a physician, an extender like  
19                  a PA or nurse practitioner, and then, medics  
20                  or corpsmen. And when one of them is gone,  
21                  somebody else knows your case.

22                  Then, the last thing -- and this

1 is the thing I like about it -- is that, when  
2 it is working correctly, and this, again, is  
3 key for Recovering Warriors -- you are able to  
4 reach somebody at anytime of the day or night  
5 who works in that Patient-Centered Medical  
6 Home pod for which you are assigned to.

7           Wouldn't you agree, most of you  
8 who have used the military health system, if  
9 you called up at 10 o'clock at night to talk  
10 to somebody who participates in your care  
11 normally and said, "I need to get a hold of  
12 them because this medicine isn't working," and  
13 they put you through to somebody who knew your  
14 care, you would probably have to get  
15 defibrillated, right? You would grab your  
16 heart and fall over.

17           What a novel concept now that,  
18 instead of getting a phone call that says, "If  
19 this is an emergency, hang up and call 911;  
20 otherwise, clinic hours are at 0800 in the  
21 morning." Okay? What a novel concept that  
22 the phone is actually answered by somebody who

1 listens to your concerns and says, "You know,  
2 your concerns are not serious. I'll take a  
3 note and pass it to your team in the morning"  
4 or "Let me put you through to the person who's  
5 got the duty for your team tonight and let  
6 them talk to you. And they can either advise  
7 you to come into the emergency room and/or  
8 they'll be able to see you tomorrow and know  
9 everything that's going on about you," which  
10 is how patients who have good coverage and  
11 good practices in the suburban and outside  
12 system get care.

13 So, those are all the things about  
14 it, and it's working. Patient satisfaction is  
15 going up. Patient cost is going down.  
16 Preventative medication and preventative  
17 health is going up. And the trick is to hire  
18 a stable critical mass workflow, including  
19 case managers, that can be embedded there.

20 One last sea story. The Marines  
21 went into this kicking and screaming. The  
22 Marines are wedded to the -- no offense, but,

1 you know, God love the Marines -- they are  
2 wedded to their Battalion Aid Stations with  
3 their mount-out boxes, their curtains. If the  
4 Lord wanted us to have running water in our  
5 clinics, we would have been born that way.

6 And we said, "Can you just try  
7 medical home?"

8 And they said, "Well, that  
9 involves us giving the care over to the  
10 military treatment facility vis our own  
11 Battalion Aid Station with our own battalion  
12 doctor."

13 "That's correct. But we think we  
14 can take better care of your Marines."

15 And the Marines, who have  
16 tremendous unit integrity, didn't want to do  
17 that. Now, a year into it, they would do  
18 nothing else. All they want is the medical  
19 home concept. Because Marines who before you  
20 would give the consult to and you would say,  
21 "Go see the dermatologist," and the Marine  
22 would say, "Yes, sir, this Marine will go see

1 the dermatologist." And a year later, you  
2 would go, "How did that go for you?" "How did  
3 what go for me, sir?"

4 So, now the case manager  
5 facilitates that Marine getting into the  
6 dermatologist and calls the gunnery sergeant  
7 and says, "Your Marine never made the  
8 appointment." Better care. Better health.  
9 Better readiness.

10 So, I just wanted to give you an  
11 overview of why we're adopting across the  
12 military medical home. And I would like to  
13 say we thought of it, but it really started  
14 with Geisinger and Intermountain Health and  
15 some other premiere marquis managed care  
16 systems. But we're doing it well.

17 And the last thing is that it  
18 requires -- and here's the good news -- we  
19 don't have a great one, but we have a decent  
20 one, an electronic medical record, that four-  
21 letter word or that five-letter word, AHLTA.  
22 But at least it supports a medical home.

1                   MEMBER PHILLIPS: Just a  
2                   supportive comment. We do learn. As you  
3                   mentioned, back in the eighties, Kaiser did a  
4                   huge study where they told their subscribers,  
5                   "If you think you have an emergency, just call  
6                   this 1-800 number, and they're able to speak  
7                   to a healthcare provider."

8                   Of the 100 percent of the people  
9                   that thought they had a real emergency, about  
10                  70 percent didn't have an emergency at all.  
11                  They were just given an appointment. About 10  
12                  or 15 percent had an urgent problem that could  
13                  be delayed for 24-48 hours. And less than 15  
14                  percent had a true emergency.

15                  So, it saved anguish, time, money,  
16                  and effort. So, this is a great step forward.

17                  MS. QUISENBERRY: That is correct.  
18                  That is correct. And we speak with our Kaiser  
19                  folks, especially I speak with the  
20                  representative for their Care Management  
21                  Institute. I want to get an idea because  
22                  that's exactly what they implemented to

1 address that type of episodic or to reduce  
2 that episodic care and maintain the continuity  
3 within their primary teams.

4 And it has worked very well for  
5 them, as opposed to the HMO model that we all  
6 heard some years ago, that you go to that  
7 provider or you have the costs associated with  
8 not going to that provider. We have all grown  
9 and realized the care management approach that  
10 they adopted in Kaiser, that we adopt in our  
11 Patient-Centered Medical Homes, and where it  
12 is a holistic type of need.

13 I think what would have helped is  
14 if I had identified at the outset for our Tri-  
15 Service Workflow AIM Form that it is for all  
16 of our beneficiaries, with our wounded  
17 warriors who come into those care management  
18 teams benefitting from that.

19 MEMBER PHILLIPS: And they had one  
20 piece of advanced technology. It was called  
21 a dial-up telephone.

22 (Laughter.)

1 MS. QUISENBERRY: Yes.

2 DIRECTOR DAILEY: So, we are  
3 intrigued by this standardization of case  
4 management, primary elements, tracking data.  
5 Can you get us a copy of what's going to be in  
6 this bullet, the new Case Management Tri-  
7 Service Workflow? Is there --

8 MS. QUISENBERRY: We should. That  
9 is going through the piloting right now.

10 DIRECTOR DAILEY: Correct.

11 MS. QUISENBERRY: So, it is  
12 morphing and changing because we want our  
13 members to be able to use that. You know,  
14 they have a core form that addresses what was  
15 just discussed, all the elements, outside case  
16 management. And we can get that to you. But,  
17 knowing that it can still be changing --

18 DIRECTOR DAILEY: Yes.

19 MS. QUISENBERRY: -- I think is an  
20 important point to make, as our case managers  
21 are using it.

22 DIRECTOR DAILEY: Agreed. Agreed.

1                   Can you get us a copy of what is  
2 being piloted?

3                   MS. QUISENBERRY: Uh-hum.

4                   DIRECTOR DAILEY: Okay. That  
5 would be great. Thank you.

6                   MS. QUISENBERRY: The next one,  
7 we're looking at the application or the impact  
8 of our medical care case managers with the  
9 implementation of the Medical Management DODI.  
10 We are going back to and identifying and  
11 recognizing the importance of our skill set  
12 development, and in doing so, moving from the  
13 current type of training that we have  
14 available to including now both our clinical  
15 and non-clinical sets as well as our VA  
16 partners.

17                   And I would like to thank Ms.  
18 Malebranche and her team. As a matter of  
19 fact, they have been working with us and  
20 provided us a really wonderful updated VA care  
21 set that we are working right now to finalize  
22 and get put out there.

1                   So, recognizing the skill set  
2                   development, the ongoing changes and benefits  
3                   that we all have through our Title 10  
4                   entitlements, the ongoing changes with the VA,  
5                   the Affordable Care Act where a lot of  
6                   questions come in and how does that impact, we  
7                   are trying to make sure that, as we look at  
8                   our education and training and our skill set  
9                   development of our case managers, that this is  
10                  moving as all the other elements around that  
11                  are moving with them.

12                  Also, what has been identified  
13                  with the skill set development is working with  
14                  our service partners in making sure we have a  
15                  concerted effort for a quarterly training  
16                  emphasis, taking the model known by Patricia  
17                  Benner of our novice-to-expert approach, where  
18                  we have our novice case managers that are  
19                  moving into this to our more advanced. How do  
20                  we identify those?

21                  We have the training available.  
22                  We are working with what we just talked about.

1 But how are we making sure that we are  
2 capturing and getting feedback from our case  
3 managers and our non-clinical case managers in  
4 their understanding of it and catching those  
5 new members and making sure that they're able  
6 to access it, get it, if they have any  
7 questions.

8           Because we have new members that  
9 move into it that might not know what a case  
10 management concept is or how to apply that.  
11 So, what we have done is our Services have  
12 identified we're going to do a quarterly  
13 training emphasis where we take our Department  
14 of Defense required training and just look at  
15 a few at a time over quarters where our  
16 Services have identified they will work  
17 specifically with their case managers, making  
18 sure that they are going to be able to access,  
19 get the training. Is there anything missing?  
20 Constant feedback allows us to continually  
21 update our courses, enhancing our skill set  
22 development of those case managers.

1                   And finally, recognizing the  
2                   impact with our interagency transitions.  
3                   Previous Department of Defense Instruction, we  
4                   worked with our Service members; we worked  
5                   within the Department of Defense. That is how  
6                   we developed that.

7                   Currently, recognizing the need  
8                   for the interagency and how we reach out to  
9                   our partners, we have included in our  
10                  Department of Defense Instruction the elements  
11                  of those VA care management teams, invited  
12                  them to the table. And they were able to help  
13                  develop that Department of Defense  
14                  Instruction, and we have the ongoing impact of  
15                  their input at our meetings where they are  
16                  invited to the table with our TRICARE Regional  
17                  Office partners, our Service partners, and our  
18                  VA partners. That is in place. It is an  
19                  ongoing feedback loop, as one impact for us to  
20                  continually involve, learn, and identify and  
21                  act on barriers as quickly as possible.

22                  Caseloads, there has not been any

1 change to designate a certain caseload for  
2 case manager because, again, as we have  
3 discussed, those remain dynamic, in line with  
4 national standards that we have, going back,  
5 again, to the guiding standard of a case  
6 manager for our CMSA, our Case Management  
7 Society of America, who, again, worked with  
8 the Social Workers' National Program Office in  
9 recognizing there has been no determined  
10 caseload per case manager. So, those remain  
11 dynamic, allow the Services to identify with  
12 whom they have, applying their case management  
13 as to the caseload per case manager, but  
14 nothing in that DODI is identified as one  
15 number.

16 Next is the identification that we  
17 have talked a little bit about with our  
18 Interagency Complex Care Coordination  
19 Partners. My office has had the opportunity  
20 to work in support with two of those Work  
21 Groups, one being the Policy and Oversight, in  
22 mainly a supportive role to help make sure

1 that's getting through concurrence and to be  
2 able to supply any information needed to our  
3 HA leadership.

4 This Policy and Oversight is being  
5 put in place as an overarching guide for our  
6 DoD and VA partners as we move toward one  
7 model of a care coordination type of concept.

8 The Community of Practice Work  
9 Group, where we have had the opportunity to be  
10 a little more involved and engaged, because it  
11 is really more with the application of the  
12 benefits and how we are engaging in the care  
13 coordination process, where we have taken part  
14 in identifying the support, working again --  
15 we have been asked if we would be able to  
16 identify some type of web-based interagency  
17 type of training support.

18 We're trying to identify how we do  
19 that, especially in a very cost-constrained  
20 environment, when you're asking one department  
21 to be able to supply that training platform  
22 for both agencies. So, we're working on that.

1                   Our VA partners at the national  
2 level are looking at possibly how they can  
3 support that through educational units that  
4 case managers and our social workers on both  
5 sides need for our individual licensure.

6                   One thing that I have been asked,  
7 and as I was working with the development of  
8 these slides with our partners, is, also, this  
9 is working towards the Lead Coordinator  
10 concept role development within these Work  
11 Groups. And one thing, if nobody has  
12 mentioned it before, I really want to focus on  
13 the fact that this Lead Coordinator is not a  
14 new position. This is not a new FTE that is  
15 being added, but using the FTEs or the case  
16 managers that are in place and identifying a  
17 lead representative and how that will be  
18 developed and identified and understood  
19 between both DoD and VA.

20                   Questions?

21                   (No response.)

22                   So, again, right now, we have this

1 MOU, our Memorandum of Understanding, that is  
2 moving through right now for this overarching  
3 guidance through our formal concurrence  
4 process that will go through all the Services  
5 and the VA. As we receive that input, this  
6 group, Policy and Oversight Group, will  
7 address and modify and change, similar like we  
8 did with our Department of Defense  
9 Instruction.

10 And again, the elements that we're  
11 looking at for this comprehensive plan is to  
12 continue to identify the role of this Lead  
13 Coordinator, the role of the care coordination  
14 process, and how this is going to work between  
15 both agencies to make sure that we're applying  
16 similar concepts through policy development,  
17 through rollout of the care coordination  
18 across the agencies, a guiding principle, so  
19 to speak, where we can come together.

20 And finally, we had the  
21 opportunity -- as you all are aware, trying to  
22 start a survey is costly in and of itself --

1 so, we had the opportunity when I was here  
2 before to identify that we were able to add  
3 questions into our existing Wounded, Ill, and  
4 Injured Survey. That survey, again, because  
5 of budget concerns and constraints, was  
6 finalized in the third quarter of 2013.

7 We took a look at that, and we  
8 proactively identified the questions that were  
9 within that survey and identified that within  
10 the Lead Coordinator concept, and how they're  
11 working and identifying the feedback from  
12 their Service members, there were similar  
13 questions that were identified. So, we are  
14 able to utilize or transition in working with  
15 that lead coordinator group to get the  
16 feedback from those questions, so we have  
17 ongoing feedback as to how we are doing.

18 Results of the ended Wounded, Ill,  
19 and Injured Survey, though, I'm glad to report  
20 we are showing that we have an 80-percent  
21 satisfaction rate, or approximately eight out  
22 of every ten individuals were satisfied. We

1 are getting good feedback, which aligned well  
2 with the last publication of the Recovering  
3 Warrior Task Force Annual Report, where we saw  
4 the positive feedback coming back with case  
5 management.

6 Two areas that we have found are  
7 the continued need for the support of guiding  
8 an individual through the care management  
9 process or the systems, obtaining medical  
10 care, both in the DoD and VA. Also, this will  
11 be, going back to that patient-centered  
12 concept, having those case managers right  
13 there. Perhaps we will be able to identify  
14 that a little earlier on and be able to be  
15 proactive in that management.

16 The other is wanting to make sure,  
17 again, that skill set development, making sure  
18 our case managers are aware of the evolving  
19 and changing benefits or any changes with case  
20 management approaches within the DoD or VA are  
21 understood, that we will be able to address  
22 through this ongoing training and education

1 with our clinical and non-clinical partners.

2 DIRECTOR DAILEY: So, this was  
3 going to be the only report you got out of the  
4 telephone survey? Because we talked to Dr.  
5 Bannick; the survey has been discontinued.

6 MS. QUISENBERRY: It has.

7 DIRECTOR DAILEY: Okay.

8 MS. QUISENBERRY: And so, what we  
9 wanted to do is make sure, to have a  
10 trendline, we want to make sure we have at  
11 least three quarters to report, to be able to  
12 report something stabilized out. And so, what  
13 he was able to provide us was those results.

14 DIRECTOR DAILEY: Okay. So, he  
15 actually went back before you implemented the  
16 new directive and took all the data from  
17 previous data that he had gathered and gave  
18 you these results?

19 MS. QUISENBERRY: Yes.

20 DIRECTOR DAILEY: Okay. So, the  
21 ability to really assess the impact of your  
22 DODI will not be evaluated by this survey

1 material?

2 MS. QUISENBERRY: No,  
3 unfortunately.

4 DIRECTOR DAILEY: But the case  
5 management that existed during the survey  
6 period --

7 MS. QUISENBERRY: Yes.

8 DIRECTOR DAILEY: -- got a pretty  
9 high rating, basically?

10 MS. QUISENBERRY: Yes.

11 DIRECTOR DAILEY: Yes. I mean,  
12 again, like you noted, case management are the  
13 heroes. Nurse case managers are many times  
14 the heroes.

15 Did you do any other parsing or  
16 did you ask him to do any other parsing of  
17 this case management survey data by Service,  
18 age group, rank? Did he parse it out in any  
19 other way?

20 MS. QUISENBERRY: We would have to  
21 go back. I don't know if he was able to do  
22 that. We only had five questions. We were

1 embedded in a larger -- because starting a  
2 survey --

3 DIRECTOR DAILEY: Yes.

4 MS. QUISENBERRY: -- as you know,  
5 you have to go through WHS and it is costly.

6 DIRECTOR DAILEY: Yes. No.

7 MS. QUISENBERRY: So, we  
8 embedded --

9 DIRECTOR DAILEY: It was very  
10 creative. I'm a real firm believer, actually,  
11 in this survey over that of the Services. So,  
12 I was disappointed when they eliminated it.

13 MS. QUISENBERRY: Yes.

14 DIRECTOR DAILEY: I was intrigued  
15 when you were going to use it as a way to  
16 measure the effectiveness and get feedback  
17 from your customers. So, that is why we  
18 wanted you to talk to us about that.

19 MS. QUISENBERRY: Yes.

20 DIRECTOR DAILEY: So, just a  
21 thought to help parse out where your customer  
22 and your service base satisfaction and

1       dissatisfaction might be would be, if he still  
2       has the data, which he does, and he can still  
3       analyze it, to ask him to go back and look at  
4       it by maybe age group --

5                   MS. QUISENBERRY:   Okay.

6                   DIRECTOR DAILEY:   -- rank,  
7       Service.  And then, you will be able to  
8       customize or look at what does a young E3  
9       need --

10                  MS. QUISENBERRY:   Right.

11                  DIRECTOR DAILEY:   -- in areas of  
12       case management.  You know, who was or is  
13       delivering services?  So, you get my point.

14                  MS. QUISENBERRY:   Right.

15                  DIRECTOR DAILEY:   Yes, if the data  
16       is there, sometimes you get very small sample  
17       sizes which might not be helpful to you, but  
18       if he has got three quarters, he might have a  
19       large enough sample size to help you identify  
20       groups and segments that could use tweaking.

21                  MS. QUISENBERRY:   And we could  
22       certainly bring it into the efforts with the

1 IC3 and say, you know, "This is what we were  
2 able to find to that granularity."

3 DIRECTOR DAILEY: Yes.

4 MEMBER EUDY: Ma'am, regarding the  
5 Tri-Service Workflow, how is the non-medical  
6 information going to be populated, then, into  
7 AHLTA? Is that going to be placed in by those  
8 non-medical care managers? Is it  
9 automatically pulled from those other systems  
10 to make sure that -- because a lot of the  
11 nurse case managers are already heavily tasked  
12 on a lot of non-medical systems already that  
13 they have to evaluate. So, how does the data  
14 get in there?

15 MS. QUISENBERRY: The case manager  
16 will be populating it. There are questions  
17 such as, you know, "What is your family  
18 support system?" If you have a job, we want  
19 to know how active you are, if you have some  
20 type of injury where that will impact your job  
21 and being able to do it.

22 I don't think they're pulling from

1 any of the systems. It's more of the care  
2 plan filled out by the case manager that  
3 you'll be able to see when we provide those  
4 elements.

5 CO-CHAIR NATHAN: You have some  
6 clinics, like at Walter Reed-Bethesda, and I  
7 don't know where else, that are primary care  
8 dedicated, organic Wounded Warrior primary  
9 care clinics, where the Wounded Warriors get  
10 their care specifically in a separate silo of  
11 a primary care Wounded Warrior clinic. Are  
12 those canvassed as well, those clinics?

13 MS. QUISENBERRY: We had the WTUs,  
14 for example. Those Warrior Transition Unit  
15 case managers were part of this development  
16 with the elements within that AIM form.

17 Ms. Lovelace had the -- we set up  
18 a Work Group and tried to include.

19 I am correct in stating that,  
20 right?

21 MS. LOVELACE: That is correct.  
22 The Wounded Warrior case managers will be

1 using the same form. We wanted to make sure  
2 it was standardized across all case  
3 management. So, all case managers in the  
4 direct-care system that are touching a patient  
5 will use this form to do their documentation.

6 MEMBER MALEBRANCHE: I know this  
7 survey is over, but do you have any feedback  
8 from the Lead Coordinator Pilot? Was there  
9 any information back from that, just  
10 preliminary? I mean, because this group is  
11 looking at Wounded Warriors. Was there  
12 anything in that pilot that was exceptionally  
13 good or exceptionally bad? Did you have any  
14 preliminary from that?

15 MS. QUISENBERRY: I do not.  
16 Because I know that they have had the two  
17 pilot sites roll out. So, we can go back and  
18 ask how the first one went, because I think  
19 they were still in the development of all  
20 those tools.

21 It might just be that point in  
22 time in that as well. So, consider that with

1 the data. But I know they're rolling out to  
2 the second.

3 MEMBER MALEBRANCHE: And the other  
4 piece is VA has their own model, if you will,  
5 of medical home, which is the Patient-Aligned  
6 Care Teams. Is there any or has there been  
7 any, when you have been doing this, any work  
8 with that group that does the Patient-Aligned  
9 Care Teams? I don't think as far advanced as  
10 this one is; it's still rolling out. But when  
11 a Service member transitions to the VA, do  
12 they transition from one home to another?

13 MS. QUISENBERRY: I don't know if  
14 they would transition to the home, because I  
15 think they have to go through those OEF/OIF  
16 teams for identification and, then, subsequent  
17 assignment. I don't know if the VA, based on  
18 their category ratings, you know, the 1, 2, 3,  
19 4 --

20 MEMBER MALEBRANCHE: Uh-hum.

21 MS. QUISENBERRY: -- I don't know  
22 if they're identified from that category

1 rating and, then, enrolled that way, in a  
2 similar fashion as we do regionally or within  
3 our MTFs, where you are put right in the home  
4 based on your eligibility in DEERS.

5 I think we would have to look at  
6 the category states of the VA versus the --

7 MEMBER MALEBRANCHE: I know the  
8 groupings are different, I mean --

9 MS. QUISENBERRY: Right.

10 MEMBER MALEBRANCHE: -- because we  
11 don't do the entire family.

12 MS. QUISENBERRY: Right.

13 MEMBER MALEBRANCHE: But just  
14 something to consider in the future --

15 MS. QUISENBERRY: Right.

16 MEMBER MALEBRANCHE: -- as you're  
17 looking, because it would seem to make sense  
18 to go from one group to another, if you will,  
19 as a pod that handles that type of care. Just  
20 thoughts.

21 Thank you.

22 CO-CHAIR CROCKETT-JONES: Thank

1       you, Ms. Quisenberry.

2                       MS. QUISENBERRY:    Sure.

3                       CO-CHAIR CROCKETT-JONES:   Okay.

4       Thank you, Ms. Lovelace.

5                       We will take a brief break and be  
6       back in 15 minutes.

7                       (Whereupon, the foregoing matter  
8       went off the record at 9:53 a.m. and went back  
9       on the record at 10:14 a.m.)

10                      CO-CHAIR CROCKETT-JONES:   Okay.

11       We are now going to hear from Mr. Richard  
12       Willis, the Director of the Technical Training  
13       Academy. Mr. Willis will provide an overview  
14       of the Training Academy and provide data  
15       describing the Academy's contribution to  
16       Wounded Warrior transition. Information can  
17       be found under tab J.

18                      And I'm going to turn it over to  
19       you. Thank you.

20                      MR. WILLIS: Thank you. Thank you  
21       very much.

22                      On behalf of the Wounded Warrior

1 Project, I want to thank you very much for  
2 allowing us to come in and talk to you about  
3 the Transition Training Academy.

4 Before we get started, though, I  
5 know that you're familiar with the Wounded  
6 Warrior Project to varying degrees, but I want  
7 to restate our mission and bold vision for  
8 this generation of Wounded Warriors. Our  
9 mission is to honor and empower Wounded  
10 Warriors, and our vision is to foster the most  
11 successful, well-adjusted generation of  
12 wounded Service members in our nation's  
13 history.

14 Now a little bit of history about  
15 the Transition Training Academy. Back in  
16 2007, Cisco went to the Labor Department with  
17 an idea to provide IT familiarity training to  
18 warriors at Walter Reed Army Medical Center.  
19 This was during the time that the headlines  
20 were filled with bad stories about warriors  
21 who were sitting around doing nothing and  
22 getting in trouble while recuperating.

1                   The Labor Department suggested  
2                   that a nonprofit organization would be more  
3                   appropriate to run this program. So, WWP  
4                   gladly accepted that role.

5                   From there, a very basic  
6                   familiarity program was created which  
7                   consisted of a six-week PowerPoint  
8                   presentation and warriors receiving a laptop  
9                   computer upon completion. Under the original  
10                  Cisco plan, warriors were getting minimal  
11                  exposure, and many of them were trying to sell  
12                  those computers on eBay. The troubling part  
13                  of this was that we were not empowering these  
14                  participants with marketable skills with this  
15                  model.

16                  Our vision was to create  
17                  coursework which would allow students to  
18                  achieve industry-recognized certifications,  
19                  which would then allow them to be competitive  
20                  in the IT field of employment. As a result,  
21                  we created the current model we use today.

22                  The Wounded Warrior Project, the

1 Transition Training Academy provides  
2 innovative information technology training for  
3 warriors, Service members, and veterans and  
4 their spouses or caregivers. All TTA courses,  
5 class material, and exam vouchers are provided  
6 free of charge to the warriors.

7 Let me tell you a little bit about  
8 the courses that we offer now. We offer four  
9 courses. The first of those courses is called  
10 the Introduction to Computer Technology. This  
11 is an introductory course. It covers  
12 computers and society, hardware, software,  
13 computer productivity, networking, the  
14 internet, mobile computing, and security.  
15 This course is designed to give students the  
16 opportunity to look into the IT field to  
17 decide if it is something that they're a right  
18 fit for. It also gives our instructors the  
19 opportunity to see if the student is the right  
20 fit for the IT field.

21 The next course that you see there  
22 is our Introduction to Computer Repair course,

1 and that's our A+ certification course. This  
2 course is an active-learning, hands-on course  
3 that prepares students to build, install,  
4 maintain, and repair computers in small office  
5 and home office and corporate environments.  
6 Students learn the basics of computer  
7 networking design and installation, and the  
8 courses also introduce computer security  
9 measures through course material and  
10 activities that will help them learn to  
11 protect computers against internet attacks.

12           What we found was that a lot of  
13 students knew how to get on the internet.  
14 They could surf the web a little bit. They  
15 could send an email. They could get on  
16 Facebook. But they didn't know that they were  
17 supposed to have security protocols set up on  
18 their computers. They were getting viruses  
19 and things like that. So, we created these  
20 courses to help them out with that.

21           The ICR course is mapped to the  
22 CompTIA A+ objectives. CompTIA, for those of

1 you that don't know, is a well-known, highly-  
2 regarded, nonprofit organization and a  
3 provider of professional certifications in the  
4 IT industry. TTA students who demonstrate  
5 they are ready to pass the A+ exams are  
6 provided free vouchers for the exams. Those  
7 exams are the 801 CompTIA A+ Essentials Exam  
8 and the CompTIA A+ Practical Application.  
9 They do have to pass both of those exams to  
10 become A+-certified.

11           Employers consider the A+  
12 certification an important industry standard  
13 for all entry-level computer technicians that  
14 could lead to the following professions: help  
15 desk technicians, support technicians, bench  
16 technicians, technical sales consultants, and  
17 network installers.

18           Which brings me to the next  
19 course, which is computer networking or the  
20 Net+ Exam. This course is designed for  
21 students who want to further their IT careers  
22 by acquiring foundational knowledge in

1 computer networking. The ICN prepares  
2 students for CompTIA's Network+ certification.  
3 Students will describe terms and technologies  
4 associated with the network media topologies,  
5 protocols, and standards. Students will  
6 demonstrate their ability to design, install,  
7 and support, troubleshoot local area and wide  
8 area networks.

9 The next course, then, that we  
10 offer is the Computer Security course. And  
11 that course is designed for students who want  
12 to further their careers by acquiring  
13 foundational knowledge in computer security.  
14 The ICS course prepares students for the  
15 CompTIA Security+ certification.

16 Now if one of our students is  
17 looking for a job in the GS realm, they have  
18 to have at a minimum the A+ certification.  
19 When they put their applications in, if they  
20 can't show that they have the A+ and they  
21 don't have that certificate, they're not even  
22 going to be considered. The other two are

1 wonderful to jump on top of the first one,  
2 which is the A+, but they must have at a  
3 minimum the A+ certification.

4 Do we have any questions so far on  
5 the certifications?

6 (No response.)

7 All right. The next slide that we  
8 have here is our locations. I know there are  
9 some questions going to come up on this one.  
10 So, we'll talk about this one a little bit.

11 You'll see these are our current  
12 locations. Down at the bottom of the slide,  
13 I have the "coming soon" locations. And  
14 you'll see that those "coming soon" and  
15 several of those locations up on the top are  
16 Regional Offices within WWP. The reason for  
17 this is we just got the memo down that several  
18 of the WTUs are going to start closing. So,  
19 we had to create a model so that we could  
20 continue this wonderful work and help these  
21 warriors get their certifications that they  
22 need.

1                   So, what we decided to do was  
2                   start moving some into our Regional Offices.  
3                   So, we're hiring instructors for those  
4                   Regional Offices to continue the work and  
5                   teach the classes right out of those Regional  
6                   Offices.

7                   San Diego Regional Office, we were  
8                   teaching at Balboa. On most of the  
9                   installations, classrooms are not a commodity  
10                  that is very plentiful. So, we lost our  
11                  classroom at Balboa. We had to move into our  
12                  San Diego Regional Office. That was actually  
13                  the very first office that we started teaching  
14                  the classes out of, and we decided this is  
15                  probably something that we really need to do.  
16                  So, we started moving some of them in there.

17                  At most of the locations, we have  
18                  talked to the command; we have talked to  
19                  garrison; we've talked to transition  
20                  coordinators, educational departments, and we  
21                  have signed MOUs with those locations.

22                  Also, there is a new form that we

1 just got. That is called the Private  
2 Organization Operation Request Form. It is a  
3 form that has to be filled out for private  
4 organizations that are not part of the DoD to  
5 be able to teach on base or on post. We have  
6 our Legal Department fill out all the blanks  
7 on that. We send it back over to the base  
8 legal department. They'll send it back if  
9 they need anything else. Otherwise, they'll  
10 approve it, and that's how we get our  
11 permissions to teach on locations.

12 We use this for Hunter. We use  
13 this for Ft. Stewart, a couple of other  
14 locations. Our benefits team actually used it  
15 up at Ft. Belvoir and a couple of places up  
16 here in the D.C. area to get permission to go  
17 on post and on base.

18 CO-CHAIR CROCKETT-JONES: In the  
19 places where you're moving to Regional  
20 Offices, how far are they from military  
21 facilities, and what how things like  
22 transportation for folks who need to get to

1       you?

2                       MR. WILLIS:  Let me address that  
3       last part first.  In most cases, the warriors  
4       are ambulatory and they're able to travel on  
5       their own by the time we get them.  Every once  
6       in a while in the ICT course we will have some  
7       that are just coming out of, they are  
8       transitioning to where they can actually start  
9       traveling a little bit and going on their own.  
10      So, we are made part of their appointment  
11      process for the week to attend our classes.

12                      After that, we put our office  
13      locations in highly-populated areas where  
14      warriors have retired and they're staying.  
15      So, that is where we put our WWP offices.

16                      If they need transportation, in  
17      most cases we can get them transportation.  
18      Most of the time, they can already just come  
19      themselves to get to the offices.  A lot of  
20      them are around highly-populated areas or  
21      WTUs, but it just means that there's a large  
22      population of Wounded Warriors in that area,

1 and that's why we put the Regional Offices  
2 there. Okay?

3 So, you can take a look at some of  
4 those. We're always willing to expand to  
5 other areas, but we have had pretty good  
6 success so far with those areas.

7 MEMBER DRACH: Richard, how many  
8 of your warriors pass the A, the A1, or  
9 whatever? How many have successfully passed  
10 it?

11 MR. WILLIS: Give me a couple of  
12 slides and I'll answer that question for you.  
13 We're almost there.

14 All right. So, the next slide  
15 here. As of 2013, over 2500 Wounded Warriors,  
16 active-duty Service members, wounded veterans,  
17 spouses, caregivers have completed the TTA  
18 program.

19 Classes are taught in an  
20 instructor-led setting, complemented by web-  
21 based exercises, online learning, and peer  
22 mentoring. One of the big things that we do,

1 we have an online learning environment. So,  
2 they are getting instructor-led. They also  
3 have components on the computer that they have  
4 to complete. There is a forum that they have  
5 to be a part of, as they are going through the  
6 class. So, there's a lot of peer mentoring.

7 And the really neat thing about  
8 our classes is that people that have already  
9 graduated from the TTA courses in different  
10 locations are coming back in the classroom as  
11 peer support for those warriors that are just  
12 starting out their training. And I think  
13 that's one of the big parts that makes us so  
14 successful.

15 Another big part that makes us  
16 very successful in what we do is that all of  
17 my instructors came out of my classrooms.  
18 They're all Wounded Warriors or spouses of  
19 Wounded Warriors, and they are just a perfect  
20 fit for this crowd, perfect.

21 You can't tell them something that  
22 they haven't heard or they haven't lived

1 already. So, that's what makes them such a  
2 great fit for it. We have trained them to be  
3 the instructors that we want them to be.

4           And the next part here, the  
5 materials developed with those are living with  
6 Post Traumatic Stress, what does that mean?  
7 We found that warriors who have Post Traumatic  
8 Stress/traumatic brain injuries learn better  
9 by touching, feeling, and doing. So, we  
10 created our courses with that in mind.

11           Our A+ course, the students  
12 actually build a computer in the classroom  
13 that they get to keep at the end of the class.  
14 That's all free to them. We have warriors in  
15 there that have traumatic brain injuries. We  
16 have warriors that are missing limbs,  
17 different catastrophic injuries. They will  
18 want to build those computers themselves, and  
19 they do not want any help. So, they're  
20 turning the screwdrivers and doing everything  
21 themselves. That part of the course helps  
22 them to remember and be able to retain and,

1 then, recall that material when they need to  
2 for those examinations.

3 Like I said, they get to keep that  
4 computer at the end of that course. Another  
5 neat thing that the Wounded Warrior Project  
6 does, when our computers, our own personal  
7 computers from the Wounded Warrior Project,  
8 break, they send them to me and I put them in  
9 the classrooms with those students that are  
10 going through the A+ course. I ask them to  
11 troubleshoot computers.

12 Now you all know, you are sitting  
13 at your desk and something goes wrong with  
14 your computer. You can call the help desk and  
15 they will walk you through: what happened?  
16 Were you doing this? Did you put this on  
17 there? What happened here?

18 Well, when they're fixing a  
19 computer, they don't have that opportunity.  
20 They don't have anybody to ask questions. So,  
21 they have to troubleshoot that all by  
22 themselves.

1                   What we ask them to do,  
2                   troubleshoot the computer, see if they can be  
3                   fixed. We will, then, buy them the parts that  
4                   need to go in those computers to fix them.  
5                   Once they're fixed, we catalog them. A  
6                   Warriors to Work member will call us and say,  
7                   "Hey, I've got a warrior that needs a computer  
8                   for this job," or somebody going back to  
9                   school. Then, we'll send a computer to that  
10                  warrior who doesn't have the funds to buy  
11                  their own computer. So, that is another kind  
12                  of a neat thing that we do in the TTA class  
13                  for our students.

14                         In 2011, we began using a  
15                         consolidated record of maintenance system  
16                         called Salesforce. This system allowed us to  
17                         track students, their progress through the TTA  
18                         program. With this program, we can run  
19                         reports, which helps us to align our students  
20                         with potential employers and keep track of  
21                         their certifications.

22                                 So, when they get a certification,

1 they send us the paper back in a PDF. We,  
2 then, install it into our Salesforce, and we  
3 have that certification and we know how long  
4 it's valid for. So, they are valid fore three  
5 years now. So, we keep those in our system.

6 That way, we can always go back to  
7 that warrior and say, "Hey, you're coming up.  
8 You need to renew yours." Or we have this  
9 employer that says, "Hey, I'd like 10 warriors  
10 to help me on this contract," or whatever it  
11 is. We can go in and we can run a report and  
12 find out who has those certifications they're  
13 looking for to better track where their  
14 certifications are and help us to align them  
15 with different jobs.

16 Now, since 2011, over 2500  
17 warriors, caregivers, spouses have attended  
18 and successfully completed the classes. Up to  
19 FY14, we had 2622. I didn't bring any numbers  
20 prior to that because we didn't have our  
21 Salesforce system up and running. So,  
22 everything here, we know for a fact that's how

1 many students we had.

2 We served 22,185 warriors, active-  
3 duty Service members, and wounded veterans;  
4 437 spouses/caregivers went through our  
5 courses; 463 Transition Training Academy  
6 graduates have become CompTIA-certified in  
7 either A+, Net+, and Security+ so far. And  
8 that's the record that we have.

9 What we are doing right now is  
10 we're trying to contact prior to FY11 and  
11 we're trying to see who we can get to come  
12 back to us on the surveys to let us know they  
13 have the certifications, a difficult process.  
14 People move.

15 One of the neat things that we do  
16 in the Wounded Warrior Project is we have our  
17 outreach calls where every single staff member  
18 will have a list of alumni to call. We call  
19 them throughout the month, and we get updated  
20 information on their addresses, phone numbers,  
21 and we can ask questions like this to try to  
22 update our data.

1                   Two hundred and fifty-one  
2           Transition Training Academy graduates have  
3           been placed into employment by Warriors to  
4           Work teams since FY13. We have a Warriors to  
5           Work Specialist that works directly with the  
6           TTA students.

7                   One of the neat things that we do  
8           in our ICT class is, during that class, the  
9           Warriors to Work Specialist will actually  
10          attend the class via remote somehow and walk  
11          them through the process of creating their  
12          resume. So, they get their resumes created  
13          right in that very first class. That way,  
14          they're in the Warriors to Work system, and we  
15          can reach out to that person, if we need to,  
16          to help them find a position.

17                   Another neat thing, for those  
18          people that have gotten jobs, the average  
19          salary that we are seeing right now is  
20          \$38,000. And that is a pretty decent starting  
21          salary for these warriors.

22                   So, that concludes the briefing

1 that I have. What other questions do you have  
2 that I haven't answered so far?

3 MEMBER REHBEIN: Sir, I guess the  
4 thing that I am most interested in, I can  
5 envision other areas outside of the IT field  
6 where these kinds of services could be  
7 offered.

8 But what I guess I would like to  
9 know is, are there hurdles to get approved to  
10 come onto base to offer these services? What  
11 kind of hurdles are there, barriers? What can  
12 the Task Force to help remove some of those?  
13 How did you get this done the first time? How  
14 did you get the first approval.

15 MR. WILLIS: The very first  
16 approval that I did, I actually created a  
17 slide presentation like this. I got time on  
18 the WTU Commander's calendar. I went in and  
19 briefed him, the Sergeant Major, Squad  
20 Leaders, on the program, what we expected to  
21 accomplish out of the program, and was allowed  
22 to go in there and do that.

1                   The very first major location that  
2                   I went to with the brand-new program that we  
3                   run now was Ft. Bragg. One of the things that  
4                   we did there, we did it exactly that way. As  
5                   a matter of fact, they contacted us and asked  
6                   us if we come in and present this to see if it  
7                   was something they wanted to do.

8                   We went in; we actually ran,  
9                   instead of an eight-week session, we ran a  
10                  four-week session. So, it was compact a  
11                  little more. And the students actually didn't  
12                  like it. It was too fast. They had trouble  
13                  catching everything. They wanted us to slow  
14                  it down a little bit. So, we are using the  
15                  current model that we have now of eight weeks  
16                  for the ICT course.

17                  From there, the word got out to  
18                  those commanders during their little  
19                  briefings, and more locations wanted us to  
20                  come, to the point where they were asking us  
21                  to come to the WTU and present, so that we  
22                  could get on base.

1                   The difficult part for us is that  
2                   there is just no classroom space available.  
3                   The education centers don't have it. The  
4                   soldier family support centers don't have it.  
5                   The WTUs don't have it. There's just no  
6                   classroom space.

7                   And there are so many other  
8                   organizations working on post that you have  
9                   your space time, these two hours, these three  
10                  hours, and that's all you have. If we had  
11                  more space and we could offer this at more  
12                  locations, then we would probably do that.

13                  Does that answer your question?

14                  MEMBER REHBEIN: Do you find that,  
15                  as the leadership of a WTU changes, that you  
16                  have to resell your program?

17                  MR. WILLIS: No, that's not the  
18                  case at all. Most of the time, the exiting  
19                  Commander has already briefed the new  
20                  Commander, and we have pretty good success.  
21                  So, it hasn't been an issue at all.

22                  DIRECTOR DAILEY: For your four

1 core classes, Mr. Willis, do these core  
2 classes prepare them to take the test in these  
3 areas? Or is that kind of self-taught and  
4 your core classes are introductory, and it  
5 kind of gets them interested? And it kind of  
6 allows them to think if they want to move  
7 forward with serious preparation for these  
8 classes, for these tests?

9 MR. WILLIS: Well, the ICT course  
10 is actually the preparatory course. It gives  
11 them an opportunity to see if they want to go  
12 into IT.

13 DIRECTOR DAILEY: Okay. Which one  
14 is ICT, the introduction, the first one?

15 MR. WILLIS: Right, right, the  
16 first one. Now all of those courses say  
17 "Introduction to...."

18 DIRECTOR DAILEY: Yes, yes.

19 MR. WILLIS: And it may be a  
20 little deceiving. A+, the computer repair,  
21 the computer networking, and the security  
22 course, they all prepare those students for

1 the exam.

2 DIRECTOR DAILEY: Okay. Okay.

3 MR. WILLIS: We have lab  
4 simulators.

5 DIRECTOR DAILEY: Okay.

6 MR. WILLIS: We have test  
7 databanks. This is not an eight-hour-a-day  
8 job.

9 DIRECTOR DAILEY: Okay.

10 MR. WILLIS: I can guarantee you  
11 that. Our instructors are there all hours.  
12 They're always available. They will even go  
13 to a hospital bed, for Pete's sake, to make  
14 sure that the warriors are prepared.

15 DIRECTOR DAILEY: Okay. All  
16 right. Yes, the introductory terminology was  
17 not jibing with -- these are actual  
18 preparation. They should be able to walk out  
19 of the computer repair class A+, they should  
20 be able to walk out of Net+ and Security+ and  
21 take the test and get certification?

22 MR. WILLIS: Yes, absolutely.

1                   DIRECTOR DAILEY: Okay.

2                   MR. WILLIS: The reason we call  
3 them "Introduction to...." is because getting  
4 the A+, the Net+, and Security+ is an  
5 introduction to IT.

6                   DIRECTOR DAILEY: Right.

7                   MR. WILLIS: It's the very first  
8 thing that you have to have.

9                   DIRECTOR DAILEY: Okay.

10                  MR. WILLIS: There are a lot of  
11 other certifications, but this is the very  
12 first one that you need to go on a little bit  
13 further.

14                  DIRECTOR DAILEY: Okay. Any  
15 statistics? We didn't know what we didn't  
16 know when it comes to asking and asking you to  
17 present for us. Any idea what success rates  
18 they're having when they're taking these  
19 tests?

20                  MR. WILLIS: Yes. So far, we're  
21 well above the 85 percent that we set four  
22 ourselves.

1                   DIRECTOR DAILEY:   Okay.

2                   MR. WILLIS:   We have key  
3 performance indicators within the Wounded  
4 Warrior Project that we have to meet --

5                   DIRECTOR DAILEY:   Okay.

6                   MR. WILLIS:   -- that we have to  
7 show our Board of Directors.

8                   DIRECTOR DAILEY:   Okay.

9                   MR. WILLIS:   And we're well above  
10 that 85 percent.

11                   DIRECTOR DAILEY:   So, your goal  
12 is, if they're taking A+ and they test, that  
13 85 percent of the people will pass it?

14                   MR. WILLIS:   That's correct.

15                   DIRECTOR DAILEY:   And they will  
16 get that certification?

17                   MR. WILLIS:   That is correct.

18                   DIRECTOR DAILEY:   That helps you  
19 ensure your instruction techniques are  
20 working.

21                               And help us with, what are the  
22 barriers for Service members?   Help us

1 understand what could we do better to prepare  
2 them to be in these classes? How do you  
3 screen them? Or what type of screening  
4 process is there?

5 MR. WILLIS: The only screening  
6 process we do is the Introduction to Computer  
7 Technology course. We're not going to turn  
8 anybody away.

9 DIRECTOR DAILEY: Yes, I  
10 understand.

11 MR. WILLIS: One of the really  
12 neat things is, as I talk to students, they go  
13 into the very first course and they'll get a  
14 few weeks into it. And, you know, "Mr.  
15 Willis, I don't know if I can really do this.  
16 You know, I'm an infantry guy" or "I'm a  
17 diesel mechanic." And my thing is try it.

18 DIRECTOR DAILEY: Right, right.

19 MR. WILLIS: If you can't do it,  
20 we'll let you know.

21 DIRECTOR DAILEY: Right.

22 MR. WILLIS: If you can't do it,

1 you're going to figure it out. But at least  
2 try it.

3 DIRECTOR DAILEY: Right.

4 MR. WILLIS: This is not their  
5 area of expertise. Like I said, they know how  
6 to send an email. They can surf the internet.

7 DIRECTOR DAILEY: Right, right.

8 MR. WILLIS: But, as far as taking  
9 care of their own computers, not very good at  
10 that.

11 We don't want to turn anybody  
12 away, but at the end of the Computer  
13 Technology course, the very first course, if  
14 they really are not a good fit for this kind  
15 of an opportunity, an IT opportunity in jobs,  
16 we'll definitely let them know. I don't know  
17 of a case yet that we have done that.

18 DIRECTOR DAILEY: Right. And on  
19 this slide, your 251 transitioning have been  
20 placed in employment. So, what's your  
21 denominator? When you're talking to your  
22 Board saying, "We've placed 251 in

1 employment," what's your denominator? These  
2 are the ones who are actually interested?

3 And we hear this a lot. We talk  
4 to the WTUs and we say, "So, who's interested  
5 in being employed?" That becomes the  
6 denominator, right? "And then, how many have  
7 you been able to employ?" And that becomes  
8 the numerator, and we are able to kind of  
9 assess who's employable and what the success  
10 rate is.

11 MR. WILLIS: That's a really good  
12 question and, actually, a really hard to  
13 answer.

14 DIRECTOR DAILEY: Yes, yes.

15 MR. WILLIS: We don't seek them  
16 out to find out if they want jobs. More, they  
17 come to us. However, when a job description  
18 comes out through one of our Warriors to Work  
19 folks, they will send it my instructor team.  
20 And my instructor team, then, will set it out  
21 in the classroom.

22 This number is probably a little

1 bit deceiving. It is actually a very high  
2 number. These are people that have gotten A+,  
3 Net+, and Security+ certifications over the  
4 years.

5           The second thing, we don't know,  
6 and there's no way for us to track, how many  
7 people have actually changed from their  
8 current career field into an IT-related career  
9 field in the military. So, that's a success  
10 that we can't put a number on. We can't get  
11 that information from the Commanders,  
12 Transition Coordinators, or anybody else. If  
13 we had that number and we could get that  
14 statistic, I think you would see that number  
15 would rise a whole lot.

16           Another part of this number that  
17 you're not seeing is how many of these people  
18 have actually gone into school, have gone into  
19 college or a technical school, because of the  
20 training that we have given them. That is  
21 another one that is very hard for us to get a  
22 grasp on. We can do this through our surveys,

1 but it is very difficult for us to get that  
2 number.

3 MEMBER DRACH: Richard, also, this  
4 tracks only those that were placed by the  
5 Warrior to Work team?

6 MR. WILLIS: Correct.

7 MEMBER DRACH: So, if I go through  
8 the course and I go out and get a job on my  
9 own, that's not included in the 251 and you  
10 can't track them, either.

11 MR. WILLIS: Right. That is the  
12 last thing I was going to say. Absolutely.

13 DIRECTOR DAILEY: Okay. So, these  
14 251 actively worked with your employment team  
15 for employment?

16 MR. WILLIS: That is correct.

17 DIRECTOR DAILEY: And you were  
18 able to gather their entry salary and track  
19 them into that first job?

20 MR. WILLIS: That is correct.

21 DIRECTOR DAILEY: Okay. And so,  
22 not everyone who comes into the program, then,

1 seeks that service from you, that employment  
2 next-step service from you?

3 MR. WILLIS: That's true.

4 DIRECTOR DAILEY: So, we have  
5 about 10 percent, and I'm only bringing that  
6 up because I did the math real quick, who  
7 -- and it's an interesting number, if you  
8 place that in the numerator, 2622 in the  
9 numerator, that's about 10 percent. And now,  
10 all I'm doing is trying to assess, then, who  
11 in this workforce -- it kind of gives us a  
12 little benchmark about who has interest in IT  
13 and how successfully they can be placed.  
14 Because I think that 251 could also be both a  
15 numerator and a denominator, being 100 percent  
16 who are interested and pursued employment in  
17 IT were successfully placed.

18 MR. WILLIS: Uh-hum.

19 DIRECTOR DAILEY: But, out of the  
20 whole population, you really would basically  
21 have 10 percent who said took advantage of  
22 that opportunity?

1                   MR. WILLIS: Well, I think that  
2                   number is a little bit skewed in the fact that  
3                   a lot of these people don't get out of the  
4                   military, and we don't know that. So, you're  
5                   going to have drop that number down, the 2,000  
6                   down.

7                   We don't know who got jobs on  
8                   their own. We don't know who went to school.  
9                   All of those are successes. So, we can't  
10                  really use that as a 10 percent. I think that  
11                  we are probably looking at higher to 40  
12                  percent or a little higher than that, from the  
13                  people that we know.

14                 MEMBER REHBEIN: We've got a fair  
15                  number of Reserve component warriors whose  
16                  injuries/illnesses are not letting them go  
17                  back to their normal job, the job they had  
18                  before they were activated/deployed. I  
19                  understand that your training methods don't  
20                  allow you to do distance learning because you  
21                  want to do hands-on instruction. But, if they  
22                  can get to you, are they able to get into the

1 courses or is that something that has to be  
2 done through the active-duty WTU?

3 MR. WILLIS: Yes, you all are  
4 probably going to be really upset with me  
5 because I didn't put this as part of my  
6 briefing. But we actually just started an  
7 online learning environment this past year,  
8 and we have been very successful at it.

9 If you taken an online course, you  
10 know that they give you a week's worth, a  
11 module worth of material that you have to do.  
12 And you get that done. You talk on forums, do  
13 your assignment, turn it in. The instructor  
14 grades that assignment.

15 We do the same exact thing.  
16 However, all of our classes are still  
17 instructor-led. So, for three hours those  
18 students are online with the instructor and  
19 the other students. So, they are still  
20 getting that peer support that they get inside  
21 the classroom. So, we have modified our  
22 online learning. So, those folks that are in

1 their home and they want to take the course,  
2 they can do it now.

3 We rolled out our A+ course in  
4 March. We're doing ICT only right now. We  
5 wanted to make sure we worked out all the  
6 bugs. We did, and in March we start the very  
7 first ICR course.

8 We lab simulations and things like  
9 that. Instead of them actually having hands-  
10 on, they will do lab simulations during that  
11 class. But we are doing a class just like  
12 that.

13 We have had students from Hawaii,  
14 New Mexico, all over the place, Germany,  
15 taking these courses now online. And our  
16 success rate has not changed.

17 MEMBER REHBEIN: Most of those  
18 certification tests, then, are also a  
19 proctored test where you have to be at the  
20 test site.

21 MR. WILLIS: Yes, we don't  
22 administer --

1                   MEMBER REHBEIN: For those that  
2                   are doing the online learning, is there a way  
3                   for them to take the test without having to  
4                   travel long distances?

5                   MR. WILLIS: Yes. There are  
6                   testing facilities in all different cities,  
7                   and we don't administer any of those tests.  
8                   Every one of our students, we hand a voucher  
9                   to them and they go to an independent testing  
10                  facility and take that exam. So, the online  
11                  students will have the same opportunity as our  
12                  classroom students.

13                  DIRECTOR DAILEY: And I heard you  
14                  say you give them the voucher for these tests,  
15                  I mean, because they can be expensive, \$150,  
16                  \$250, to sit down and take --

17                  MR. WILLIS: Three hundred and  
18                  forty-five per test.

19                  DIRECTOR DAILEY: Holy cow. Okay.

20                  MR. WILLIS: And, yes, we do give  
21                  them all the vouchers.

22                  DIRECTOR DAILEY: Okay.

1                   MR. WILLIS: We actually have an  
2 agreement with CompTIA and they gave us a  
3 gift-in-kind of over 5,000 vouchers for our  
4 students. So, all we do is we submit their  
5 name and we send them a voucher number. They,  
6 then, take that voucher, call the testing  
7 facility, and set up their test.

8                   CO-CHAIR CROCKETT-JONES: Are you  
9 comparing yourselves to industry-offered  
10 courses, success rates, things like that? And  
11 how is that looking?

12                   MR. WILLIS: Yes, the standard  
13 rate that CompTIA gave us for A+ is about 75  
14 percent pass rate. For Net+ and Security+  
15 it's about 72 percent. And we are well above  
16 those at 85 percent and above.

17                   I think the big difference with  
18 ours is, you know, our classrooms are not  
19 Charlie Brown's teacher up there. They're not  
20 standing at a podium and giving the class.  
21 They're actually behind the students and  
22 they're walking the students through it.

1 Those students have peer mentors sitting right  
2 there with them to help them get along with  
3 the material.

4 If our instructors need to go out  
5 and help a student, they need to meet with  
6 them one-on-one, they do that, and that's not  
7 something that you see in a lot of tech  
8 skills, ITT Tech or places like that. We  
9 don't charge anything. So, it's easy for us  
10 not to do that. With them, they're looking  
11 for money; we're not. We're looking for  
12 success.

13 CO-CHAIR CROCKETT-JONES: Any more  
14 questions? Okay.

15 DIRECTOR DAILEY: One more time.  
16 In the locations where you're at, if you  
17 haven't been able to get on-installation  
18 support, do you think being at a Regional  
19 Office is deterring participation?

20 MR. WILLIS: I'm sorry, the last  
21 part?

22 DIRECTOR DAILEY: Yes. Do you

1 think that being off the installation deters  
2 participation?

3 MR. WILLIS: I don't know yet.

4 DIRECTOR DAILEY: Hard to say?  
5 Yes.

6 MR. WILLIS: We just started this.  
7 I think what you're going to find is that our  
8 marketing team has set up a pretty good  
9 marketing campaign to get students into the  
10 seats. And we have had so many students reach  
11 out and say, you know, "I'm not allowed to be  
12 on base anymore. Are you going to offer this  
13 at different places?"

14 So, I don't think we're going to  
15 have any difficulty. I really don't. We may  
16 see our numbers drift a little bit, but I  
17 think they'll pick right back up.

18 DIRECTOR DAILEY: Other than the  
19 moving to Nashville and Phoenix, I mean,  
20 that's a good question: pent-up demand,  
21 delayed, you know, wait lists, anything like  
22 that for your program?

1                   MR. WILLIS: Online, we have a  
2 huge wait list for online.

3                   DIRECTOR DAILEY: You have a huge  
4 wait list for online?

5                   MR. WILLIS: Yes. I actually have  
6 a job out for a second online instructor right  
7 now. I've got about 80 people waiting for the  
8 Introduction to Computer Repair course and  
9 over 100 waiting for Introduction to Computer  
10 Technology. So, I've got to get another  
11 instructor onboard for that.

12                   As soon as we put it out -- we  
13 actually it out in Regions to a very small  
14 population because we didn't want to get  
15 inundated, and it happened anyway.

16                   DIRECTOR DAILEY: And you are  
17 advertising to wounded, ill, and injured or  
18 anyone leaving the Service? I mean, your  
19 Charter kind of drives you to the wounded,  
20 ill, and injured?

21                   MR. WILLIS: That's what we would  
22 like.

1                   DIRECTOR DAILEY:  Yes.

2                   MR. WILLIS:  However, there are  
3                   some very good instructors out there that want  
4                   to do it for the right reason.  You know, if  
5                   you're here to make a name for yourself,  
6                   you're going to the wrong place.  But, if  
7                   you're here to help warriors, that's the guy  
8                   we want.  That's the lady we want.  We want  
9                   the one that is going to devote themselves to  
10                  what we do it and how we do it and why we do  
11                  it.  So, that's the person we're looking for.

12                  DIRECTOR DAILEY:  As a student?

13                  MR. WILLIS:  Instructor and  
14                  student.

15                  DIRECTOR DAILEY:  Instructor and  
16                  student.  Okay.

17                  Yes, I mean, if you open it up to  
18                  the 250,000 people a year who leave the  
19                  military, end their contract, redeploy, that's  
20                  overwhelming.

21                  MR. WILLIS:  It absolutely is.

22                  CO-CHAIR CROCKETT-JONES:  Thank

1       you, Mr. Willis.

2                       MR. WILLIS:  You're very welcome.  
3       And that was a lot easier than I thought it  
4       was going to be.

5                       CO-CHAIR CROCKETT-JONES:  We have  
6       10 minutes until our next presenter or are we  
7       ready?

8                       DIRECTOR DAILEY:  They are here.  
9       The IPO office is here, and we'll take a few  
10      minutes just to get them set up, but we're on  
11      time to start in a couple of minutes.

12                      (Whereupon, the foregoing matter  
13      went off the record at 10:51 a.m. and went  
14      back on the record at 10:57 a.m.)

15                      CO-CHAIR NATHAN:  Okay, we'll go  
16      ahead and get started with our next  
17      presentation.

18                      So, this next presentation for the  
19      Task Force will be given by Mr. Christopher  
20      Miller and Dr. Stephen Sears.

21                      Gentlemen, how are you today?  
22      Good to see you.

1                   They are going to be speaking in  
2                   regards to the Interagency Program Office, the  
3                   artist otherwise known as IPO. Mr. Miller is  
4                   the Acting Director for the IPO, and Steve is  
5                   the Chief of Staff. They are going to discuss  
6                   the new mission and the Charter of the IPO as  
7                   well as the implementation of new integration  
8                   and collaboration efforts. Please refer to  
9                   tab K for their information.

10                   Mr. Miller, as you start, I've  
11                   looked at your slides, and we look forward to  
12                   them. But kind of give us quick the "IPO for  
13                   Dummies" overview of what the general gist is  
14                   of what the IPO is doing.

15                   MR. MILLER: Yes, will do, sir.  
16                   Thanks for the time.

17                   So, I guess my first comment to  
18                   everybody is, whatever you think you know  
19                   about the IPO, please forget. We are on  
20                   Version 3, maybe 4, depending on how you think  
21                   about how we are trying to solve this really  
22                   important problem. But many of the things

1 that you may have heard previously about the  
2 IPO or IEHR, I would ask you just to kind of  
3 forget and move on.

4 Because at this point I want to  
5 kind of walk through sort of what the two  
6 Departments are doing. I actually wear two  
7 hats. On one side, I am the Program Executive  
8 Officer for Mr. Kendall, Under Secretary for  
9 AT&L, managing a portfolio of health IT  
10 programs. The biggest, of course, is the  
11 DoD's modernization program of its Electronic  
12 Health Records.

13 But on my other hat, I am the  
14 Acting Director for the Interagency Program  
15 Office. We refer to it as the IPO.

16 Let me just give you the Reader's  
17 Digest version of sort of what the IPO does  
18 today and kind of quickly talk about some  
19 things. A year ago, if I were to be up here,  
20 I would tell you the IPO was literally a  
21 multibillion dollar acquisition to provide a  
22 single system across the VA and the DoD. But

1 in this past year, both Departments have  
2 basically come to some hard decisions, been  
3 through a lot of storming and norming and  
4 figuring out. And so, today what I am up here  
5 to talk to you about is basically how each  
6 Department is going to modernize its own  
7 systems and, then, the role of the IPO in  
8 making sure we do that right.

9           And the IPO, basically, as I'm  
10 going to talk about today, is really a  
11 technical organization focused on how we make  
12 sure that we're sharing information in a  
13 seamless manner, that things are flowing, and  
14 that we're basically making sure that all of  
15 our veterans and our Service members and  
16 people -- you all know the horror stories; you  
17 all know what happens. But we're trying to  
18 get at the problem of how you share medical  
19 health information.

20           It's important that everybody  
21 understand that what I want to talk about  
22 today is an EHR, an Electronic Health System.

1 This is what clinicians use to do their day-  
2 to-day job. EHRs do not equal the service  
3 treatment record. Do we all have an  
4 understanding of sort of how that fits?

5 Because I think it is important;  
6 it is an important clarification because  
7 there's lots of discussions right now about  
8 backlog and STRs and all those things. The  
9 EHR system is basically what runs our  
10 hospitals. It is what our clinicians use. It  
11 is what our people go into. It is where you  
12 go to get a lot of information about what is  
13 going on. It is a very detailed system. It  
14 is an operational system that is supporting a  
15 lot of things that happen throughout our  
16 military health system as well as the VA  
17 system.

18 But it is not directly what gets  
19 provided when people move from active status  
20 over to the VA. So, I bring that up just so  
21 everybody kind of understands they're related  
22 and they support each other, and there's a

1 relationship there. But I think it is  
2 important we all understand what we're talking  
3 about today.

4 The best equivalent I ever can  
5 come up with when I try to explain to people  
6 what we're talking about for the medical  
7 community is basically like an enterprise  
8 resource planning system -- think SAP, Oracle,  
9 ebusiness -- for our medical community.

10 This is a very complicated system.  
11 It does a lot of things. It has a lot of  
12 capability. And that is kind of what we're  
13 going to go through.

14 But it is also important to keep  
15 in mind that this is an emerging IT area and  
16 it's important that we have a lot of smart  
17 people like Captain Sears and other people  
18 that are making sure we're doing the right  
19 things.

20 Just so you understand, you know,  
21 a little bit about me, I have been in the job  
22 a little over four months. I had a great job

1       previously. I was living in Charleston. I  
2       was running one of the Navy Warfare Centers.  
3       I had been a PEO before. I thought I had that  
4       box checked. And then, I got a call from Mr.  
5       Kendall saying, "I need some help."

6                 And so, I'm coming at this from an  
7       acquisition/IT background because that's kind  
8       of what I have done my entire life. But I'm  
9       lucky that I've got a lot of smart clinical  
10      people like Captain Sears and a whole bunch of  
11      people that work with me to make sure we're  
12      doing the right thing.

13                That's kind of the quick and  
14      dirty. I will quickly go through some slides.  
15      Captain Sears has got some slides.

16                But, more than anything, I would  
17      just ask, let's just have an informed  
18      discussion. I have no problem answering  
19      questions. I know it is hard subject, and I  
20      know that you have probably been briefed  
21      previously. So, some of these things are  
22      probably going to be new and probably

1 different, and there's probably a lot of  
2 things that are not well-conveyed in slides  
3 that we could more easily and effectively deal  
4 with in sort of an open dialog.

5           So, this is what I will go over.  
6 I think I covered most of this. I'll talk  
7 about sort of what we do on the DoD side.  
8 I'll talk about the Interagency Program  
9 Office, which is still a joint organization  
10 between us and the VA. And then, Captain  
11 Sears will get into sort of the details on  
12 what the IPO is doing. So, that's what you  
13 asked the most questions about. And then,  
14 we'll kind of go through some questions and  
15 answers at the end.

16           So, real quickly, what are we  
17 trying to do here? At the end of the day,  
18 what we are really trying to effect is really  
19 improving how we provide healthcare across  
20 both the DoD and the VA. And one of those big  
21 things is looking at this as a multinational  
22 problem.

1 I mean, a lot of people get  
2 focused on what we share between the DoD and  
3 the VA. But, when you look at the data, over  
4 60 percent of our healthcare -- and the VA has  
5 a similar statistic -- is actually performed  
6 out in the commercial sector. And these are  
7 through the managed care contracts that DHA  
8 awards. And so, this is problem that we're  
9 really trying to drive at really gets at more  
10 than just sharing of information between the  
11 DoD and the VA.

12 It has actually got to be a  
13 problem that we think at the national level  
14 because any of you that have been out to meet  
15 your private care provider, you've got the  
16 same challenge if you ever move from one city  
17 to the next city. Well, it is very similar to  
18 the problem that our Service members are  
19 facing.

20 The adoption rate of Electronic  
21 Healthcare Systems like EHRs out in the  
22 commercial world is ahead of the projections.

1 This has been a number of different factors,  
2 but they are on a pace right now to basically  
3 to be at the point in the next few years where  
4 just about everybody's medical information is  
5 being contained in some kind of Electronic  
6 Health System.

7 Our first big thing, besides  
8 dealing with that interoperability and data-  
9 sharing, is really just modernization of our  
10 current systems. As I mentioned earlier, the  
11 IPO had this task. And I would just be here  
12 to tell you that, you know, running a joint  
13 program in the Office of the Secretary of  
14 Defense is hard enough, but trying to make  
15 that work with another agency is even more  
16 difficult.

17 And I think what you saw  
18 previously back in February, when the SECDEF  
19 got involved and the Secretary of the VA got  
20 involved, I think there was some realization  
21 that we really need to step back, think about  
22 this, and think about how to smartly move out.

1       Because I think everybody understands the  
2       urgency, but I think we are coming at it from  
3       slightly different perspectives, and we have  
4       got to figure out a smart way to move forward.

5                   MEMBER PHILLIPS:  A quick  
6       question.  I may be jumping way ahead.

7                   MR. MILLER:  That's okay.

8                   MEMBER PHILLIPS:  But, as you  
9       modernize the software, as you upgrade the  
10      software, is there a plan to upgrade the  
11      hardware and the training?  Because we know  
12      that one has to follow the other.

13                  MR. MILLER:  So, on the DoD side,  
14      I will tell you that our acquisition strategy  
15      is to pursue a competitive approach.  As part  
16      of that competitive acquisition strategy, we  
17      are going to be asking industry to propose how  
18      they are going to meet the requirement from a  
19      hardware perspective.

20                  I will tell you that in the  
21      commercial world most of this is not running  
22      on local hardware.  Most of it is accessed

1 through tablet devices like iPads, through  
2 laptops, through almost any kind of device.

3 Kaiser Permanente is probably the  
4 closest example in terms of size and scale as  
5 far as somebody that does something similar.  
6 They run their entire operation out of two  
7 data centers. They do not field stuff  
8 locally. There are local devices. You know,  
9 obviously, your imaging devices and other  
10 things, but they are all connected to the  
11 network, and that feeds back to these data  
12 centers that actually host the software.

13 As far as training, change  
14 management, supportability, that is where the  
15 majority of the cost and the emphasis is in  
16 our acquisition process. Because, you know,  
17 the actual material procurement is less than  
18 10 percent. What is really important here is  
19 how do we get about really thinking about  
20 standardizing our business processes and our  
21 workflows, and making sure that we can go  
22 train those and get them effectively deployed.

1                   Again, a great analogy is, you go  
2 talk to anybody who has been through a major  
3 financial transition with an ERP, they go  
4 through the same kind of process.

5                   Real quickly, the last bullet up  
6 there in our goals is to really engage the  
7 national level. The big player at the  
8 national level is under HHS. It's called the  
9 Office of the National Coordinator, which this  
10 group, basically, goes out there and figures  
11 out for the health community all the various  
12 standards that we need to be engaged with.  
13 And so, when I say "standards communities"  
14 here, these are some organizations like HL7  
15 and some other people that are sort of unique  
16 in the community, or unique to that respective  
17 community, but there's also some larger  
18 standards bodies that they're involved with.  
19 But we want to make sure that we're a player  
20 there. Because, when you think about the size  
21 and scope of DoD and VA combined, we believe  
22 we have a lot to offer.

1                   On the acquisition side, or  
2 actually buying things, a couple of near-term  
3 things: the IPO wrapped up a bunch of near-  
4 term improvements in terms of our  
5 interoperability. And you will hear things  
6 like Joint Legacy Viewer and some other things  
7 that we have done to improve the  
8 interoperability. And that has been a good  
9 win for us. We got asked to go do that, and  
10 we did that.

11                   And then, the longer-term piece,  
12 the DoD, like I mentioned, is going through a  
13 competitive acquisition process. The first  
14 draft RFP will be out this week to kind of get  
15 some feedback from industry, kind of give them  
16 a sense of where we're headed.

17                   And then, you see the VA is on a  
18 path to modernize our VistA system. And this  
19 is kind of what I was getting at, that both  
20 Departments were kind of in a different place.  
21 You know, the VA had a large base with VistA.  
22 It was their system that they had been using

1 forever. Whereas, DoD had a collection of  
2 systems, and we kind of felt on the DoD side  
3 that we would get more bang for the buck if we  
4 were to go through a competition. But we are  
5 very much open to solutions that build upon  
6 the VistA baseline.

7 And then, moving forward, I would  
8 just tell that the VA and the DoD are -- go  
9 ahead, sir.

10 MEMBER PHILLIPS: Again, a quick  
11 question. With the open competition, will you  
12 be reaching out to other government agencies  
13 that have experts in this area? I know you  
14 want to maintain the commercial aspect of  
15 this, but there is a lot of internal folks  
16 that can help out?

17 MR. MILLER: So, we have already  
18 reached out. And so, I have already had ONC  
19 involved. I've already had VA involved. It  
20 is a competitive acquisition. So, it is  
21 obviously targeted towards our industry  
22 partners, and those partners include both

1 people that make the commercial systems, the  
2 Epics, the Cerners, the Allscripts -- you  
3 know, there's about more than 20 of them -- as  
4 well as people that provide the training and  
5 the deployment support, and all those things.

6 We welcome the engagement by other  
7 government agencies, but, obviously, you know,  
8 we are trying to keep this thing kind of  
9 moving on a pace to meet the 2016 timeframe.

10 Like I said, the bottom bullet  
11 here is we're continuing to work with the VA.  
12 Not a day goes by that I'm not talking to them  
13 or we're co-staffed in the IPO. You know,  
14 they contribute to our efforts; we contribute  
15 to their efforts. We do still partner on a  
16 lot of things.

17 But what you see here is it's  
18 really more of we're collaborating and  
19 partnering by a single organization trying to  
20 deliver a single system. I think that's the  
21 big takeaway here, is that we have kind of  
22 rethought the problem. We are trying to make

1       sure we meet the congressional mandates, and  
2       we are trying to make sure we move out  
3       smartly.

4                   And I think what you're going to  
5       see over the next year from both Departments  
6       is you're going to see a lot of forward  
7       progress. Both Departments have recognized  
8       that we've got to collectively do the right  
9       thing here and start moving.

10                   So, I'm pretty excited. As I say,  
11       I've been on the job four months. A lot of  
12       great things have happened. And I think you  
13       will see a lot of continued collaboration and  
14       movement here.

15                   MEMBER REHBEIN: Sir?

16                   MR. MILLER: Yes, sir.

17                   MEMBER REHBEIN: If I may quickly,  
18       one word. When you talk about the VA  
19       modernizing their capabilities, their existing  
20       VistA program, can you give me a little bit  
21       more definition of what you mean by modernize?

22                   MR. MILLER: So, they have their

1 VistA system that they have used for some  
2 time. And so, what they're in the process of  
3 is going and looking at what the user  
4 interface looks like as well as standardizing  
5 VistA currently. I mean, currently, there are  
6 multiple versions of VistA out there. And so,  
7 they're looking at both standardization to get  
8 to a more common baseline; they are looking at  
9 refreshing their user interfaces, as well as  
10 bringing in some new functional capabilities  
11 that make it on par with some of the  
12 commercial offerings out in industry.

13           So, I mean, again, I can't totally  
14 speak for the plan. They're still finalizing  
15 that. But, for the most part, they're trying  
16 to make sure it can meet the Meaningful Use  
17 requirements and some of the other functional  
18 requirements that their users are looking for.

19           DIRECTOR DAILEY: And, Mr. Miller,  
20 you say, "Anticipate VistA-based solutions to  
21 be part of the competitive." So, those  
22 companies and organizations providing VistA

1 services to the VA could very well come into  
2 this competition and offer solutions that  
3 would be agreeable or maybe competitive. And  
4 in some strange world, they may be the most  
5 qualified lowest bidders, and we end up in the  
6 VistA world anyway.

7 MR. MILLER: We could. I mean, I  
8 have no dog in this hunt. I'm not sure if you  
9 read my bio, but I have never been in the  
10 medical world. So, I don't understand all  
11 this stuff completely.

12 I will tell you, from an  
13 acquisition perspective, I really don't care.  
14 What I care about is how much of the  
15 taxpayers' money we spend.

16 And for those of you who aren't  
17 aware, the VA has gone through an effort to  
18 open source their software baseline. And so,  
19 what we're looking for here is potentially  
20 some people out there that might take that  
21 baseline and propose it.

22 But, I will tell you, at the end

1 of the day I'm a pretty simple guy. You know,  
2 I'm a Marine. And so, my mission is I've got  
3 a set of requirements. I've got "X" amount of  
4 money, and I'm just trying to find a solution  
5 at the end.

6 I really don't want to get into  
7 all the politics and everything else because  
8 it will give me a headache, and, you know,  
9 that's just painful.

10 But that's kind of where we're at.  
11 And so, we have had a number of industry days.  
12 We've had a number of discussions. And I  
13 think we will see proposals coming back on  
14 that. But, again, I've got to honor the  
15 process here. That means put the right smart  
16 people in the room, let them work through the  
17 source selection and find the best value.

18 MEMBER PHILLIPS: You mentioned  
19 during your introduction that there's a huge  
20 civilian medical input. Will you be looking  
21 at bids that will include the harmonization  
22 with the civilian sector?

1                   MR. MILLER: Harmonization is a  
2                   difficult world, a difficult word choice  
3                   there. I would tell you, what we're looking  
4                   for is, obviously, interoperability is an  
5                   important piece, right? So, we want to be  
6                   able to have interoperability with the  
7                   commercial sector. But the commercial sector  
8                   is still evolving. And so, there is not a  
9                   single answer out in the commercial right now.  
10                  ONC is driving some standardization, and we're  
11                  on that path with them, as part of Meaningful  
12                  Use.

13                   The most important thing that we  
14                   want to have is full interoperability with the  
15                   commercial world. But I will tell you, the  
16                   commercial world, it is still sort of sorting  
17                   its way out in terms of capabilities, in terms  
18                   of the vendors and the providers.

19                   What I'm after is competition. I  
20                   mean, I'm going to be kind of ruthless on this  
21                   one to some degree because I'm trying to  
22                   really save money. And I think what we're

1       trying to get at is make sure I meet those  
2       requirements for things like interoperability,  
3       but I want to let the system play out, so that  
4       we really do get the best solution.

5                   MEMBER PHILLIPS: Well, the  
6       objective of the civilian sector is a bottom-  
7       line objective. I mean, they purposefully  
8       have firewalls and blockades, so one hospital  
9       system can't communicate with another. And  
10      that is really counterproductive. So, I would  
11      just mention that.

12                   MR. MILLER: Yes, and a lot of  
13      that is being addressed by where the  
14      Meaningful Use standards are going. But, I  
15      mean, I will be the first to tell you that,  
16      you know, even some of the large people like  
17      Kaiser, they're still trying to figure out,  
18      even though they're all on one system, this is  
19      why it has been sort of fascinating. Even  
20      some of these big organizations that deploy a  
21      single system and could have a lot of sharing,  
22      they're struggling to your point, to be able

1 to fully share all that.

2 But we're trying to drive that.  
3 You know, I'll tell you, if you read our RFP,  
4 the interoperability piece is not optional.  
5 We are trying to very much mandate that  
6 whatever we got after has got to be fully be  
7 able to share information with the VA.

8 Now it's a lot of data, right? I  
9 mean, it is kind of staggering how much data  
10 we do share. People don't recognize today we  
11 already share over a million lines of  
12 information every single day, right? So, I  
13 think it's important that everybody recognize  
14 it. It's not just about sharing data; it's  
15 actually about having useful data.

16 And that is really what we're  
17 trying to also drive at as part of this  
18 process, is get beyond just sending tons of  
19 information and really start making those  
20 things meaningful and useful on the other  
21 side.

22 MEMBER PHILLIPS: That's a good

1 point. I mean, scanning doesn't really work.

2 MR. MILLER: Right. And I think  
3 that's a realization. And that's why it has  
4 been an interesting dialog with us and  
5 Congress, is because we're trying to tell  
6 folks, you know, we do share lots of data.  
7 The question is, how effective and is it  
8 useful?

9 And so, I think that is the  
10 maturity that we are starting to finally have.  
11 And this is also where the standards are  
12 coming in, because now there are starting to  
13 be standards that we can all use for how we  
14 map things and how we exchange data.

15 And it is actually kind of  
16 fascinating. It is very similar -- in my  
17 previous life, I did C4I programs for the Navy  
18 -- it is very similar to the problem in the  
19 intelligence world was solving right after  
20 9/11, because you have lots of data. You're  
21 trying to figure out how to have a reference  
22 point in terms of how things all correlate and

1 what they mean. And so, it's a very similar  
2 problem.

3 And so, the positive thing for me  
4 is I don't think we've got a lot of technical  
5 issues. I think our biggest issue is a lot of  
6 process things and figuring out how to get  
7 things connected. And so, I think we're on  
8 the right path. And that's kind of why I'm  
9 upbeat about what is going to happen over the  
10 next year.

11 DIRECTOR DAILEY: And I apologize,  
12 one more question. ONC, can you give us what  
13 that --

14 MR. MILLER: That's the Office of  
15 the National Coordinator underneath HHS.

16 DIRECTOR DAILEY: Okay.

17 MR. MILLER: So, what ONC does is  
18 ONC is basically the people on behalf of the  
19 overall government, the federal government;  
20 figures out the Meaningful Use criteria, and  
21 they're the people that certify these various  
22 commercial systems to make sure they're

1 meeting the criteria.

2 This goes into some -- and I'm not  
3 going to get on all the details; the Captain  
4 is here maybe to help. But there are a lot of  
5 incentives and things tied in the outyears to  
6 the commercial world for basically having a  
7 modern Electronic Health System that meets  
8 their standard.

9 There was initially money set  
10 aside for these companies. And on the back  
11 side, there will be basically penalties if the  
12 commercial systems do not meet certain  
13 standards later on down the road.

14 They are not a standards body. I  
15 think it is important to understand that ONC  
16 is who coordinates it. They sort of cultivate  
17 it, but they're not a standards organization.

18 Real quickly, on the organization  
19 chart, you can't have a DoD presentation  
20 without an org chart. So, there's me at the  
21 top. And then, basically, I've got three, if  
22 you think about it, three offices that kind of

1 work for me.

2 The one on the left is that big  
3 modernization program. That is the one that  
4 we are actively working right now and are  
5 going to start seeing things.

6 The one in the middle is basically  
7 a bunch of near-term interoperability efforts  
8 with us and the VA. I hate to throw out  
9 acronyms, but these are things like BEE HEE  
10 and FEE HEE. And there's all these different  
11 exchange mechanisms that we have today that  
12 we're trying to modernize, so that we can  
13 improve the usefulness of the data exchange.

14 And we're trying to do some things  
15 over the next couple of years to make it  
16 better. So that, when I actually do deploy  
17 the follow-on modernized program, it actually  
18 goes out faster.

19 And it is actually kind of a  
20 complicated slide -- I probably could have  
21 given you a headache -- all the different ways  
22 things flow and how they flow. And so, we're

1 trying to do some near-term smart things in  
2 the interoperability space before that.

3 And then, there is the IPO, which,  
4 as I talked about, they really are the single  
5 point of accountability in terms of technical  
6 standards, specifications. A good analogy is  
7 they are sort of like NAVSEA 08 in the Navy,  
8 right? You know, NAVSEA 08 doesn't build  
9 carriers; they don't build ships, but they  
10 make sure that they're built to the  
11 appropriate standards. They measure and do  
12 all the right things.

13 And that's kind of our model here.  
14 And so, Captain Sears will kind of go into  
15 some details about that.

16 The IPO actually reports to both  
17 Departments. And so, on one hat, they report  
18 through me up to Secretary Kendall. And then,  
19 on the VA side, they report up to the VA's  
20 OI&T, which is their IT organization. That is  
21 sort of the best equivalent to the DoD  
22 acquisition side. So, it is CIO plus

1 acquisition over there, and that's who they  
2 report to. So, we have a very collaborative  
3 organization that comes together and basically  
4 manages sort of the day-to-day activities of  
5 the IPO.

6 I won't spend a whole lot of time  
7 here. I have talked about all of this, and I  
8 think about sort of what is on here, sort of  
9 our three goals. But it really does come down  
10 to, at the end of the day, you know, really  
11 impacting and making decisions better, right?

12 I'm going to modernize the system,  
13 but we are not losing sight of the fact that  
14 what we're really trying to do is make the  
15 clinicians' life better. And that means  
16 either giving them back time, making decisions  
17 easier, helping them get their job done.

18 And you kind of see some things up  
19 there about sort of what I have talked about  
20 in terms of the competitive acquisition as  
21 well as the coordinating or adoption of  
22 national standards. And again, I've talked

1 about everything here, and I would rather kind  
2 of let Captain Sears get up here and answer  
3 all your really hard questions.

4 MEMBER PHILLIPS: The middle box,  
5 "Provide technical solutions," are you at the  
6 point where you can give any examples?

7 MR. MILLER: I think a great  
8 example there would be JLV, so Joint Legacy  
9 Viewer. And so, what we have done in that  
10 area is that we have basically provided a  
11 viewer that can see both records. And so, if  
12 you are one of the poly-trauma sites or a  
13 couple of other locations, you would be able  
14 to actually pull the record up from the VA  
15 side as well the DoD medical record and see  
16 them side-by-side.

17 And this is kind of interesting  
18 because, as I am finding out, there's a  
19 different culture in the medical world. And  
20 so, one of the things we're starting to find  
21 is, even though we provide that information,  
22 we are still trying to work through how they

1 will deal with that information.

2           There is this whole trust but  
3 verify kind of thing out there. And so, we  
4 have done some really great things. And I  
5 think those are the kinds of solutions you  
6 will see.

7           A lot of it has kind of been on  
8 the back end in terms of how we share data and  
9 how we map the data. But I think one of the  
10 great examples would be that JLV.

11           It's actually interesting because,  
12 originally, this was designed for the clinical  
13 community. And now, the VA has come in and  
14 saying, "Hey, this would be a great thing for  
15 our benefits folks." And so, we're kind of  
16 working through sort of the challenges there  
17 because it does provide a lot of capability.  
18 So, a single pane of glass, you can basically  
19 see both records side-by-side.

20           MEMBER REHBEIN: Sir, about a year  
21 ago, we were out at the Lovell facility in  
22 North Chicago and they demonstrated something

1 called JANUS.

2 MR. MILLER: That's the same  
3 thing.

4 MEMBER REHBEIN: Is that the same  
5 thing?

6 MR. MILLER: Yes. Unfortunately,  
7 the "J" in JLV is JANUS. So, it is the JANUS  
8 Legacy Viewer. There are a couple of minor  
9 differences up at North Chicago, but it is the  
10 same basic thing.

11 MEMBER REHBEIN: Good. I just  
12 wanted to get all the terms in the right boxes  
13 in my head.

14 MR. MILLER: Yes, I'm with you.

15 All right. So, looking back, 13,  
16 just some of the things that we have done.

17 You know, the big thing, I will  
18 tell you, is we have got both Departments kind  
19 on a plan -- and that kind of goes back, and  
20 I'll show you a slide here in just a second --  
21 sort of a plan and a strategy for how we're  
22 going to move forward.

1                   And I have spent a lot of time  
2 with both Departments trying to make sure  
3 we're on the same page. And that's something  
4 that you will see here in a second.

5                   I just talked about JLV, but we  
6 did provide that at seven additional sites, in  
7 addition to the two. And we can talk offline  
8 if you want to know more about that.

9                   And then, the viewer is one  
10 product. And the second bullet up there is  
11 really how we have mapped data, and we have  
12 mapped seven clinical domains. So, we're all  
13 sharing terms.

14                   It is actually this whole mapping  
15 of data is quite fascinating. You would think  
16 that in our medical communities we would have  
17 some normalization. Well, actually, it is  
18 kind of crazy. Some are in pounds and some  
19 are in metrics. There's lots of different  
20 interpretations of how we do things.

21                   And so, one of the big near-term  
22 things we are doing is trying to get to some

1 national standards in terms of data  
2 terminology, and Captain Sears will talk about  
3 that.

4           And then, we have also done things  
5 with Blue Button. And then, on the Blue  
6 Button side, Blue Button basically allows  
7 anybody -- it's like a little blue button  
8 icon. You go in and you can download your  
9 medical record, right? So, this gets to the  
10 point where, instead of having, like when I  
11 left active duty, having to print it all out,  
12 you can now put it into basically a  
13 downloadable format.

14           I will be the first to tell you  
15 that there's a lot more we would like to do  
16 here, and this is on the DoD side, why we are  
17 moving to a competitive acquisition, because  
18 industry has taken this to the next level.  
19 But we have provided the initial capability.

20           And then, on the network piece, we  
21 have been doing a lot of work to make sure  
22 that our networks -- I mean, this gets kind of

1 to the questions from Dr. Phillips here -- we  
2 may all be doing it in the same space, but  
3 sometimes our networks don't usually allow and  
4 facilitate sharing of information. So, we  
5 have been doing some things there to improve.

6 Now, as far as modernizing, a  
7 couple of things have happened. You know, we  
8 have already stood up this new program office.  
9 It's at the PEO.

10 We have had two industry days,  
11 major interest from our industry partners  
12 about what is going on here. And like I  
13 mentioned, we're on a path to get our first  
14 draft of our RFP out this week.

15 On the requirements side, which is  
16 a very important thing for DoD, we have stood  
17 up this functional Advisory Council,  
18 basically, to kind of be like a mini-JROC, if  
19 you will, that kind of maintains sort of  
20 requirement standardization. Because in any  
21 of these big IT programs, the requirements  
22 management is a very important thing, and it

1 is important that we really do understand and  
2 we keep tight configurations on our  
3 requirements.

4 All right. So, let me just show  
5 you this slide. And there is a lot going on  
6 here. I'll try to be quick, so that Captain  
7 Sears can get up here.

8 But the very top of the level  
9 between the DoD and the VA, there is this  
10 group called the Joint Executive Committee.  
11 This is chaired by Mr. Riojas, who is acting  
12 as a Deputy Secretary on the VA side, and Ms.  
13 Wright, who is the Acting Under Secretary for  
14 PNR.

15 That is the most senior body  
16 between the DoD and the VA, and they oversee  
17 a lot of interactions between the two  
18 Departments. One of them just happens to be  
19 what we're doing with Electronic Health  
20 Records.

21 But, for that group of people, the  
22 requirements come into this thing called the

1 Health Executive Committee. And so, this is  
2 where Dr. Petzel and Dr. Woodson get together  
3 with their functional and their clinical  
4 representatives, and they basically bring in  
5 all the requirements.

6 And then, on the left, obviously,  
7 we have our supporting budget processes. But  
8 that group at the top, that JEC, which  
9 includes, you know, the leadership of both  
10 Departments, is basically who directs where  
11 the IPO is going and, also, directs where both  
12 modernization programs are going to stay  
13 synchronized.

14 This group meets at least once a  
15 quarter, and they've always got a lot of stuff  
16 going on because this is, obviously, a very  
17 complicated thing.

18 The sort of more tactical  
19 leadership is what is provided by that box  
20 just below, which is the DoD/VA Senior  
21 Steering Group. And that is chaired by the VA  
22 CIO, Steph Warren, and Mr. Kendall on the DoD

1 side.

2 That is basically my boss when I  
3 am wearing either one of my hats, and it is  
4 also who the VA reports to as their senior  
5 official. That is the person that or that is  
6 the group that meets more regularly, at least  
7 once a month, and they are the folks that are  
8 basically sort of giving the direction day-to-  
9 day.

10 Then, what you see down at the  
11 bottom are sort of the three components,  
12 right? And all three of these components work  
13 closely together. We're all collaborating.  
14 We're all talking. But you've basically got  
15 a VA program, a DoD program, and you've got  
16 the IPO in the middle.

17 And the IPO, arguably, is the most  
18 important piece because, without the  
19 interoperability piece, we're not going  
20 anywhere. And so, as I mentioned earlier,  
21 that interoperability piece is actually bigger  
22 than the VA. It also includes what we do in

1 the commercial space. But you see sort of  
2 what their responsibilities are in terms of  
3 adoption and standards and making sure we're  
4 doing the right technical things.

5 And then, down at the bottom it  
6 kind of gives you some ideas of what the  
7 outputs are and who does what to who.

8 You know, at the end of the day,  
9 there are some things where the DoD and the VA  
10 have to agree. We have to have common  
11 solutions. And so, we're working on those  
12 things, things like our management. DoD has  
13 CAC cards; VA, we're working through how they  
14 get PIP cards and other things. And so, those  
15 are the kinds of issues that we have to work  
16 through as well as things like how we do our  
17 network and other things.

18 And then, obviously, you'll see on  
19 either side is basically the big acquisition  
20 programs. That is kind of how we all fit  
21 together, and this is kind of how we all  
22 operate.

1                   As I said, a year ago, if I had  
2                   been up here, I would have showed you this one  
3                   big program that, arguably, was so complicated  
4                   and so difficult, it was almost unwieldy,  
5                   given the complexities of what we're trying to  
6                   deal with.

7                   DIRECTOR DAILEY: Mr. Miller, so  
8                   back on page 6, you also talk about another  
9                   Functional Advisory Council. How does it fit  
10                  into --

11                  MR. MILLER: So, the Functional  
12                  Advisory Council feeds this group up here.

13                  DIRECTOR DAILEY: It feeds what  
14                  group?

15                  MR. MILLER: The Health Executive  
16                  Committee.

17                  DIRECTOR DAILEY: Okay. And this  
18                  is the first time they've had one? There has  
19                  not been a previous one?

20                  MR. MILLER: Okay. This thing  
21                  right here is a inter-Department level, right?

22                  DIRECTOR DAILEY: I understand

1 that, yes.

2 MR. MILLER: So, this is where the  
3 two Departments come together.

4 DIRECTOR DAILEY: I understand  
5 that.

6 MR. MILLER: When I talk about the  
7 fact that it is the first time DoD has had a  
8 clinical requirements body -- why are you  
9 shaking your head? Show me a signed  
10 requirement by anybody in the Department that  
11 really gets at this kind of thing.

12 DIRECTOR DAILEY: Okay. I know  
13 there are parts of the --

14 MR. MILLER: We have JROC, right?

15 DIRECTOR DAILEY: Yes. I know  
16 there are parts of the Joint Executive Council  
17 that have been working on clinical  
18 requirements for a long time.

19 MR. MILLER: That is the ICIB.  
20 ICIB is that body you're talking about. ICIB  
21 is, again, an interagency piece.

22 What I'm talking about is how does

1 the DoD get its collective requirements  
2 together to feed the ICIB, which is another  
3 input into the Health Executive Committee.

4 DIRECTOR DAILEY: Okay. All  
5 right.

6 MR. MILLER: It's complicated.  
7 And I'm not making any of this up because a  
8 lot of these groups up here are  
9 congressionally-mandated.

10 All right. So, real quickly, I've  
11 talked about some of this. On the  
12 interoperability side, it is a very close  
13 partnership with ONC. Hopefully, one of the  
14 things you're taking away from here is that  
15 the commercial world is moving very quickly.  
16 And so, ONC is critical because ONC is who  
17 deals with the commercial sector and the  
18 private sector. And so, we've got to stay  
19 tight with them, and we've got to make sure  
20 we're in partnership.

21 This will be one of the larger  
22 acquisitions. And so, we're trying to figure

1 out how to partner with them, so that we can  
2 help them move their agenda forward in terms  
3 of the standards, the data-sharing, and some  
4 of those things.

5 And then, what you're also looking  
6 at is we're not crazy. We're going to try to  
7 do some incremental things. I'm trying to  
8 avoid the big bang because that just kind of  
9 sets us up for issues down the road.

10 But we are also being very smart  
11 in terms of how we think about our  
12 architecture. We are very committed to an  
13 open-architecture approach. We do not want to  
14 get locked into a specific vendor. This is an  
15 evolving space, and there's lots of  
16 competition here, which is good, but we don't  
17 to pick beta in the beta/VHS world, right? We  
18 want to make sure that we're a little smarter  
19 about who we pick and have flexibility to kind  
20 of be moving forward in the future.

21 And so, this just kind of outlines  
22 sort of from an acquisition piece where we're

1 at. And then, I think the next piece up will  
2 be the IPO. So, I'll let Captain Sears come  
3 up and we continue to just have some dialog  
4 and answer some questions.

5 CAPTAIN SEARS: Mr. Miller, thank  
6 you, sir. Ladies and gentlemen, thanks.

7 I apologize in advance. I'm  
8 getting over a cold. So, if my voice is  
9 breaking up, I apologize.

10 A couple of things. Again, I'm  
11 Steve Sears. I am the Chief of Staff for the  
12 IPO. I've been in this shop about two months  
13 now, and previous to that I had many jobs  
14 within the IPO previously.

15 A couple of messages I want to  
16 make sure I bring home for you today. No. 1  
17 is that the IPO is all about standards. We're  
18 not all about acquisition. We're not all  
19 about development. We're all about standards.

20 And No. 2 is, and probably it  
21 should have been No. 1, is we are the  
22 interagency group. We're all about DoD and VA

1 together helping make sure that we get to the  
2 standards we want to use.

3 Our mission objectives, really,  
4 again, it is that single point of  
5 accountability in the development and  
6 implementation of the Electronic Health Record  
7 systems. And in this, it is about the  
8 standards, making sure that the standards we  
9 all select we adhere to; we end up with the  
10 interoperable records that we want and need  
11 for our beneficiaries.

12 We are going to lead the  
13 Departments' implements these National Health  
14 Data Standards. We are also going to be that  
15 group that helps monitor and make sure that,  
16 as we implement these things, we can report up  
17 to our superiors as to how well it's going,  
18 how successful we are, and what the end  
19 results. And we are working now on metrics to  
20 help us look at the outcome side of that as  
21 well.

22 The objectives we are going to

1 establish, monitor, and approve, this clinical  
2 and technical standards, right, because it is  
3 not just about technical standards by which  
4 things move about. So, there are terminology  
5 standards, much like the NLM works on. We  
6 need to all be speaking the language, or when  
7 we send things back and forth, we won't  
8 necessarily understand it. We also need to  
9 put those messages that go back and forth  
10 between organizations into a common construct,  
11 so that when I get a message, I know how to  
12 take apart and put into the construct for my  
13 place.

14           And then, in the transition,  
15 right, that transmission piece, we have to use  
16 common standards to transmit those. And so,  
17 it's technical side as well as the terminology  
18 side standards will be the only way.

19           Obviously, we will work hand-in-  
20 hand with the group, the Interagency Clinical  
21 Informatics Board, which you heard before.  
22 That's one. That is the clinical informatics

1 DoD/VA group of functions that sit and look at  
2 requirements, that look at use cases, that  
3 look at our needs going forward and help guide  
4 us, as well as with the Health Architecture  
5 Review Board, those people who help construct  
6 and guide and maintain the standards on our  
7 technical infrastructure as we go forward.

8 MEMBER PHILLIPS: Captain, sir, do  
9 you have some international input? I mean,  
10 the international language of medicine is  
11 English, and the standard language of the  
12 world, as Mr. Miller was mentioned. Is there  
13 some international input for the standards?

14 CAPTAIN SEARS: So, at this point,  
15 we are looking at all the different standards  
16 development organizations. And obviously, as  
17 you say, some of those are national standards  
18 development, but some of those are  
19 international standards. And to that extent,  
20 yes. We don't currently have any other direct  
21 international activity. Will there be in the  
22 future? I suspect, given the international

1 standards development organizations and  
2 things, we will have interactions there.

3           And we're going to represent and  
4 lead the DoD efforts with ONC, the Office of  
5 the National Coordinator for HIT, again, that  
6 group that helps identify standards for the  
7 national side, as we work on the DoD side of  
8 the house, I'm sorry, the DoD and VA side of  
9 the house. And again, we called out the  
10 national and the international standards  
11 development organizations there that we need  
12 to be working with.

13           New IPO Charter and, you know, you  
14 may have heard new IPO Charter a couple of  
15 times before. As Mr. Miller said, this is  
16 Version 3 or Version 4. This was signed out  
17 in December and set us on the course we're on  
18 today.

19           You know, it leverages the Joint  
20 Executive Council Charter as a model, so our  
21 parent organization; leveraged that  
22 legislation that created the IPO. And again,

1 it scopes us to be a health data standards  
2 guidance and enforcement entity.

3 The thing I would like to point  
4 out here, and it's called out here, is that we  
5 are no longer the modernization and  
6 integration of legacy systems. We're not the  
7 acquisition and development side of the house  
8 any longer. As you saw on Mr. Miller's chart,  
9 that belongs to the other organizations.

10 So, what are our future efforts.  
11 Really, these are the efforts we're  
12 undertaking right now. Really three big  
13 goals, right?

14 The data interoperability  
15 standards identification and development.  
16 Again, what terminology standards, what  
17 communications standards are we going to use  
18 to move data back and forth.

19 Working closely with ONC. Our  
20 goal is not just to interoperate between DoD  
21 and VA, but to create a record and to help  
22 drive, as ONC is driving, that record where

1 all of the data from your health record can be  
2 displayed in one place because it all meets  
3 the same standards.

4 Identify and prioritize the data  
5 domain terminology, technical standards. We  
6 already talked about that.

7 And then, to our point, it is  
8 developing those standard specifications that  
9 DoD and VA are going to meet in their  
10 modernization and in their acquisition, again,  
11 working with ONC and making sure they are the  
12 same standards we're using nationally and  
13 internationally.

14 Supporting the data  
15 interoperability standards implementation.  
16 So, once we have identified them, someone has  
17 to help make sure that, as our groups go to  
18 use them, we can help interpret the pieces  
19 where it is less obvious or where we run into  
20 challenges in implementation. And so, we have  
21 a division that is going to be working with  
22 DoD and VA as they go through that process.

1           The third piece, obviously, is the  
2 monitoring and reporting. It is clearly  
3 called out in our Charter as well as in the  
4 legislative language that it is part of our  
5 job to monitor these implementations across  
6 both agencies and to report back on how we're  
7 doing, both terminology mapping issues, are we  
8 speaking the same language, as well as how  
9 effective is that. As we are implementing  
10 these changes, how is it affecting the  
11 interoperation of data and supporting  
12 healthcare really?

13           ONC collaboration, a big piece.  
14 Again, you heard it on slide after slide after  
15 slide. It is not just about what do we think  
16 the standards are. It is about what are the  
17 national and international standards and  
18 working with those groups.

19           Two big areas of ONC  
20 collaboration, the first one doesn't belong to  
21 me specifically in IPO. This is ONC and our  
22 DHMSM, our DoD side acquisition/modernization

1 side, working with ONC, again, helping make  
2 sure that, as they select and go into the  
3 competition on their next product, that  
4 they're leveraging Meaningful Use and the  
5 other pieces that need to be leveraged in  
6 order to identify the best choice going  
7 forward for DoD.

8 The IPO, again, that single point  
9 of accountability, right? And you have seen  
10 these statements again. Identify, draft, and  
11 implement the interoperability standards and  
12 ensure that VistA and modernization and DHMSM  
13 acquisition adhere to those, again, working  
14 with ONC, working with the  
15 national/international groups.

16 Yes, I get a lot of questions  
17 about, "Well, what are you going to do if and  
18 what are you going to do when, and what if  
19 there is not a standard?" So, we have dealt  
20 with that already. I would offer that DoD and  
21 VA in the long-ago timeframe, back more years  
22 ago than I care to admit, when I was an intern

1 and we were installing CHCS brand-new in my  
2 hospital, we were on the cutting edge. And we  
3 were developing how we were going to do things  
4 before such standards existed.

5 We are lucky now. Lots of  
6 standards exist. So, you know, kind of three  
7 categories of this world exist, I think, now.

8 The first is there is a clear  
9 national standard or international standard,  
10 right, the domains covered by an ONC-endorsed  
11 standard, in which case that's what we use,  
12 right? That is what commercial should be  
13 using. That's what we use, right?

14 So, that's this pathway, right?  
15 And again, it leads us to always continuing to  
16 work with the standards development  
17 organizations because these things evolve over  
18 time. Terminology evolves over time.  
19 Technical standards evolve over time, and we  
20 need to evolve with them.

21 The second case is where there is  
22 kind of a near --

1                   MEMBER PHILLIPS: I was going to  
2                   say question --

3                   CAPTAIN SEARS: Go ahead.

4                   MEMBER PHILLIPS: -- about the  
5                   Health Data Dictionary. It's a 3M product  
6                   which they have released for use. Will we be  
7                   able to upgrade that and manipulate it? Are  
8                   there any restrictions? Do you know?

9                   MR. MILLER: No. It is actually  
10                  part of our contract. We also paid the open-  
11                  source parts. So, we have addressed those.  
12                  But I think as Captain Sears is going to get  
13                  to, that is an interim solution.

14                  But, to your concerns, yes, that's  
15                  part of the contract, is to keep it up-to-date  
16                  as well as make it available to other people.

17                  CAPTAIN SEARS: Thank you, sir.

18                  You know, the second  
19                  classification is where there is not obviously  
20                  an ONC-endorsed standard yet, but there is  
21                  really a near standard. It's almost there.  
22                  It is the candidate. It is broadly used

1 internationally or nationally. And in those  
2 cases, it is likely that DoD and VA are going  
3 to say, "Let's use that near-term candidate  
4 and, then, continue our work with the  
5 standards development organizations and the  
6 ONC to mature it, make sure that it becomes  
7 what we all need it to be.

8           And the third case is kind of that  
9 hard case. And that's where really no  
10 standard yet exists, either because it is  
11 something special to DoD and VA or one of our  
12 agencies or because people just haven't gotten  
13 to it yet. It hasn't been identified as a  
14 need.

15           And in that case, we do have, as  
16 was discussed, we have the HDD, the Health  
17 Data Dictionary, which is a product, a 3M  
18 product under contract with us, and we can use  
19 that to help us do the translation between the  
20 two agencies while we work on what is the  
21 final standard.

22           So, at least in the interim we can

1 interoperate that data while we work toward a  
2 final. And again, those arrows all lead to  
3 continuing to work with those standards  
4 development organizations and the ONC to make  
5 sure that we get the standards to where they  
6 need to be to support us.

7           What does success look like? I'll  
8 address this one, if you like, sir. I think  
9 this is both of our slide. You know, really,  
10 for all of us, it's about can the right health  
11 data get into the right authorized users'  
12 hands at the right time to make whatever is  
13 the decision faster and easier, right?

14           For Service members and veterans,  
15 that looks like increased record portability  
16 and accessibility. You heard about Blue  
17 Button. You've seen patient portal kind of  
18 concepts. DoD and VA clinicians, right, it  
19 improves their decisionmaking based on  
20 integrated patient information, right, not  
21 just reams of scanned information and stuff  
22 put in front of me, but presenting the data in

1 such a way that they can efficiently process  
2 it and efficiently make a decision, clinical,  
3 benefits, whatever the proper decision is,  
4 based on that data.

5           For the IPO, if we become  
6 recognized as the health data interoperability  
7 authority for DoD and VA, we are effectively  
8 a partner with the ONC and the other health  
9 data standard organizations. We achieve the  
10 SMART objectives and the Joint Executive  
11 Committee's Joint Strategic Plan, and we  
12 successfully guide our Departments to  
13 implement the technical data interoperability  
14 standards, profiles, so that that data goes  
15 back and forth to support all those other  
16 challenges.

17           The interoperability team, the  
18 team that has been putting the technical  
19 solutions in place that you saw, delivering  
20 those federated data elements iteratively,  
21 right, taking all of our standards and  
22 effectively making that data move back and

1       forth from the technical standpoint.

2                   DHMSM, fielding that modernized  
3       DoD system by '17.

4                   And for VistA evolution, achieving  
5       their initial operating capabilities by  
6       October 2014, as they're defining them, and  
7       achieving a modernized system at full  
8       operational capability in the 2017 range.

9                   So, in the end, it is all about  
10       positively impacting those outcomes, right,  
11       ensuring that the data is there, that people  
12       are able to make the right decisions, and that  
13       we positively impact the lives of our  
14       clinicians, our beneficiaries, our active  
15       military, and our veterans.

16                   MEMBER MALEBRANCHE: I have a  
17       question. As part of the Recovering Warrior  
18       Task Force, one of the things that I  
19       understand Mr. Miller went earlier and said  
20       this is about the health record, not the  
21       service record. However, I know at one point  
22       it was all mixed up together. What has

1       happened to that piece of, I guess it would  
2       have been VLER, because is that under the  
3       Benefits Executive Council? Because that does  
4       affect for our Recovering Warrior some of that  
5       information.

6                   MR. MILLER: Right. So, a couple  
7       of things have gone on. HAIMS has been a  
8       near-term effort by both Departments, right?  
9       That is basically where we are taking the  
10      medical record, digitizing it, back to your  
11      comments -- today it is a PDF, but we are  
12      digitizing that, and it's being sent over to  
13      the VA.

14                   So, that is being done by DHA.  
15      But that to the end of supporting of STR. And  
16      what I was trying to get earlier is the data  
17      in the EHR feeds the STR, but they are not  
18      exactly the same, right?

19                   Let me give you an example of what  
20      I mean. When you go in for an inpatient stay,  
21      you know, you're getting lots of data  
22      collected on you. But when you go to the STR,

1 there's like a summary of that stay. There is  
2 not all the underlying every single thing that  
3 happens, right, because --

4 DIRECTOR DAILEY: Let me just hold  
5 -- STR?

6 MR. MILLER: Service Treatment  
7 Record.

8 MEMBER MALEBRANCHE: Okay.

9 MR. MILLER: Because that is what  
10 the benefits analysis people need in the VA.  
11 So, there is a separate effort between the two  
12 Departments called HAIMS to automate that and  
13 to make it better.

14 And I'm not responsible for that,  
15 but I can at least give you the sort of  
16 Reader's Digest. So, by January of this year,  
17 they had completed the initial deployment or  
18 starting to do that.

19 But I would encourage you to reach  
20 out to either the VA or DHA and they can come  
21 in and give you an idea of what is going on.  
22 But there has been a lot of effort over the

1 last year to make that be a digital electronic  
2 sharing, and the program is called HAIMS.

3 VLER is a little different. VLER  
4 is the Virtual Lifetime Electronic Record.  
5 There are multiple flavors of VLER, and there  
6 are some that's benefits, some that's health.  
7 But that is also a national thing. And so,  
8 when you think VLER, you have to be thinking  
9 about sort of the private sector as well as  
10 military.

11 So, we are using parts of VLER for  
12 sharing information with the private sector.  
13 And there are different ONC-endorsed product  
14 offerings that we field as part of VLER. But  
15 VLER is basically part of a national agenda to  
16 kind of have some standards for how you share  
17 medical information.

18 Unfortunately, it is kinds of  
19 complicated because it does kind of get in  
20 some of the same areas as the STR, but it is  
21 more done at the national level, and the STR  
22 has more information in it for the benefits

1 people than just to be covered by a VLER kind  
2 of exchange of information.

3 MEMBER PHILLIPS: I would just say  
4 that was a great presentation. Thank you.

5 Obviously, in a perfect world, we  
6 would like to have one system for all, but  
7 this is not a perfect world.

8 MR. MILLER: That's way above my  
9 pay grade.

10 (Laughter.)

11 MEMBER PHILLIPS: And mine as  
12 well.

13 But let me just ask -- and I think  
14 I know the answer -- you talked a lot about  
15 display of information. Everybody will be  
16 able to display and read the information. How  
17 about the next step to make that usable,  
18 interoperable?

19 MR. MILLER: So, that is kind of  
20 what I was saying about the medical community.  
21 And I will let Captain Sears to give his  
22 perspective.

1                   But what I have gathered, I think  
2                   we are going to get to the point where we can  
3                   provide the data, right, and it will be usable  
4                   data. But I think there is another discussion  
5                   in terms of the business process and how  
6                   willing a medical professional or a clinician  
7                   is willing to accept, right? I mean, it's  
8                   that trust but verify thing.

9                   I don't think there is a technical  
10                  issue here of connecting systems, sharing. I  
11                  mean, we have proven -- I mean, like I said,  
12                  it is above my pay grade to say we're going to  
13                  be one system now -- but we have proven in the  
14                  technical world, and I don't care what other  
15                  system you look at, we can figure out how to  
16                  build the standards and share information, but  
17                  it is a whole different discussion when you  
18                  talk about whether or not the clinicians are  
19                  actually going to use that data as part of  
20                  their decisionmaking.

21                  And Captain Sears can give his  
22                  perspective, but I think that is a whole other

1 debate and discussion area. And that's where  
2 Admiral Nathan and some other people can tee  
3 up, because that is more, I think, of a  
4 functional and clinical discussion than it is  
5 a technical discussion.

6 MEMBER PHILLIPS: I think you're  
7 right. I mean, it requires a cultural change.  
8 As a cardiac surgeon, I was taught not to  
9 trust anybody but myself.

10 (Laughter.)

11 MR. MILLER: You're not the first  
12 person that's told me that from this  
13 community.

14 CAPTAIN SEARS: As a radiologist,  
15 they taught me the same thing.

16 Sir, I would offer, also, that I  
17 think what you're addressing is that next  
18 step. At the first step, we have got to get  
19 the data that we have in the condition it's in  
20 to go back and forth in an effective manner.

21 And then, the next step is, you  
22 know, interoperability is really two parts.

1 It is not just, can I send you the data and  
2 can you read it, but can you do what you want  
3 with it. In some cases, all you want to do is  
4 view it. Great. That's an easy one. But, in  
5 cases where you want to be able to do  
6 computational, graphic, you know, as we all  
7 talk about in the medical world, this kind of  
8 nirvana of clinical decision support where it  
9 is able to synthesize some things in the  
10 background, look at the literature, and tell  
11 me, think about this; think about that. You  
12 know, that's those next steps out there that  
13 we need to look at how we get to. And I think  
14 those are next steps.

15 MR. MILLER: Yes, and I think it  
16 is also important to take away, and as I said  
17 in my opening remarks, this isn't just a  
18 DoD/VA challenge. I think anybody here who  
19 has gone to get care in the private community,  
20 you got the same thing.

21 Maybe you're local, go to a INOVA.  
22 They're in the process of deploying it. I

1 mean, you will be impacted by this and you  
2 will want to be able to move your medical  
3 record, and you will want to do the exact same  
4 things that we're trying to get at between the  
5 DoD and the VA in the private sector.

6 So, that has been the real game-  
7 changer. And as Captain Sears kind of  
8 highlighted, you know, a decade ago, DoD and  
9 VA were at the forefront of this technical  
10 area because we had hard requirements. We  
11 were trying to solve some really hard  
12 problems.

13 It has changed, and I think if you  
14 were to go out and look at the investment, the  
15 research dollars, and the things that are  
16 happening in the commercial sector, it's  
17 staggering right now. And so, the market has  
18 fundamentally changed, and I think it is  
19 important that both Departments figure out how  
20 to take advantage of that and figure out how  
21 to leverage it.

22 I mean, it is very similar to --

1 you know, I hate to say it, but when I first  
2 came on active duty, I was an IT guy. We were  
3 trying to build email systems. Eventually, we  
4 said, "We can't compete with Microsoft." At  
5 some point, I think we have got to kind of  
6 have the same realization to figure out how to  
7 take advantage of that commercial investment  
8 and really get it to where we need to be  
9 because we're not all that different.

10 I mean, this is the other thing  
11 I've been really having some hard discussions  
12 with the leadership of the DoD. We like to  
13 say that we have a lot of hard requirements,  
14 but our requirements are not all that  
15 different than what the commercial care  
16 providers do.

17 In fact, some of our hospitals  
18 don't even push some of the technical  
19 requirements that you will see in some of  
20 these large deployments, right? Now we do  
21 have some interesting things. Like I have got  
22 to support forward deployed forces. I've got

1 to make it work on a submarine, right? There  
2 are some unique things, but those things are  
3 not nearly as overwhelming as a lot of people  
4 think they are.

5 And I think, with the right kind  
6 of discussion on our processes and how we do  
7 things, I think we can overcome that and  
8 really get a lot of value and ride the wave of  
9 where the commercial world is going.

10 MEMBER PHILLIPS: And I think  
11 you're absolutely correct that the devil is in  
12 the details. I mean, you're struggling with  
13 CAC cards or PVI cards.

14 As a clinician, I would love to  
15 see a hyperlink, say, in a medical record if  
16 somebody had a cadaver bone graft or a  
17 pacemaker, to be able to track that down. You  
18 know, I just mention that as an example.

19 MEMBER REHBEIN: So, when you talk  
20 about increased record portability -- and I'll  
21 use the Command Sergeant Major here as an  
22 example because he is National Guard -- and

1 when we are in a high Op Tempo, we've got  
2 people going back and forth between active  
3 duty and off deployments, I wouldn't be at all  
4 surprises in a period of four or five years he  
5 has probably received care from the DoD, from  
6 the VA, from civilian providers. So, that  
7 kind of portability is going to be able to go  
8 all directions, I hope.

9 MR. MILLER: Yes, that is where we  
10 want to go. That is our objective, right.  
11 So, I think the way you just highlighted it is  
12 one of those use cases that we are trying to  
13 solve.

14 I think the simple one, right, is  
15 obviously you start in DoD and you go to the  
16 VA. Where it gets much more complicated is  
17 National Guard, Reservists. But that is  
18 exactly where we are trying to go, but it  
19 requires coordinations on at least a couple of  
20 fronts, right? I think when you're just  
21 talking DoD and VA, I could put us all in a  
22 room; we could all agree. But when you start

1 talking about exchanging with the private  
2 sector, it gets more complicated, but that's  
3 where the relationship with ONC, that's where  
4 the national standards are going, things like  
5 VLER play in. But that is exactly the problem  
6 that we're trying to get at.

7 So, it doesn't matter where the  
8 care is being provided; we can get the  
9 portability, so that the information moves  
10 and, also, so that the Service member or the  
11 veteran has the ability to move their stuff.  
12 If they get frustrated with one provider and  
13 they want to go somewhere else, they can take  
14 it with them as well.

15 MEMBER MALEBRANCHE: Okay. Any  
16 other questions?

17 (No response.)

18 Okay. Well, I would like to thank  
19 you, Mr. Miller and Captain Sears.

20 MR. MILLER: Yes, thank you.

21 CAPTAIN SEARS: Thank you, ma'am.

22 MEMBER MALEBRANCHE: And the

1 Committee will now adjourn for lunch.

2 (Whereupon, the foregoing matter  
3 went off the record at 11:51 a.m. and went  
4 back on the record at 1:00 p.m.)

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

2 1:00 p.m.

3 CO-CHAIR CROCKETT-JONES: Okay.

4 Welcome back from lunch.

5 This afternoon we welcome Mr.

6 Frank DiGiovanni, Director for Force Readiness  
7 and Training, to discuss job training,  
8 employment skills training, apprenticeships,  
9 and internships. Mr. DiGiovanni will be  
10 updating the Task Force on information  
11 provided in April 2013, including the status  
12 of DODI 1322.29. Please turn to tab L for Mr.  
13 DiGiovanni's information.

14 I'm going to turn it over to you,  
15 sir.

16 MR. DiGIOVANNI: Okay. Thank you.

17 So, it has been about a year since  
18 I've talked to you last. I think there are  
19 some familiar faces in here. I do recognize  
20 a few.

21 But I am just going to go through  
22 this briefing. We have an hour, right?

1 CO-CHAIR CROCKETT-JONES: Yes.

2 MR. DiGIOVANNI: It may or may not  
3 take an hour. I like questions, so don't be  
4 bashful.

5 So, I am going to go through the  
6 slides relatively quickly. Please raise your  
7 hand and bring a point to my attention if  
8 there is something here that you need more  
9 information on.

10 This is the legislation which  
11 actually created the DODI. So, this was in  
12 2012. You can see that one of the things that  
13 is really clear here is the -- there is the  
14 laser pointer -- right here where it said that  
15 the program will be carried out in accordance  
16 with regulations as prescribed by the  
17 Secretary of Defense.

18 So, this DODI, which is now  
19 signed, the good thing I can tell you is that  
20 1322.29 is now a signed and official DODI and  
21 is being used. So, that was effective as of  
22 24 January 2014, so just in time for this

1 meeting.

2 Some of the things that are in the  
3 DODI I do want to kind of cover, at least  
4 expose you to them. So, the Secretaries of  
5 military departments are the ones that will  
6 ensure compliance with the document.

7 You can see here about providing  
8 opportunities, identification of Service  
9 members. One of the things that we're going  
10 to have to do as we go along is identify and  
11 document these civilian sector job training  
12 opportunities. And so, there's actually a  
13 form in the DODI that we will ask the Services  
14 to fill out as people participate, so that we  
15 can track what the type of training that is  
16 being offered, and then, how many people are  
17 participating in the program.

18 Memorandums of Understanding, this  
19 is a best practice. Special Operations  
20 Command has been using this authority through  
21 the DTM process for almost a year now, in  
22 fact, over a year.

1                   One of the things that they do  
2                   with many of the training opportunities and  
3                   the intern opportunities is to do an MOU with  
4                   the organization. So, it is clear as to what  
5                   authorities, responsibilities, et cetera, that  
6                   each party has as far as the program.

7                   Methodology, standards for  
8                   collecting metrics, and, of course, reviewing  
9                   proposals by the training providers.

10                   So, this slide I think is really  
11                   important. So, I will spend a few minutes on  
12                   this one. This really outlines the tenets of  
13                   the program, and there are several in here,  
14                   some of them added by lawyers, if you can  
15                   tell. I don't know how many lawyers are in  
16                   the room, but there is some lawyer-speak in  
17                   here, too.

18                   But the first one is that it is  
19                   voluntary. In other words, the Service member  
20                   themselves must take action to participate.  
21                   They will be informed about the opportunity,  
22                   but the Commander or your Platoon Sergeant is

1 not going to take you by the arm and say,  
2 "Okay, here, let's go participate in this  
3 program." It's voluntary. There is work to  
4 ensure that the Service member is  
5 knowledgeable on the opportunity, but you're  
6 not going to get your hand held here.

7 In fact, if you really think about  
8 the program, you want someone who is a self-  
9 starter because we'll talk in a minute why  
10 that is important.

11 Authorized by the first field  
12 grade commander with UCMJ authority. Why?  
13 Because the duty location for this individual  
14 could be miles away from the installation, and  
15 there is no supervision for that person.

16 So, this is why I think it is  
17 important that the person be a self-starter.  
18 I mean, they have to be motivated to want to  
19 do this and to complete it.

20 And the UCMJ piece is to make sure  
21 that that individual knows that they are going  
22 to be held accountable, because they are a

1 member of the United States military, to their  
2 behavior and completion of the training.

3 Mission requirements. So, again,  
4 this is a privilege, not a right, which means  
5 that if the mission can support allowing this  
6 person to participate, then the Commander will  
7 make that determination.

8 No conflict of interest, that is a  
9 lawyer thing to make sure that there isn't any  
10 conflicts between the training provider and  
11 the individual or the Department of Defense;  
12 undue conflicts, put it that way.

13 You can be recalled. So, if, for  
14 example, a balloon goes up and they put stop-  
15 loss in, and you need that individual back,  
16 they can be recalled back to their duty  
17 location to perform the military mission.

18 Training must be offered at  
19 minimal or no cost. Okay. This is a filter  
20 to make sure that they're not doing something  
21 that is in the end going to cost them a lot of  
22 money with maybe no favorable outcome for the

1 individual.

2 MEMBER DRACH: Sir?

3 MR. DiGIOVANNI: Yes?

4 MEMBER DRACH: Excuse me. If  
5 there is any cost, it is assumed by the  
6 Service member, not by the --

7 MR. DiGIOVANNI: That's correct.  
8 The one thing that we put in the DODI is that  
9 no appropriated funds can be used for this  
10 program, which means you're not going to be on  
11 TDY status. You're not going to get anything  
12 other than your normal salary and benefits.

13 MEMBER MUSTION: But you can go on  
14 a permissive TDY status?

15 MR. DiGIOVANNI: Correct.  
16 Correct. In fact, it is interesting to see  
17 how the Services will do it. We think it will  
18 be a permissive TDY because of the timing, but  
19 the Commander could just say that your duty  
20 location is Location X. But there is no TDY  
21 or per diem associated with this program.

22 And I think the last one, again,

1 is the high probability of post-employment.  
2 So, you want to make sure that, if you are  
3 going to let this person go and you're going  
4 to get a DoD salary, that there's a good  
5 probability that they will actually be  
6 employed if they successfully complete the  
7 training. So, this is why we're collecting  
8 statistics, because we have to understand the  
9 efficacy of the program.

10 But I think these are really the  
11 key tenets of it, and it also puts providers  
12 on notice to say, look, this isn't free, good.  
13 I mean, we're looking for training. You need  
14 to make that investment in the individual.  
15 And, too, there needs to be the potential for  
16 a job at the end of the training or  
17 internship.

18 MEMBER PHILLIPS: Would this cover  
19 certain technical schools where they'll train  
20 you and they promise we'll get you a job  
21 afterwards? Or is this directly with an  
22 employer?

1                   MR. DiGIOVANNI: The technical  
2 school issue, it depends. Most of the  
3 technical schools will not give you training  
4 for free, right, or at little or no cost? So,  
5 it doesn't really -- it is not designed to  
6 teach that.

7                   What it is designed to do is -- I  
8 can give you some examples. So, there is an  
9 apprenticeship program with the Pipefitters  
10 Union at Ft. Lewis-McChord. Okay? I think  
11 it's a 16-week training course. It's offered  
12 at no cost to the individual. They leave  
13 normally with a certification and a promise  
14 for a job. And I think 100 percent of their  
15 people, if you successfully completed and  
16 decide to move forward, are placed. That's  
17 the kind of program we're talking about.

18                   I've got another program where  
19 we're working with the construction industry,  
20 and we're not talking like small construction,  
21 but big construction, highways, bridges,  
22 things like that, the large buildings. They

1 will provide training for free and, then,  
2 place you in the construction industry. And  
3 the companies are like DynCorp, Fluor,  
4 Techtel, I mean big companies.

5 And so, those are the types of  
6 training opportunities that we are talking  
7 about.

8 MEMBER DRACH: So, are you working  
9 at all with Helmets to Hardhats?

10 MR. DiGIOVANNI: Yes, we have  
11 worked with Helmets to Hardhats. In fact, I  
12 also worked with the Guard and Reserve on  
13 Heroes to Hired. Also, in fact, I just took  
14 a briefing from them earlier this week.

15 But, again, what we are looking  
16 for is companies, industry, that are willing  
17 to invest in a Service member because that  
18 Service member's capabilities has value to the  
19 company. That's what we're looking for.

20 Any other questions on that slide?

21 MEMBER PHILLIPS: One quick  
22 question.

1 MR. DiGIOVANNI: Sir?

2 MEMBER PHILLIPS: The 180 days, I  
3 mean, how does that number come down in the  
4 Service?

5 MR. DiGIOVANNI: The temperature  
6 of the water in talking to the Services is  
7 that six months is going to be a pretty hard  
8 push. The program is authorized by law up to  
9 six months. We think that in application it  
10 is probably going to be somewhere in the 120  
11 to 90 to 60 days. It will be hard to get  
12 someone out six months prior.

13 We don't know yet because the only  
14 people that have used this authority so far  
15 has been Special Operations Command and Ft.  
16 Lewis-McChord, and I think a couple of the  
17 Marines, right? Have the Marines done it?

18 MR. CAIN: Yes, the Army at Joint  
19 Ft. Lewis-McChord and, then, also starting  
20 programs at Carson and Ft. Hood soon, and the  
21 Marines a little bit in the field.

22 MEMBER PHILLIPS: I was wondering,

1 next year or two years down the road, can that  
2 number be changed? Can that be flexible? Or  
3 does this have to go through the whole --

4 MR. DiGIOVANNI: The 180 days?

5 MEMBER PHILLIPS: -- the 180 days.  
6 If you find out that they really need 200 or  
7 75 or --

8 MR. DiGIOVANNI: See, that  
9 actually resulted in a change to Title 10.  
10 So, if you want to look up the passage, it's  
11 -- and I've quoted it a lot -- it's Title 10,  
12 Section 1143, paragraph (e).

13 MEMBER MALEBRANCHE: Yes, it's  
14 legislative, sir. So, yes.

15 MR. DiGIOVANNI: So, you would  
16 have to change Title 10. I mean, it's  
17 possible, but when you talk to the Services,  
18 you know, a four-year enlistment potentially  
19 becomes a three-and-a-half-year one. So, I  
20 don't know what the temperature of the water  
21 is to increase it. My guess is it's probably  
22 going to stay at the six-month period.

1                   These are some, you know, in an  
2                   attempt to help the Commander have some vetted  
3                   programs upfront, these types of resources are  
4                   the kinds of things that we would expect the  
5                   Service member and the Commander to talk about  
6                   when the Service member would propose  
7                   participating under this authority.

8                   You can see the internship piece  
9                   here at the bottom. So, that clearly falls  
10                  into the sweet spot for what the unions want  
11                  to do. I think another union organization we  
12                  have talked to is the Teamsters. They have a  
13                  similar program to the Pipefitters.

14                  One other thing on this, anybody  
15                  here from the VA? There should be, right?

16                  DIRECTOR DAILEY: Sorry, we lost  
17                  Ms. Malebranche to the briefing she had to  
18                  give to Secretary Shinseki.

19                  MR. DiGIOVANNI: Okay. So, I want  
20                  to take just a second to talk about an  
21                  opportunity we're working with the VA. So, we  
22                  are working with their Innovation Department,

1           and they have sponsored digital training that  
2           was DARPA-based. It is called Education  
3           Dominance.

4                        I think we have put about -- what  
5           is it? -- three cohorts of 20, Mr. Cain?  
6           What's the number? Somewhere in that area.

7                        What they have been doing is the  
8           VA actually paid for veterans to come and go  
9           through 18 weeks of training in Palo Alto,  
10          California. It is in the IT sector. You  
11          didn't particularly have to have any IT  
12          background; in fact, they didn't want you to.  
13          You had medium-level ASVAB scores.

14                       The three cohorts that have  
15          graduated averaged \$70,000 salaries and one  
16          graduate got a \$140,000 job with Amazon. And  
17          these guys had no tech background before they  
18          showed up.

19                       So, we are looking at the  
20          potential to use the 1143(e) authorities to  
21          put people through that DARPA course in Palo  
22          Alto. So, I just throw it out as an

1 opportunity.

2 But the \$140,000 graduate is a  
3 young man that is now basically digitizing one  
4 of Amazon's warehouses, and he is doing all  
5 the code with three other graduates. A pretty  
6 fantastic deal, and again, with no IT  
7 background before he went to an 18-week  
8 course. So, there are some great training  
9 opportunities out there, if we just simply  
10 leverage them.

11 This is an update from the chart  
12 that I showed you last year. I think it was  
13 2011 data last year. This is 2012 data. This  
14 gives you an idea of the demographics that  
15 people are getting out of the military. This  
16 is who got out in 2012.

17 And you can see here we used the  
18 number around 250,000. You can see here about  
19 273,000 people got out of the military in  
20 2012.

21 I'm going to through these pretty  
22 quickly, but we did a licensing/credentialing

1 pilot mandated by law. You can see the  
2 statistics up here, about 3500 Service  
3 members. These are the pilots that we worked  
4 on on the left through the congressional  
5 program. And then, on the right are the  
6 pilots that we worked with the White House to  
7 work through.

8 If you notice, each of these areas  
9 where there is a nice confluence of civilian  
10 and military occupations.

11 Some of the pilot findings --

12 MEMBER DRACH: Sir, excuse me.

13 MR. DiGIOVANNI: Yes. Go ahead.

14 MEMBER DRACH: I went back to the  
15 previous slide, but there was very specific  
16 criteria, 180 days active duty and within 180  
17 days of discharge. Is there any criteria for  
18 eligibility for the pilot?

19 MR. DiGIOVANNI: No. So, I  
20 changed gears on you just a little bit. This  
21 is a slightly -- in fact, it is a different  
22 initiative. It was required by Congress, and

1           what we are supposed to do is look at  
2           licensing or credentialing of Service members  
3           while they are still in the Service and, then,  
4           look at, is it more effective to do it while  
5           you're serving or is it more effective to do  
6           from an effectiveness and a cost perspective  
7           once you get out?

8                         And so, I will tell you, in the  
9           Services I get mixed reaction when I say this,  
10          but I think there is an advantage to the  
11          Department to licensing and credentialing our  
12          people, not just when they are ready to get  
13          out, but throughout their entire life cycle.

14                        Because, you know, we talk about  
15          the profession of arms and, yes, we have a  
16          very professional force, but I think it adds  
17          to our words about being professional if you  
18          can also show that you have met benchmarks in  
19          the civilian sector as far as the quality and  
20          level of competence of the people in the  
21          military.

22                        So, what I normally say about this

1 is the licensing/credentialing thing is not  
2 limited to separating Service members. There  
3 actually is an advantage to the Department to  
4 seek civilian licensing and credentialing  
5 while you're still in the Service.

6 And the last point I will make on  
7 this, also, from a lot of procurements that we  
8 are doing, we are doing a lot of off-the-shelf  
9 types of procurements and buying things that  
10 are available in the civilian community. So,  
11 knowing more about how that stuff works I  
12 think also helps us.

13 MEMBER DRACH: So, then, there's  
14 really no criteria other than to have your MOC  
15 be compatible with one of the occupations?

16 MR. DiGIOVANNI: Yes. A couple of  
17 the criteria were, you know, we picked these  
18 because they were similar to the MOCs that we  
19 have in the military. There was the high  
20 probability of employment post-military  
21 services, and the salaries were somewhat  
22 commensurate to the salaries that our Service

1 members were getting.

2 We actually looked at three  
3 different pipelines:

4 Initial functional training. So,  
5 you went through your initial training to be  
6 a welder or a mechanic. And if you were able  
7 to at that time, go ahead and seek a  
8 certification or license.

9 Mid-career, once you have the  
10 necessary experience, five-seven years is what  
11 a lot of these required.

12 And then, that, actually, one-year  
13 to 18-month point, as you get ready to  
14 separate, to again look at an opportunity to  
15 get a licensing/credential.

16 So, we actually looked at three  
17 lines of action, at three different phases in  
18 one's career, for licensing or credentialing  
19 opportunities.

20 The key findings, nothing I don't  
21 think that is earth-shattering here. I mean,  
22 obviously, we do see that an opportunity to

1 get these credentials on a voluntary basis is  
2 desirable in gaining institutional support.

3 There are some barriers, and a lot  
4 of those barriers are really related to  
5 finance. For example, there are restrictions  
6 on use of tuition assistance to do these kinds  
7 of work because tuition assistance is mainly  
8 focused on higher education.

9 So, I think in this legislation  
10 they passed inflexibility and to be able to  
11 use TA, is that right? No?

12 MR. CAIN: No, we thought they  
13 were, but they did not.

14 MR. DIGIOVANNI: It didn't pass?  
15 But at least there was some consideration of  
16 doing that.

17 But a lot of it is it's going to  
18 be up to the individual to pay for the  
19 licensing and credentialing opportunity above  
20 and beyond what the military needs are. I  
21 think that's what No. 2 is getting at.

22 So, there were some pilot programs

1 to look at using TA. We will see where the  
2 Services go with that.

3 This Item No. 10 here is a little  
4 misleading. You know, that's essentially the  
5 cost of the credential to take the test. It  
6 doesn't address any gap training or education  
7 that might be necessary to actually to meet a  
8 prerequisite. It is just what it costs to  
9 take the test.

10 Sir?

11 MEMBER DRACH: If the Service  
12 member is eligible for the GI bill as a result  
13 of his or her active duty, will the VA pay for  
14 the credentialing cost? They used to. I  
15 don't know --

16 MR. DiGIOVANNI: I believe that  
17 the answer to that question is yes.

18 MR. CAIN: Thank you. The GI bill  
19 after 2010 will, in fact, pay for  
20 credentialing costs, but for every credential  
21 you take, you knock a month off your 37-  
22 months' benefit. So, a benefit is worth total

1           \$2500-\$3500, depending on where you are and  
2           where you go to school. For a credential, it  
3           may cost less than \$500. So, it may not be a  
4           very good cost/benefit. But, right,  
5           technically, you can do that.

6                         MEMBER DRACH: Let me just follow  
7           up on that. I don't know whether the 2010  
8           legislation addressed this or not, but at one  
9           point in time -- think it was the Montgomery  
10          GI bill -- they would pay for the cost of the  
11          test, but they wouldn't pay for any costs  
12          associated with prep for the test.

13                        MR. CAIN: I believe that is  
14          correct.

15                        MEMBER DRACH: Okay. Thank you.

16                        MR. DiGIOVANNI: Yes. And what  
17          Mr. Cain is getting at is that, to take one  
18          test, you would have to burn a month's worth  
19          of GI bill benefits. That is what he is  
20          getting at.

21                        MEMBER MUSTION: So, is the  
22          Department of Defense taking on any action at

1 the national level with some of the national  
2 accrediting or credentialing agencies, unions,  
3 and other trade organizations to seek a waiver  
4 for a soldier, sailor, airman, and Marines to  
5 obtain credentialing?

6 Because what you have done is you  
7 have put the burden on the services to work  
8 their way through this. And I contend that at  
9 the national level this is something the  
10 Department of Defense --

11 MR. DiGIOVANNI: Yes.

12 MEMBER MUSTION: -- should be  
13 forging arrangements/agreements, MOUs of  
14 sorts, to recognize the program of instruction  
15 and certification that all members of the  
16 Department of Defense, depending on the  
17 specialty, have completed. Truck drivers, for  
18 example --

19 MR. DiGIOVANNI: So, are we on  
20 licensing/credentialing or are we on the job  
21 skills training?

22 MEMBER MUSTION: I'm talking about

1           licensing/credentialing.

2                       MR. DiGIOVANNI:  Yes.  So, you're  
3           right.  We have had dialogs with the VA for  
4           sure.  This is one reason why I asked if we  
5           had someone from the VA here.

6                       In the end, I will tell you that  
7           most of the burden is on the Service member  
8           because, when you look at the opportunities  
9           for paying for these things outside of  
10          military requirements, it is on the individual  
11          Service member.

12                      I do think, well, I do think that,  
13          as we look at military compensation, your  
14          question becomes important.  And I'll just  
15          leave it at that.

16                      MEMBER DeJONG:  I think I kind of  
17          understood what you said a little differently,  
18          sir, and let me try it with this.  Why  
19          wouldn't the Department of Defense work with  
20          these certifying agencies, the Department of  
21          Transportation to get truck drivers a CDL  
22          license; the Department of Health and Human

1 Services to give medics paramedic licenses,  
2 EMT licenses? Why wouldn't they work with  
3 these at the national level --

4 MR. DiGIOVANNI: Okay.

5 MEMBER DeJONG: -- to ensure that  
6 this is done? Is that what you were --

7 MR. DiGIOVANNI: Okay. Okay, I  
8 got it. So, I've got good news there. And in  
9 fact, most of the licenses that we talk about  
10 are actually granted by states. There are  
11 federal licenses, but most of them are granted  
12 by states.

13 So, for example, in the last year,  
14 we will be -- what? -- in four months 100  
15 percent complete, probably in that area. In  
16 four months, 100 percent of every state in the  
17 Union will offer a military Service member a  
18 military skills waiver to get a commercial  
19 driver's license. Every one of them have  
20 passed. And why? Because our office, in  
21 association with the Military Community and  
22 Family Policy, has actively worked with the

1 states to change legislation which allows them  
2 to do that.

3 And the First Lady challenged  
4 every Governor last year in February to get  
5 after the thing that you just said.

6 On the EMT and the medic issue,  
7 similar kinds of legislation. I don't think  
8 we're at the 100-percent mark, but --

9 MR. CAIN: Forty-six of the 50  
10 states.

11 MR. DiGIOVANNI: Thank you. I  
12 knew it was right around 50 percent. So,  
13 about 50 percent of the states actually will  
14 give you credit for having experience or  
15 training in the medical area.

16 Now the other thing I'm working on  
17 is we made a promise, right? So, we have  
18 asked these states to change legislation to  
19 give military members credit. Well, we can't  
20 pull the rug out from underneath them because  
21 the next question is going to be, well, what  
22 is a 68 Whiskey and what does the POI look

1           like and how much experience and training and  
2           education do they get? And how much credit do  
3           they get?

4                        So, I'm actually on contract, and  
5           we have been on contract now for about six  
6           months, to have a company build what I call a  
7           tech data package. Essentially, what it is is  
8           I looked at several -- and I'm focused on the  
9           medical profession, in particular -- I'm  
10          looking at several programs where community  
11          colleges have done a deep dive on programs of  
12          instructions in the medical field.

13                       And that's at three different  
14          levels. So, your basic medic; your kind of  
15          independent-duty corpsman, and a special  
16          operator medic. And they understand what each  
17          of the training and education that comes with  
18          those four kind of POIs.

19                       They have also developed a two-day  
20          competency-based exam. So, you can't always  
21          understand what somebody knows if you just  
22          look at what they got taught. So, then, they

1           put them through kind of a practical exam, two  
2           days. And at the end of that, they custom  
3           design a program for you if you want to be a  
4           paramedic, if you want to be an RN, if you  
5           want to be an LPN, whatever it is that you  
6           want to do.

7                        So, what I'm doing is I'm taking  
8           -- there are three schools that have done it,  
9           Tulane, Lance Community College, and Texas  
10          A&M. So, I'm having this guy go out there and  
11          look at all three of those programs and, then,  
12          build a technical package that says here's the  
13          decoder ring and here's three schools that  
14          have already done it that are accredited.

15                       So that, when someone asks, "Well,  
16          what did this person do," I go, "Look, here's  
17          the tech data package. You can kind of find  
18          that individual, you know, look up their  
19          qualifications in here, and that will at least  
20          give you some idea of how much credit you  
21          should award them."

22                       The other thing that I think they

1 absolutely have to do is they've got to look  
2 at a competency-based exam. You know, if  
3 you're really going to do this, what you learn  
4 on a combat battlefield is not written down  
5 anywhere, but you probably have some skills  
6 that you may not take credit for unless  
7 somebody asks you to do something.

8 So, we're going to encourage them  
9 to look at competency-based skills exams when  
10 they look at awarding a license or credit  
11 toward a license for a military Service  
12 member.

13 So, I think those are probably the  
14 two main thrusts. The other one we're looking  
15 at is in the law enforcement area. So, we are  
16 working with the National Governors  
17 Association because the states also have  
18 accrediting for police officer training and  
19 they have reciprocal agreements or reciprocity  
20 agreements with other states. So, we are  
21 looking at those three areas right now.

22 MEMBER DRACH: And I go back just

1 a couple of steps --

2 MR. DiGIOVANNI: Yes, sir.

3 MEMBER DRACH: -- to the earlier,  
4 the apprenticeship program. Are you doing  
5 anything to reach out to make this information  
6 available to those wounded, ill, and injured  
7 that are assigned to a WTU?

8 MR. DiGIOVANNI: Yes. So,  
9 probably not as active because my area is in  
10 training, and I'm mostly focused on Service  
11 members.

12 What I have done is, for example,  
13 in SOCOM I have a very good relationship with  
14 the Care Coalition Director. And on the DARPA  
15 program I talked about, I have actually said,  
16 "Look, let's look at opportunities to put some  
17 of those folks in, either using the 1143(e)  
18 authorities or, if you're already out, use  
19 your Voc Rehab capability to pay for that 18  
20 weeks of training.

21 So, I have, initially, in the last  
22 two weeks, I have opened up a dialog with the

1 WTUs, with the Reserve folks, and, also, I  
2 have had one with the Care Coalition for about  
3 18 months. So, that's kind of where I'm at on  
4 that. I'm probably not as far as I would like  
5 to be, but we're starting to coalesce.

6 MEMBER REHBEIN: Sir, in some of  
7 the skilled trades -- and welding is one of  
8 them; I see that as a White House pilot -- a  
9 certified welder is certified by the employer.  
10 And so, if that welder changes jobs, he has to  
11 recertify.

12 That presumes that, then, before  
13 you came become a certified welder, you have  
14 to be employed as a welder. PWS handles those  
15 things. Is there any work to try to get a  
16 certification for the military person?

17 MR. DiGIOVANNI: Let me see if I  
18 can answer, and then, I'll get Mr. Cain on it.  
19 So, what we have done is we have got, I think  
20 it is the schoolhouse at Ft. Pickett, right?

21 MR. CAIN: Ft. Lee.

22 MR. DiGIOVANNI: Ft. Lee.

1                   So, we've actually got military  
2                   instructors, third-party certified, to give  
3                   the welding exam to graduates. So, that kind  
4                   of helps them navigate that system because  
5                   they have been certified by the American  
6                   Welding Society to give that exam. And by the  
7                   way, that affects Army and Marines.

8                   And so, we have looked at a way to  
9                   do that, so that you don't have to be  
10                  employed, that we have actually got  
11                  instructors that are military that are  
12                  certified to do that.

13                  I talked to some folks up in  
14                  Canada that are working the oilfields. And  
15                  they don't care if you're certified or not.  
16                  They told me, they said, "Look, you can come  
17                  with all the certifications in the world, but  
18                  we are going to give you a competency exam.  
19                  So, we're going to tell you to do three types  
20                  of welds. And if you pass those welds, you  
21                  get a job."

22                  So, it is kind of what you said.

1           In some cases, people are going to want to do  
2           that anyway because of the liability  
3           associated with that kind of work.

4                     But I think the third-party thing  
5           answers your question, your concern.

6                     MEMBER PHILLIPS: I'm curious  
7           about potential pushback from an employer.  
8           For example, if someone goes through the DARPA  
9           skilled program, and before they leave active  
10          duty they come back and say, "Well, I have a  
11          new skill. I want to stay in and be in Cyber  
12          Command," does that happen? Because the  
13          employers are putting time and effort into  
14          this.

15                    MR. DiGIOVANNI: We haven't had  
16          anybody go through the DARPA course, for  
17          example, on the IT side. They have all been  
18          vets.

19                    I think you have to already have  
20          filed for separation, which means that the  
21          only way you could actually come back is the  
22          military would have to say, "Okay, let's tear

1 up your separation papers." And they might,  
2 and there is some liability there.

3 I would think that would be  
4 something you would want to talk about if you  
5 did an MOA with somebody to say, "Look, we're  
6 not going to let you train these people for  
7 free and, then, steal them back." I mean, we  
8 probably should say, no, if they go into this  
9 program, they're getting out. But that is an  
10 interesting thing, and I will keep that in  
11 mind.

12 I'll tell you, there is some  
13 concern with this program on the other side,  
14 which is we go around and tell people that  
15 we've got this opportunity, and then,  
16 Commanders don't take advantage of it, right?  
17 So, I don't want to overpromise, either.

18 This program is very new, which is  
19 why we need to collect data on it to say,  
20 "Well, our Command is actually releasing  
21 people to go do these programs," or not.

22 MEMBER DeJONG: I think you're

1 going to have a hard time with that.

2 MR. DiGIOVANNI: I think there are  
3 concerns there as well. I think your comment  
4 -- which is why I mentioned it, because I do  
5 want to make sure that I don't overpromise the  
6 program.

7 MEMBER MUSTION: I don't think so  
8 they can take issue with it, at least on the  
9 active side, for the next three to five years  
10 because we're going from 525-528 in the Army  
11 active side down. Early-out authorities that  
12 were recently received approval of to let  
13 soldiers out of the Army after 360 days or 265  
14 days early.

15 In the readiness path we're on, I  
16 think the challenge that we will have is  
17 finding enough opportunities for these  
18 internship programs or our apprenticeship  
19 programs and credentialing programs. So that  
20 we can facilitate a smooth transition for  
21 soldiers and others from the other Services  
22 out of the military and into the civilian

1 world, the civilian sector.

2 MEMBER DeJONG: No, I understand  
3 that.

4 MEMBER MUSTION: I think the model  
5 that we had at JBLM and what that union was  
6 able to work is a great example, but that is  
7 an isolated pocket of success of 20 or so  
8 soldiers. So, how do you proliferate that  
9 across the United States?

10 MR. DiGIOVANNI: Yes, sir.

11 MEMBER DRACH: So, your current  
12 slide says, "Key pilot program findings".  
13 Does that mean that there is a full-blown  
14 report? And if so, can it be shared?

15 MR. DiGIOVANNI: That report, I  
16 don't think it's posted publicly. Or is it  
17 now public?

18 MR. CAIN: It's available to the  
19 public. I mean, we didn't post it on the  
20 website.

21 MR. DiGIOVANNI: Yes.

22 MR. CAIN: But it has been

1 released to Congress.

2 MR. DiGIOVANNI: Yes. So, if you  
3 would like a copy of it, please let me know  
4 and we'll get you a copy of it.

5 MR. CAIN: I'll send David a copy.

6 MR. DiGIOVANNI: But it was open.  
7 We sent it to Congress, so it is an open  
8 report.

9 But it's focused on that  
10 licensing/credentialing pilot, and not on the  
11 1143(e) stuff, just to be sure I manage the  
12 expectations. Okay?

13 So, I'm rolling this out. This  
14 will be the first time it has been rolled out  
15 publicly.

16 This is an app that we're working  
17 on. Mr. Vollrath named it Skillbridge. And  
18 just what it sounds like, what it is, it's an  
19 app that will be used by both employers and  
20 the Service member to link them to job  
21 training opportunities while they are still in  
22 the military.

1                   So, we are hoping to use the  
2                   Transition GPS and word of mouth to ask  
3                   people, to say, "Look, if you're interested in  
4                   these job training opportunities, then this  
5                   app is one way that employers can connect to  
6                   you."

7                   I don't think there's another  
8                   slide here. No.

9                   So, what this thing has is it uses  
10                  tweets. It is a Twitter-based app. There's  
11                  a specific format you have to follow.

12                 And really, the vision here was to  
13                 kind of look, what's the 21st century version  
14                 of a classified ad for a job training  
15                 opportunity. So, a tweet is actually about  
16                 right when you look at brevity of characters  
17                 and communicating a maximum amount of  
18                 information in a little bit of space.

19                 And so, if you look at the  
20                 demographs that we were trying to communicate  
21                 with, they're not going to read a War and  
22                 Peace document. But a tweet that you get a

1 notification on on your mobile device that  
2 says, "Hey, the Ft. Lewis-McChord guys are  
3 going to kick off their next welding course,  
4 and it's going to be in three weeks. If  
5 you're interested, here's the URL link to link  
6 to their site to sign up for it." That's kind  
7 of how it is going to work.

8 So, employers can go into this  
9 thing and provide job training announcements.  
10 You sign up for hashtags. So, look, I'm not  
11 a big Twitter guy, but I'm just going to --  
12 and you're laughing, as you should -- I'm not  
13 a big Twitter guy, but my vision is to divide  
14 the job training categories by hashtag.

15 So, if you're interested in being  
16 a commercial drive or if you're interested in  
17 being a welder, if you're interested in the  
18 construction business, then you can sign up to  
19 get tweets about job training opportunities  
20 categorized by hashtag. Okay? So, everybody  
21 got me on that?

22 MEMBER DeJONG: Just to clarify,

1 I'm not laughing at you; I'm laughing with  
2 you.

3 MR. DiGIOVANNI: There you go. I  
4 do tell people that I am a digital immigrant.  
5 I do tell them that. I am a digital  
6 aborigine. So, I was here before they had  
7 Twitter.

8 But I think this is an excellent  
9 opportunity. I mean, many of you have heard  
10 this, but over and over again industry says,  
11 "How do I talk to the Service member before  
12 they get out? How do I do that?"

13 You're not going to get everybody  
14 on the base. There isn't time nor facilities  
15 to do that. But, if you can reach out to them  
16 virtually via a tweet, then you've just opened  
17 up some great opportunities for our Service  
18 members and for industry that are looking to  
19 hire Service members, to notify them of job  
20 training opportunities.

21 And I do advanced distributed  
22 learning for the whole federal government.

1           So, that was actually a built in-house level  
2           of effort. So, no cost there. I just  
3           reprioritized what they were doing.

4                        But that's about ready to get  
5           rolled out. In fact, if any of you would like  
6           to help me prototype it, I'm looking for some  
7           people to help me prototype it. I don't have  
8           it.

9                        We're also talking about whether  
10          or not we're put it -- you know, when I say,  
11          "Put it out in the wild," what I mean is that  
12          you could go to the Apple store and download  
13          or you can go to the Android store and  
14          download it. Or, if it is going to be  
15          something that's in-house, you have to go to  
16          a website and download. We're still looking  
17          at it. But I'm more likely to try to put it  
18          out in the wild where it is more accessible.  
19          That is kind of where we're going with that.

20                       And then, I think this next one  
21          was just the last slide, and I think I've  
22          covered everything.

1 Questions?

2 DIRECTOR DAILEY: Real quick, Mr.  
3 DiGiovanni, that particular Skillbridge, is it  
4 going to be advertised also through the GPS  
5 Transition classes? Okay. So, that's --

6 MR. DiGIOVANNI: So, a strategic  
7 partnership with Dr. Susan Kelly --

8 DIRECTOR DAILEY: Okay. Good. We  
9 know Dr. Kelly, yes.

10 MR. DiGIOVANNI: to make sure, and  
11 we have been working with her very closely  
12 through the entire development period.

13 DIRECTOR DAILEY: Yes, yes.

14 MR. DiGIOVANNI: Because,  
15 otherwise, it's word of mouth.

16 DIRECTOR DAILEY: Sure.

17 MR. DiGIOVANNI: The only way to  
18 get it out to Service members is by word of  
19 mouth.

20 DIRECTOR DAILEY: Right. Good.  
21 So, GPS Transition programs will be passing  
22 out that information on how to link into

1 Skillbridge?

2 MR. DiGIOVANNI: Yes.

3 DIRECTOR DAILEY: Because, as you  
4 noted, 273,000 people left the military last  
5 year.

6 MR. DiGIOVANNI: Yes.

7 DIRECTOR DAILEY: Theoretically,  
8 they're all supposed to be going through GPS  
9 Transition programs.

10 MR. DiGIOVANNI: Yes.

11 DIRECTOR DAILEY: And  
12 theoretically, you would, then, be delivering  
13 that to all 270,000 departing individuals.

14 MR. DiGIOVANNI: Yes.

15 DIRECTOR DAILEY: That would be  
16 not a bad marketing effort annually.

17 Okay. So, good. Thank you.

18 MR. DiGIOVANNI: One other quick  
19 thing on that that I would tell you will help  
20 us is, right now, we're looking at having a  
21 very small interface. In other words, we  
22 don't want just anybody putting their job

1 training opportunity up there because they  
2 could have malicious intent, or just whatever.

3 So, there will be a small filter  
4 that says, "Look, if you want to post here,  
5 then there's a small vetting process."

6 The other thing that does is it  
7 allows us to look at statistics. So, how many  
8 people are using the website? How many people  
9 are actually responding to a tweet? How many  
10 people have signed up to give us jobs?

11 So, we think that collecting  
12 statistics on that will help us understand if  
13 these kinds of programs are going to be really  
14 effective.

15 MEMBER DeJONG: Sir, have you  
16 reached out to any of the major employment  
17 agencies, CareerBuilder, Monster, anybody like  
18 that? Because I know particularly  
19 CareerBuilder was building an MOS tool similar  
20 to what you were talking about that actually  
21 broke it down as far as the ASVAB score to  
22 look at fine technical -- more than just a GT

1 score like they normally use in the Army.

2 So, in lack of duplicating efforts  
3 like we do so well, have you reached out to  
4 them and seen what --

5 MR. DiGIOVANNI: In fact, I've  
6 talked to Monster.com a couple of times. And  
7 Heroes to Hired also has a very -- in fact,  
8 they told me, they said, "Look, you know,  
9 don't waste your time building one of those  
10 crosswalk things. What we have in that  
11 program is really, really good."

12 This thing is kind of niche in  
13 that my purpose for doing it is job-skills-  
14 training-focused only. And it's for while  
15 you're still in the military. Now, when you  
16 get out, can you still use it? Yes, I'm not  
17 going to -- I don't think we should try to  
18 filter that. But it is focused on a very  
19 niche thing. It's getting the people to sign  
20 up to use it and, also, getting the industry  
21 to post things there.

22 MEMBER DeJONG: And I guess

1 further to go with that, that might be a way  
2 to reach out to industry to come back. Those  
3 agencies know who is looking for work. They  
4 also know the skills. But they are also for-  
5 profits. So, you've got to play the --

6 MR. DiGIOVANNI: You're right,  
7 which is why that 1143(e), the lawyers took  
8 some time before they put the caveats in there  
9 that they did, because they were worried about  
10 just those kinds of things that you just said.

11 MEMBER DRACH: A couple of things.  
12 I just want to throw this out without a  
13 recommendation.

14 MR. DiGIOVANNI: Sure.

15 MEMBER DRACH: Are you aware of  
16 DirectEmployers, based in Indianapolis?

17 MR. DiGIOVANNI: I'm not, sir.

18 MEMBER DRACH: Okay. It's  
19 something to think about, kind of building on  
20 what the Command Sergeant Major just said  
21 about reaching out. I need to think whether  
22 that is a good conduit or not.

1                   I may be mixing apples and oranges  
2                   in this next comment or question, but they're  
3                   both in the same bucket. I know your program  
4                   is statutory, your pilot.

5                   MR. DiGIOVANNI: Uh-hum.

6                   MEMBER DRACH: I don't know  
7                   whether the one that NGA is doing with the  
8                   Department of Labor and the six-state pilot,  
9                   whether that is statutory or not.

10                  MR. DiGIOVANNI: It is statutory.  
11                  It is driven by the VOW Act.

12                  MEMBER DRACH: That's what I  
13                  thought.

14                  And you mentioned doing work with  
15                  NGA. Have you all compared notes and the  
16                  like --

17                  MR. DiGIOVANNI: Yes, absolutely.

18                  MEMBER DRACH: -- at the  
19                  beginning?

20                  MR. DiGIOVANNI: Yes. We have  
21                  been --

22                  DIRECTOR DAILEY: Okay. Hold on.

1 NGA is --

2 MR. DiGIOVANNI: National  
3 Governors Association.

4 DIRECTOR DAILEY: Thank you.

5 MR. DiGIOVANNI: Sorry.

6 We have been a partner from the  
7 very beginning with the Department of Labor  
8 and the National Governors Association. And  
9 that NGA partnership was competed by the  
10 Department of Labor, and that's who won the  
11 competition.

12 MEMBER DRACH: Did you have any  
13 input or wish you had had input into the six  
14 states that they identified for the pilots?

15 MR. DiGIOVANNI: We did. Not only  
16 did we have input in the states, but we also  
17 had inputs in the occupational focus. In  
18 fact, I believe that the law enforcement focus  
19 came from us. They looked and said, "Hey, we  
20 want to do medical; we want to do truck  
21 drivers. What else can we do?" And we  
22 settled on police.

1                   MEMBER DRACH:  So, you have  
2                   submitted your report to Congress.  Do you  
3                   know whether or not NGA has submitted their  
4                   report?

5                   MR. DiGIOVANNI:  That report is  
6                   still ongoing.  When is that report due, Mr.  
7                   Cain?

8                   MR. CAIN:  The states are working  
9                   the details now.

10                  MR. DiGIOVANNI:  Just tell me what  
11                  it is, and I'll repeat it.

12                  MR. CAIN:  Early 2015.

13                  MR. DiGIOVANNI:  Early 2015 for  
14                  the report from the Department of Labor and  
15                  NGA.

16                  MEMBER DRACH:  Thank you.

17                  MR. DiGIOVANNI:  Anything else?

18                  DIRECTOR DAILEY:  We were just  
19                  down talking with Kevin McDonnell and his  
20                  team.  We gathered many of the same products  
21                  that he has provided you, and we were going to  
22                  put them in the report as opportunities for

1 the Services to use them as templates.

2 Obviously, you have already done that in your

3 DODI. Thank you very much.

4 MR. DiGIOVANNI: Uh-hum.

5 DIRECTOR DAILEY: Mr. McDonnell

6 and SOCOM have also been very, very strongly

7 advocating their program for intelligence-

8 based job hunting. Can you give me what you

9 thought of that program and their advocacy for

10 this type --

11 CO-CHAIR CROCKETT-JONES:

12 Crossroads or Soft Crossroads.

13 MR. DiGIOVANNI: Yes, the good

14 thing is I don't know the company.

15 DIRECTOR DAILEY: Good.

16 MR. DiGIOVANNI: So, that's good.

17 I did see a demo of it and I talked to them

18 about -- actually, I think I talked to them

19 last week about it.

20 So, I think there is an area where

21 that could be useful because a lot of the

22 systems that we have now that do job searches

1 or they do resume searches, it is a pure word  
2 search kind of thing. And so, you really do  
3 need to have some kind of artificial  
4 intelligence that understands that, if you  
5 say, you know, that you're -- I don't know.  
6 He showed an example. It had to do with  
7 something in intelligence, that you knew that  
8 intelligence has multiple other kinds of  
9 meanings. Because a lot of these word search  
10 things, if you don't find the specific word,  
11 then you get kicked out.

12 So, it helps both companies to  
13 look at resumes to see, well, what I really  
14 wanted was a security analyst that was focused  
15 on counterespionage. Okay. So, you put in  
16 counterespionage. And then, if you don't find  
17 the word "espionage," then you get kicked out.  
18 But if it has intelligence, it knows that, oh,  
19 well, maybe if you have intelligence  
20 background, you probably have some espionage  
21 background. So, let's give them that. Let's  
22 give them that resume.

1                   So, I think there is a lot of  
2                   capability out there. There are other things  
3                   besides what SOCOM is pursuing in that area.  
4                   I mean, in the end, it still is a rule-based  
5                   AI, artificial intelligence. So, it is not  
6                   perfect.

7                   But I do think that there is some  
8                   ground to be gained by looking at innovations  
9                   like that to make better matches.

10                  Anything else?

11                  (No response.)

12                  All right. Boy, I got off a lot  
13                  easier this time than I did the last time.

14                  (Laughter.)

15                  DIRECTOR DAILEY: Thank you, Mr.  
16                  DiGiovanni.

17                  MR. DiGIOVANNI: You're welcome.  
18                  Thank you.

19                  DIRECTOR DAILEY: And we're very  
20                  appreciative of your efforts to get this DODI  
21                  published. We have been tracking it for a  
22                  while. Anyone who can get a DODI published

1           who has taken on the Services with as much  
2           pushback as we know you got and said, "We're  
3           going to do this anyway," is a hero for us.

4                       MR. DiGIOVANNI: Thank you.

5                       DIRECTOR DAILEY: Thank you.

6                       CO-CHAIR CROCKETT-JONES:

7           Absolutely. It must be nice, you didn't have  
8           to bury the lead. You could just give us the  
9           answer we were bugging you for last time. It  
10          must have been a little less --

11                      MR. DiGIOVANNI: Well, I knew you  
12          would ask me again.

13                      CO-CHAIR CROCKETT-JONES:

14          Absolutely.

15                      Thank you very much.

16                      MR. DiGIOVANNI: You're welcome.

17          Thank you very much for what you do.

18                      CO-CHAIR CROCKETT-JONES: We'll  
19          take a 10-minute break and come back in time  
20          for our next briefing.

21                      (Whereupon, the foregoing matter  
22          went off the record at 1:48 p.m. and went back

1 on the record at 2:00 p.m.)

2 CO-CHAIR CROCKETT-JONES: Okay, we  
3 now welcome representatives from TRICARE  
4 Management Activity, Health Net Federal  
5 Services, and United Healthcare, who will  
6 brief the Task Force on programs and processes  
7 for Recovering Warriors through Health Net and  
8 United Healthcare.

9 On the phone, we have joining us  
10 Ms. Patricia Reilly, a nurse consultant from  
11 the TRICARE Regional Office West, as well as  
12 Ms. Sheri Erickson, Ms. Teresa Pierce, Ms.  
13 Yvonne Harrington, who are representatives  
14 from United Healthcare. In person, we also  
15 have Ms. Brandi Barnette, a nurse consultant  
16 with TRICARE Regional Office North, and Ms.  
17 Eileen Yeager, the National Capital Region  
18 Director of Medical Management for Health Net  
19 Federal Services. The members can find this  
20 information under their tab M.

21 I'm going to turn this over to Ms.  
22 Barnette and Ms. Yeager.

1 MS. BARNETTE: Thank you. Good  
2 afternoon, Task Force Members.

3 I'm going to apologize in advance  
4 for my voice. I am getting over laryngitis.

5 I would like to thank you all for  
6 the opportunity to talk to you about how the  
7 purchase care system also supports our  
8 Recovering Warriors.

9 And I work at TRICARE Regional  
10 Office North. And so, Health Net Federal  
11 Services is our Managed Care Support  
12 Contractor. I am going to talk about their  
13 program, which is the Warrior Care Support  
14 Program.

15 Okay. The Warrior Care Support  
16 Program provides individualized care  
17 coordination and transition planning to  
18 active-duty Service members in any of the  
19 uniformed Services, including Reserve  
20 component and National Guard members with  
21 active-duty status who are severely injured or  
22 ill and who meet the Warrior Care Support

1           Program diagnosis criteria, which we will  
2           cover in a later slide.

3                       The collaboration between the  
4           Managed Care Support Contractor, which is  
5           Health Net, and the government includes  
6           collaboration with the NTF staff as well as  
7           the Warrior Transition Unit staff, case  
8           managers.

9                       The role of the case manager for  
10          the Warrior Care Support, who are known as  
11          Healthcare Coordinators, they serve as a  
12          single point of contact for the warrior and  
13          their families or for the NTF or WTU case  
14          managers for all the civilian care  
15          coordination.

16                      Okay. The Warrior Care Support  
17          Program was established in August of 2007.  
18          Since inception, there have been 5,887 Service  
19          members that have been enrolled. There are  
20          currently 319 Service members receiving  
21          services at this time.

22                      And then next slide reviews the

1 demographics, with the Army having the highest  
2 number of enrollees, followed by the Marine  
3 Corps, and then, the other Services.

4 We had a question regarding  
5 customer satisfaction. At this time --

6 DIRECTOR DAILEY: Hang on. Hang  
7 on just a minute. I apologize.

8 MS. BARNETTE: Yes.

9 DIRECTOR DAILEY: We do have some  
10 puzzled looks among my members. So, let me  
11 see if I can clarify.

12 So, at the TRICARE Management  
13 Agency level, there are some dedicated  
14 resources that -- and I'll use this -- MCSC,  
15 this is the Military --

16 MS. BARNETTE: The Managed Care  
17 Support Contractor.

18 DIRECTOR DAILEY: Okay. This is  
19 the Managed Care Support Contract. And so,  
20 these are TRICARE Management Agency and  
21 contractor resources that are dedicated to  
22 facilitating the civilian care piece for

1 wounded, ill, and injured and that categorized  
2 as wounded, ill, and injured?

3 MS. BARNETTE: Yes, ma'am.

4 DIRECTOR DAILEY: Okay? Are we  
5 all clear now? This is not MTF. This is not  
6 a nurse case manager in an MTF. This is  
7 TRICARE Management Agency and contractor  
8 resources facilitating civilian care services.

9 Okay. You may proceed.

10 CO-CHAIR CROCKETT-JONES: Can I  
11 ask, is the IC3 the lead coordinator and aware  
12 of and is this part of their --

13 DIRECTOR DAILEY: That might be  
14 one of my questions. It might be one of the  
15 questions.

16 CO-CHAIR CROCKETT-JONES: I'll be  
17 patient. Okay.

18 MS. BARNETTE: It is not one of  
19 the questions that we were supplied.

20 DIRECTOR DAILEY: Well, let us get  
21 there, then.

22 MS. BARNETTE: Okay.

1                   DIRECTOR DAILEY: I need everyone  
2                   to get the same knowledge base, understand the  
3                   A's, B's, C's, and then, we'll get to more  
4                   sophisticated questions.

5                   MS. BARNETTE: Okay. Okay, so  
6                   customer satisfaction, at this time surveys by  
7                   the Managed Care Support Contractors are  
8                   prohibited by the DHA, but they have received  
9                   positive feedback thus far regarding their  
10                  program.

11                  And the next slide covers the  
12                  diagnosis criteria that will allow access into  
13                  the program. They have to be severely ill or  
14                  injured and, as you see above, the following  
15                  diagnoses will grant them access into the  
16                  program as far as the purchased care side.  
17                  Reserve components are eligible as well, as  
18                  long as they show eligible in DEERS.

19                  MEMBER EUDY: So, if they happen  
20                  to fall out of DEERS on the Reserve component  
21                  side, do they, then, have to be re-placed in  
22                  there? Or do they stay in the program as long

1 as they have been inputted initially?

2 MS. BARNETTE: Ms. Yeager, I'll  
3 let you answer.

4 MS. YEAGER: They have to be  
5 TRICARE-eligible. It's a TRICARE program.

6 DIRECTOR DAILEY: So, if fall out  
7 of DEERS, they have fallen out of TRICARE, and  
8 they have to go through the process of re-  
9 enrolling. So, yes.

10 MS. BARNETTE: Okay. As far as  
11 referrals, referrals are received from the  
12 NTF, from the VA. And Health Net has an  
13 internal medical management system that is  
14 based on the diagnosis codes that will also  
15 refer wounded, ill, and injured into their  
16 program.

17 CO-CHAIR CROCKETT-JONES: Okay,  
18 but here's one of my questions: the diagnoses  
19 that you list, though, we have huge numbers  
20 with some of those diagnoses. Is there a  
21 further criteria that triggers enrollment?  
22 Because your enrollment numbers versus those

1           who have been, say, separated due to TBI and  
2           PTSD, medically retired, you know, those  
3           numbers are pretty large.

4                       I'm wondering if there is some  
5           secondary -- put it this way: how do you  
6           assess that someone is severe enough to be in  
7           your program beyond those diagnoses?

8                       MS. BARNETTE: Would you like  
9           to --

10                      MS. YEAGER: I'll give that a  
11           stab.

12                      The criteria for selection, these  
13           are Service members who are getting care in  
14           the civilian network. So, that takes a lot of  
15           them out.

16                      CO-CHAIR CROCKETT-JONES: Okay.

17                      MS. YEAGER: When we receive a  
18           care request for any kind of civilian care, it  
19           is an active-duty Service member and they are  
20           primarily injury codes and for behavioral  
21           health, Post Traumatic Stress Disorder. It  
22           triggers an automatic referral.

1                   And we will follow them as long as  
2                   they are receiving civilian care until they  
3                   either do not want to be engaged in the  
4                   program or they return to full duty or they  
5                   are medically retired. If they still have  
6                   needs at that time, we will transition them to  
7                   our traditional case management program.

8                   MEMBER MUSTION: So, if I could  
9                   maybe a question from a little bit different  
10                  angle? At a couple of installations that we  
11                  have been to, we were told that a number of  
12                  soldiers that are in our WTCs or WTUs at some  
13                  installations are being referred into the  
14                  network to receive care, principally  
15                  behavioral healthcare at one particular  
16                  installation.

17                  So, would those soldiers be part  
18                  of this program?

19                  MS. YEAGER: Yes.

20                  MEMBER MUSTION: I mean, I can't  
21                  give you a specific name or those sorts of  
22                  things, but --

1 MS. YEAGER: Yes, yes. For  
2 behavioral health, we are focused on Post  
3 Traumatic Stress Disorder diagnosis. When we  
4 receive a referral, we contact the case  
5 manager at the military treatment facility or  
6 if they are in a WTU, and we collaborate to  
7 determine who is going to follow the case.  
8 Sometimes we do that together. Sometimes we  
9 are told, "We're doing okay by ourselves."  
10 Most of the time, we enroll them in our  
11 program and work collaboratively with the  
12 direct-care system.

13 MS. BARNETTE: Okay. Which is a  
14 nice segue into our next slide, which is  
15 assisting with psychological needs. They do  
16 have Behavioral Health Coordinators that work  
17 with the Recovering Warriors with PTSD, as Ms.  
18 Yeager stated.

19 They do screening services to  
20 include the PHQ-2 Depression Screening and the  
21 PTSD screening, which is also used by the VA;  
22 communicate the findings to the PCM and

1 coordinate/collaborate with direct care with  
2 the civilian and the VA providers and offer  
3 transition planning, which she covered.

4 Okay. In reference to care  
5 coordination and case management, the focus is  
6 on coordinating the civilian care, the  
7 purchased care, with the direct-care system on  
8 behalf of the Recovering Warrior, and to also  
9 support transition from active-duty status.

10 Through Health Net, they are able  
11 to monitor all civilian care and anticipate  
12 the coordination needs at the time of  
13 separation and collaborate with all involved  
14 parties, NTF, VA, and other entities, in  
15 coordinating the care.

16 MEMBER DeJONG: Can I ask a quick  
17 question? And this may be self-explanatory,  
18 but I'm trying to see if I'm interpreting it  
19 right.

20 What types of conditions would the  
21 VA refer an individual to? Is it just  
22 something that the VA facility itself can't

1 handle? I'm kind of lost at where the VA  
2 would refer someone to outside care. And  
3 could you further explain that to me and how,  
4 or give me an example of how that would work?

5 MS. YEAGER: Would you like to  
6 answer?

7 DIRECTOR DAILEY: Well, so when  
8 someone is going to the VA under their TRICARE  
9 benefits --

10 MEMBER DeJONG: Right.

11 DIRECTOR DAILEY: -- they're  
12 getting TRICARE, and VA doesn't have an MRI at  
13 that facility.

14 MEMBER DeJONG: Okay. That's what  
15 I thought.

16 DIRECTOR DAILEY: Okay.

17 MEMBER DeJONG: I just wondered.  
18 Okay. But that's what I thought and I just  
19 wanted to clarify that.

20 DIRECTOR DAILEY: Now, reality --

21 MS. YEAGER: Generally, in this  
22 program these are folks who are still active-

1 duty. So, they haven't transitioned to the  
2 VA. But it would be very similar.

3 A good example would be someone  
4 who is being discharged from a military  
5 hospital and needs home healthcare, and they  
6 don't have home healthcare as part of the  
7 direct-care system. So, they would send an  
8 authorization to us, to Health Net, to arrange  
9 for and authorize home healthcare.

10 MEMBER DeJONG: Okay. That makes  
11 sense. Thank you.

12 MS. BARNETTE: And that is all of  
13 the briefing. I'll open it now to any other  
14 questions.

15 MEMBER REHBEIN: When you talk  
16 about the screenings, the psychological needs,  
17 let me make sure I understand correctly.  
18 You're talking on that slide about people that  
19 already have a PTSD diagnosis, correct? I  
20 guess I'm wondering what the additional  
21 screening does.

22 MS. YEAGER: We would be doing

1           that screening on Service members who came to  
2           us for another diagnosis. So, perhaps they  
3           came with a trauma diagnosis or a burn. We  
4           would do the Post Traumatic Stress Disorder  
5           screening with them.

6                         DIRECTOR DAILEY: Okay. So, when  
7           you say, "We would do...", you mean that you  
8           would authorize the provider --

9                         MS. YEAGER: No, we would  
10          actually --

11                        DIRECTOR DAILEY: Who's "we"?  
12          Who's "we"?

13                        MS. YEAGER: Okay. We have nurses  
14          and social workers who serve in the role of  
15          Warrior Care Support Coordinators with Health  
16          Net Federal Services.

17                        DIRECTOR DAILEY: Okay. Some way  
18          or another, I'm not getting you in that  
19          speaker. I'm not hearing you.

20                        MS. YEAGER: Oh, okay. Is that  
21          better?

22                        DIRECTOR DAILEY: There you go.

1           Much better.

2                       MS. YEAGER: My fault.

3                       Okay. We have clinicians who are  
4 working in the role of Warrior Care Support  
5 Coordinator. They are primarily nurses. We  
6 have some social workers doing behavioral  
7 health.

8                       And they would, when they worked  
9 with the Service member around their care  
10 coordination, they would be administering the  
11 Post Traumatic Stress Disorder screening tool  
12 with the consent of the vet, of the Service  
13 member.

14                      So, if they are already coming to  
15 us with that diagnosis, we wouldn't be looking  
16 for it. These would be folks with physical  
17 health diagnoses.

18                      DIRECTOR DAILEY: Okay.

19                      MS. YEAGER: So, we just want to  
20 identify who hasn't been identified.

21                      DIRECTOR DAILEY: Okay.

22                      MEMBER REHBEIN: So, you get a

1 nurse face-to-face with everyone that's  
2 referred into your system?

3 MS. YEAGER: It's telephonic.

4 MEMBER REHBEIN: It's telephonic?

5 MS. YEAGER: It's telephonic, yes.

6 DIRECTOR DAILEY: All right. So,  
7 there is no office space that you have set up  
8 where they're coming to you for a service?

9 MS. YEAGER: No. No.

10 DIRECTOR DAILEY: Okay. So, these  
11 screenings are telephonic?

12 MS. YEAGER: Correct.

13 DIRECTOR DAILEY: And it's not a  
14 referral. It is being delivered by your  
15 services?

16 MS. YEAGER: Correct.

17 DIRECTOR DAILEY: Okay.

18 MEMBER REHBEIN: And it's looking  
19 for additional conditions?

20 MS. YEAGER: Yes. It's trying to  
21 identify anyone who may have gone undetected.  
22 And then, we just report that. We have a

1 conversation with the primary care manager and  
2 let them take it over. We are not treating  
3 people.

4 CO-CHAIR CROCKETT-JONES: So, what  
5 are your caseloads like? You have 319 current  
6 Service members receiving these services. How  
7 many folks do you have for those 319?

8 MS. YEAGER: We have six, six  
9 people. Now we have levels in the program.  
10 When we started the program, we wanted to be  
11 very careful that we didn't duplicate or  
12 create too many people for the Service members  
13 to deal with because many of them are engaged  
14 with case management in the direct-care  
15 system.

16 So, when we get a referral -- and  
17 I think I mentioned that earlier -- the first  
18 thing we do is we get to the military  
19 treatment facility case management team and  
20 say, "We can be the primary on this, if you  
21 want. But you're leading it. We'll be  
22 primary for you."

1                   So that, if the case manager, say,  
2                   at Walter Reed is managing, you know, say they  
3                   have 40 people, and they need to know  
4                   something about a Service member, they don't  
5                   have to call all over Health Net. They have  
6                   one dedicated person who's taking care of all  
7                   of their civilian care coordination on their  
8                   side. So, they team it. So, that allows for  
9                   a slightly-bigger caseload.

10                   CO-CHAIR CROCKETT-JONES: So, a  
11                   portion of your 319, your contact is primarily  
12                   with another case manager --

13                   MS. YEAGER: Correct.

14                   CO-CHAIR CROCKETT-JONES: That's a  
15                   portion --

16                   MS. YEAGER: Correct.

17                   CO-CHAIR CROCKETT-JONES: Okay.

18                   MEMBER PHILLIPS: When you have  
19                   someone being cared for through your contract,  
20                   MCSC, are you having difficulties? Are you  
21                   getting any followup as far as the medical  
22                   information being sent back to their primary

1 care or any issues with that, if they go out  
2 for a test or they go out for consultation?

3 MS. YEAGER: Not that have been  
4 identified. That hasn't been an issue for us.  
5 I can't speak necessarily to the direct-care  
6 system because we're not receiving that  
7 information.

8 MEMBER PHILLIPS: Yes, I would  
9 guess there may be some difficulties, but  
10 you're not aware of them?

11 MS. YEAGER: You're talking about  
12 like when a primary care manager sends someone  
13 outside for a specialty visit? Yes, there are  
14 requirements are that.

15 In the previous contract, we were  
16 involved in that paper chase, but now the  
17 Military Treatment Facilities are handling  
18 that on their own.

19 CO-CHAIR CROCKETT-JONES: Any  
20 other questions?

21 DIRECTOR DAILEY: So, this system  
22 is embedded now in all three Regions, West,

1 North, and --

2 MS. YEAGER: South.

3 DIRECTOR DAILEY: -- South? Is  
4 that a correct statement?

5 MS. BARNETTE: That is correct.

6 DIRECTOR DAILEY: Okay. So, we  
7 first heard about it in San Antonio. And so,  
8 on the line we have North and West, because we  
9 initially heard about it in the South, TRICARE  
10 Region South or the contract South.

11 Do all three Regions -- so, this  
12 number that you have here is for all Regions?  
13 Okay. All right.

14 MS. BARNETTE: No, ma'am. It's  
15 just the North.

16 DIRECTOR DAILEY: This is only for  
17 the North? Okay. So, this information is  
18 only for the North?

19 CO-CHAIR CROCKETT-JONES: So, that  
20 319 number of current -- is that only for the  
21 North or is that programwide?

22 MS. BARNETTE: That is only for

1 the North.

2 CO-CHAIR CROCKETT-JONES: Okay,  
3 and a followup on that IC3, the Lead  
4 Coordinator Working Group that is working  
5 between both the DoD and VA agencies, have  
6 they talked to you or gotten input? Is there  
7 any communication going on there?

8 MS. BARNETTE: Not to date, but I  
9 am going to be included in the IC3 group and  
10 will be participating in the meetings.

11 CO-CHAIR CROCKETT-JONES: Also, is  
12 this part of case management training or RCC  
13 training? Do you know if the folks that bring  
14 that, if this is -- they're either --

15 MEMBER EUDY: This was touched on,  
16 but very briefly. It is more designated  
17 towards Service-specific, that it would be  
18 something that would be even in-depth after  
19 the RCC course. To what level of depth, I'm  
20 unsure at this time, but I'm willing to bet  
21 that, amongst the RCC community, the knowledge  
22 is very low, as a lot of this is coming out.

1                   DIRECTOR DAILEY:  Actually, I have  
2                   an RCC in the room who's going, "Never heard  
3                   of it."  But, okay, I get it.  And that's why  
4                   we wanted to get it out on the table really.

5                   I mean, when we were in San  
6                   Antonio in Texas in September, we realized  
7                   there was another level of case management  
8                   being executed at the TMA Regional level, and  
9                   we wanted to understand it better.

10                  And so, this briefing right here  
11                  is only from North.  If you'll flip a couple  
12                  of pages, you'll see the West briefing.  I've  
13                  got the West guys on the line here, and  
14                  they're going to go through the same set of  
15                  slides for you.

16                  CO-CHAIR CROCKETT-JONES:  Okay.  
17                  Let's have them do --

18                  DIRECTOR DAILEY:  Good.  So, we  
19                  did have South come in and brief us while we  
20                  were in San Antonio.  I know it was a long  
21                  time ago and some of you weren't here.  So,  
22                  you're not connecting all the dots, and that's

1           okay. I'm expecting a lot.

2                         But we had the South at San  
3           Antonio. We just finished the North and their  
4           caseload and their clients. And I've got West  
5           on the line, and we are going to turn it over  
6           to them.

7                         MS. REILLY: Good afternoon,  
8           everyone. This is Trish Reilly, the nurse  
9           consultant at TRO West. Can you all hear me  
10          okay?

11                        DIRECTOR DAILEY: You're good.

12                        MS. REILLY: Okay. Great.

13                        Thank you again for inviting  
14          myself and my colleagues at United to be able  
15          to brief you about the program that United  
16          provides to the active-duty Service members  
17          and, in particular, the Recovering Warriors.

18                        So, I'm on slide 2. That is a  
19          component of Department of Healthcare Agency.  
20          We have just changed our agency recently, as  
21          of October.

22                        And this is the DHA vision: "A

1 joint, integrated, premiere system of health  
2 supporting those who serve in the defense of  
3 our country." And so, we are part of the  
4 military healthcare system.

5 So, during this brief, what I'll  
6 be doing is I will introduce you to my  
7 colleagues who are also on the phone. We are  
8 all in separate locations. So, bear with us.

9 A brief overview of United and the  
10 relationship with the contract that we  
11 affectionately refer to as "T3," TRICARE 3;  
12 the programs and points of contact, and any  
13 questions.

14 So, to start with, I'm on slide  
15 No. 4.

16 On the phone with me is Shari  
17 Erickson, who is the Vice President of Medical  
18 Management at United Healthcare Military and  
19 Veterans. We also have Terry Pierce, retired  
20 Colonel, U.S. Army nurse, who is the Director  
21 of Military Programs, and Yvonne Harrington,  
22 who also is a former active-duty Army nurse

1           who served in Iraq. And she is the Warrior  
2           Advocate Case Manager. And United refers to  
3           their specific program as the Warrior Advocate  
4           Program.

5                           Next slide.

6                           I think this overview might help  
7           give a little perspective of the current  
8           contract, the different contractors, TRICARE  
9           in general, and I think there might have been  
10          a little bit of confusion earlier for some of  
11          the members.

12                          So, the TRICARE contracts are  
13          divided into three Regions, and they had to do  
14          that because of the vast size of the United  
15          States. So, there is, now you know, the  
16          TRICARE Regional Office North, South, and  
17          we're in the West. And we have a big chunk  
18          geographically of the country, though much of  
19          it is rural. We have Hawaii and Alaska as  
20          well.

21                          So, United Healthcare Military and  
22          Veterans is the Managed Care Support

1 Contractor for the West Region, Health Net in  
2 the North, and Humana has the South.

3 United Healthcare Military and  
4 Veterans didn't get started with this  
5 contract, this current contract, until April  
6 1st of 2013 because there were protests  
7 related to the contract.

8 So, to give you some perspective,  
9 TRO North and Health Net started first on  
10 April 1st, 2011, followed by the South; the  
11 next year, April 1st, 2012, now United. Both  
12 Health Net and Humana were incumbents and  
13 already had the previous TRICARE contract.  
14 United Healthcare is brand-new to this TRICARE  
15 business. And so, we are less than a year  
16 into this contract.

17 Next slide, please.

18 The difference on this contract,  
19 the current T3, TRICARE 3, contract, and "3"  
20 relates that there was an initial contract  
21 many years ago. Then, we did Tnext, the next  
22 generation. And now, we're on the third

1 version of the contract.

2 And there was a change in the  
3 language in that contract that now provides  
4 that the Managed Care Support Contractor can  
5 provide case management and coordinate with  
6 the MTF clinical staff and civilian providers  
7 for active-duty Service members whose care is  
8 projected to occur in full or in part in the  
9 civilian sector.

10 So now, active-duty Service  
11 members have access to United general and  
12 specialized case management programs. Those  
13 include the cancer clinical trials, cancer  
14 support, community case management, integrated  
15 case management, transplant, and the Warrior  
16 Advocate Program.

17 Now community and integrated case  
18 management programs can include a blend of  
19 both medical/surgical case management and  
20 behavioral health case management. So, you  
21 can have a combination of both types of case  
22 managers involved in the case at United. You

1           may have one predominating over the other, a  
2           balance of both. There's always just one case  
3           manager who is the primary case manager.

4                       The Warrior Advocate Program --  
5           next slide, please -- did get started April  
6           1st, 2013, when the start of healthcare  
7           delivery began in the West Region. It now  
8           supports the current TRICARE contract, which  
9           includes that language that allows the  
10          contractor to work with the Military Treatment  
11          Facilities, or MTFs, as we call them, and  
12          whose care will be in part or in whole out in  
13          the network.

14                      The current contract did not  
15          specifically require that the contractor, the  
16          Managed Care Support Contractor, have a  
17          separate, unique Wounded Warrior or Warrior  
18          Advocate, you know, type program. What it did  
19          say, though, is you will work with the MTFs as  
20          well as with other case management entities in  
21          the military healthcare system to help  
22          coordinate and corroborate for active-duty

1           Service members.

2                       So, United developed this  
3           specialized program that they call the Warrior  
4           Advocate Program in response to that language  
5           and, also, recognizing that there was a need  
6           for a specific program, due to the unique and  
7           complex issues that face the Wounded Warrior  
8           population.

9                       Next slide.

10                      So, this program is led by Yvonne  
11           Harrington, who I introduced you to on the  
12           phone, who spent seven-and-a-half years on  
13           active duty with the Army. So, she has been  
14           also deployed to Iraq herself. So, she is not  
15           only an advocate for the Service members  
16           having served, but also, I think,  
17           understanding the issues that the deployed  
18           Service members face uniquely, and as well as  
19           Terry Pierce is a valuable asset to us because  
20           of her expertise with the Army Nurse Corps.

21                      So, her responsibilities include  
22           coordinating with the MTF clinical and case

1 management staff, the civilian providers; in  
2 addition, all of the other non-medical and  
3 medical case managers that may be involved  
4 with an active-duty Service member's care,  
5 including CBWTUs, WTUs, VA providers and case  
6 managers, RCCs, and FRCs.

7 The focus is on identifying the  
8 specific needs of the Recovering Warrior and  
9 to provide an integrated case management  
10 program to meet that Service member's needs.  
11 And they look at this as more of a holistic  
12 identification of needs and integrated case  
13 management, blending that ability to do the  
14 medical/surgical part of it as well as the  
15 behavioral health part.

16 And there was a question earlier  
17 about what kind of screening is done for  
18 behavioral health. And there is a tool that  
19 United uses, again telephonically, where they  
20 are screening when they are doing their case  
21 management assessment. And that, as the  
22 representative from Health Net mentioned, is

1 to help recognize and identify somebody who  
2 might have fallen through the cracks, as well  
3 as understanding that you may have a  
4 medical/surgical issue, but there can be  
5 behavioral issues that are complicating that  
6 or that result because of that injury or  
7 illness.

8 And next slide.

9 Warrior Advocate Program, Ms.  
10 Harrington also serves as the internal United  
11 consultant for other cases that they have at  
12 United that may not be in this Warrior  
13 Advocate Program. So, those that are in the  
14 cancer clinical trials or transplant, she  
15 works as a subject matter expert internally at  
16 United to help them with all of the issues  
17 surrounding active-duty Service members. And  
18 she has an expertise in that as well as Terry  
19 Pierce.

20 And it allows for collaboration  
21 and coordination of care over time and across  
22 treatment settings to improve the outcomes of

1 the management of the active-duty Service  
2 members with complex medical and social  
3 problems.

4 So, that's the unique program that  
5 United has developed that they call the  
6 Warrior Advocate Program.

7 There is a question in the agenda  
8 about addressing the needs of the caregiver.  
9 And I think we all realize that the caregivers  
10 become pretty overwhelmed with the multitude  
11 of new and somewhat shocking responsibilities  
12 that they face. And the Warrior Advocate  
13 Program, as well as the other case management  
14 programs United offers, recognizes that  
15 providing resources specific to their needs  
16 can be invaluable.

17 They recognize that others may  
18 have also provided resources to those  
19 caregivers and spouses. But, as we know, in  
20 these circumstances much information doesn't  
21 get absorbed. So, the repetitiveness of it  
22 and additional reminder about resources that

1 are out there for those spouses, I think, and  
2 the caregivers is important.

3 Because they offer this integrated  
4 case management and they are working  
5 collaboratively with all of these other  
6 providers who are involved in the Service  
7 member's care, they recognize that  
8 transitioning these cases is very important,  
9 and that is where we have seen some people run  
10 into trouble.

11 So, we have transitioning from  
12 active duty to retired status, active duty to  
13 no longer active duty. We have people  
14 transitioning from Region to Region. So,  
15 there is a formal process for how to do that  
16 within the Regions and to the other Regions.  
17 So, working collaboratively with Health Net,  
18 "We have a Wounded Warrior coming to your  
19 Region, and they'll be retiring in the North."

20 We have an example of one. I was  
21 emailing Yvonne today about somebody who is  
22 leaving today from the West Region and heading

1 to the South. TRO South is already aware of  
2 it. This Service member, in particular,  
3 declined case management services through  
4 Humana's program. So, that Service member's  
5 care has all been coordinated with the VA that  
6 he has been assigned to.

7 So, the next slide is going to  
8 talk a little bit about metrics.

9 DIRECTOR DAILEY: Hold on. Can I  
10 ask a question, please, ma'am? Hang on.

11 so, when you are transitioning  
12 them, and he did not want a transition to the  
13 TRICARE management but to the VA, who in the  
14 VA are you coordinating with?

15 MS. REILLY: I will let Yvonne  
16 Harrington answer that question or Terry  
17 Pierce --

18 DIRECTOR DAILEY: Okay.

19 MS. REILLY: -- since Yvonne is  
20 actually the one who has handled the case.

21 DIRECTOR DAILEY: Hi, Yvonne.

22 MS. HARRINGTON: Hi. This is

1 Yvonne Harrington.

2 When we have a transitioning  
3 Service member going into the VA, if they are  
4 a combat veteran, the first point of contact  
5 that we'll make, if the MTF already hasn't  
6 done so, would be with the OIF/OEF Program  
7 Manager at that MTF -- I'm sorry -- at the VA.

8 DIRECTOR DAILEY: Okay.

9 MS. HARRINGTON: And if they  
10 haven't, we usually will make contact with the  
11 VA to see if there is another point of contact  
12 that is not within their combat program, and  
13 make sure they have a single point of contact  
14 at the VA when they are transitioning.

15 DIRECTOR DAILEY: Okay. Thank  
16 you.

17 MS. REILLY: So, on to the  
18 metrics. The Recovering Warriors served  
19 through the Warrior Advocate Program since  
20 April 1st of 2013 is a total of 201. So, the  
21 numbers are different from what I think the  
22 other Regions are reporting. And I would say

1           that United is still in the process of  
2           developing their program. But I think that  
3           the way that programs are set up -- and this  
4           question came up earlier -- is each of the  
5           contractors has developed their own unique  
6           program on how they manage the active-duty  
7           Service members and, in particular, the  
8           Recovering Warriors. So, it is different  
9           because there is no contract requirement for  
10          it to be the same.

11                         And United has developed their own  
12          unique program. And so, currently, they are  
13          able to pull data that shows that they have  
14          touched at least 201 lives in this unique  
15          program.

16                         And then, we have broken it out  
17          for you by military grade, which was one of  
18          the questions, and then, population by  
19          Service. Surprisingly, it was a greater  
20          number of Air Force than Marine Corps.

21                         Now we don't do, United does not  
22          measure the severity measure that is

1 equivalent to the DODI Instruction 1300.24,  
2 where they get the rating of between 1 and 3.  
3 They do a case management screening that  
4 determines if a Service member or any case, as  
5 a matter of fact, requires case management.  
6 And it is a very detailed screening process.

7 So, if the members would like  
8 that, we can provide that after this is over,  
9 if they want to see United's criteria for case  
10 management and their different case management  
11 programs.

12 The conditions overall we have  
13 been unable to provide data related  
14 specifically to the Warrior Advocate Program,  
15 but the total overall that is active-duty  
16 Service members, when they did a data pull,  
17 they were able to see that trauma-related  
18 events like orthopedic injuries, fractures,  
19 dislocations are No. 1 that come up when that  
20 data is pulled. And I think that is not  
21 surprising. But we don't have anything  
22 specific to the Warrior Advocate Program to

1 provide at this time.

2 The next slide, please.

3 And the next slide gives you a  
4 percentage or a breakout, that there are 20  
5 current Warrior Advocate cases right now that  
6 Yvonne is managing. And the remainder of  
7 these Service members are in the other case  
8 management programs, specialized case  
9 management programs, that United offers. So,  
10 there's a total of 61, the remainder being in  
11 those other programs. And you can see the  
12 breakout there.

13 And the next chart below that,  
14 TRICARE has an enrollment plan code. So,  
15 anybody who is enrolled in TRICARE will have  
16 an enrollment code attached to them, and they  
17 attach the number 415 to anybody who is  
18 enrolled to the WTU, to a WTU, and 416 is  
19 CBWTU.

20 And out of the Western Region,  
21 there's a total of 1734 with a WTU enrollment  
22 code, 361 with CBWTU enrollment code. So,

1           that's just numbers of who shows up in the  
2           enrolled population for the West Region.

3                       The active-duty Service members  
4           enrolled with one of those plan codes that  
5           sometime has been involved in case management  
6           was 44 out of the WTU and 26 out of CBWTU.  
7           So, out of that total of 201, we know that a  
8           total of, let's see, 70 were assigned to  
9           either a WTU or a CBWTU.

10                      Next slide, please.

11                      One of the questions related to  
12           the referral process. And the referrals can  
13           come to United directly from the Military  
14           Treatment Facility, the MTF. They can come  
15           from other Regions. As I mentioned earlier,  
16           they can come from other case management  
17           programs or other departments who have  
18           identified a need in a Recovering Warrior.

19                      Internal Utilization Management  
20           Staff Coordinators at United also frequently  
21           will refer, because they are the ones that are  
22           doing the reviews when an active-duty Service

1 member is hospitalized. So, whether or not  
2 it's a planned admission, United does do  
3 utilization management reviews on those cases,  
4 and they will have an awareness, an alert that  
5 there's an active-duty Service member who has  
6 been hospitalized. And they may refer that,  
7 if it looks like it is something beyond an  
8 appendectomy that might need more concentrated  
9 level of care.

10 And the other program that they  
11 use -- and we'll go to the next slide -- is a  
12 system that is a healthcare analytics tool  
13 called ImpactPRO that United uses that helps  
14 them identify potential cases. And they can  
15 do this through a variety of screening  
16 elements that can be customized.

17 So, they can go out and look at  
18 any given time and look for active-duty  
19 Service members, high costs, diagnosis PTSD,  
20 TBI, trauma, that type of thing. So, they  
21 have a variety of different ways that they are  
22 able to get referrals, and they have used the

1 ImpactPRO system in the past.

2           There was another question about  
3 the Reserve component, and that's the next  
4 slide. The target population of the Warrior  
5 Advocate Program is the active-duty Service  
6 members. However, the Warrior Advocate  
7 Program case management enrollment is open to  
8 TRICARE Reserve Select population with United  
9 supervisor approval.

10           And if a Service member, during  
11 the course of the ongoing case management, is,  
12 then, separated from active-duty service and  
13 is not eligible for ongoing TRICARE coverage  
14 -- and an example would be the case I  
15 mentioned earlier of a Service member who is  
16 transitioning to the South. That Service  
17 member has been rated, and his disability does  
18 not qualify him for lifetime TRICARE benefits.  
19 He will have TAMP. So, he would be an example  
20 of that. It is that the case manager will  
21 assist the transitioning Recovering Warrior in  
22 connecting with the VA, something that Yvonne

1           has done in that particular case, and other  
2           community-based resources.

3                       So, that was one of the  
4           unfortunate things about the Service member  
5           declining case management services from  
6           Humana, but we haven't given up on that  
7           Service member. Yvonne asked his permission,  
8           if she could follow up with him next month to  
9           make sure that everything is going smoothly,  
10          and his needs may have changed over the course  
11          of his travels to his new place of living back  
12          home in the South. And so, he may reconsider.  
13          However, he has been provided with all the  
14          contact information as well, and he can always  
15          self-refer, get some information.

16                      And so, I think the final point on  
17          that is that the case manager does ensure that  
18          transitional needs are met prior to closing  
19          the case. So, they do whatever they can  
20          within their power to provide all the  
21          resources to the Service member before they  
22          close that case.

1                   And the cases can range from a  
2                   month, a very short period of time, to longer.  
3                   Cases with potential for long-term case  
4                   management, those will definitely need  
5                   transition to either the TDRL list or to the  
6                   VA.

7                   An example, another question came  
8                   up earlier about needing an example of VA  
9                   referring to United. And while this is fresh  
10                  in my mind, we had a case up in the Minnesota  
11                  VA, Minneapolis, where it was an active-duty  
12                  Service member with severe traumatic brain  
13                  injury. The VA case manager there was working  
14                  very closely with the United case manager  
15                  because they needed to transition that active-  
16                  duty Service member to a lower level of care,  
17                  a different level of rehab care, because he  
18                  had maximized his benefits at the VA's Rehab  
19                  Program.

20                  So, that is an example of when the  
21                  VA and the contractor can work very  
22                  collaboratively. That case was extremely

1 complex, and Yvonne is still following that  
2 case. Whereas, the VA case manager stepped  
3 out of it at that point because where the case  
4 ended up at a different facility, it was  
5 closer to another VA. And so, the VA case  
6 manager there has picked it up and is working  
7 with Yvonne on that.

8 The case will be closed when the  
9 Service member has met all their short-term  
10 and long-term goals and objectives, and until  
11 we can ensure that the gaps in care closed or  
12 the care has stabilized. And, you know, the  
13 gaps in care I think is the major issue  
14 because I think with the Task Force, one of  
15 the goals that you're trying to achieve is  
16 finding out what resources are available, what  
17 is redundant, and how do we all coordinate  
18 this together to make sure that we're not  
19 having people slip through the holes in the  
20 system.

21 And all of the cases, Yvonne  
22 reviews all of the cases. And she mentioned

1           this earlier when she was speaking about the  
2           VA case. She will close out with the WTU or  
3           the CBWTU or MMSO, if they are involved in a  
4           case, before the case is closed.

5                       Next slide, please.

6                       It goes into a little bit more  
7           detail about behavioral health/psychological  
8           health needs. And I mentioned earlier that  
9           they are screened and that they have the  
10          ability at United to collaborate and co-manage  
11          on cases internally. And I think that is a  
12          very important resource that is available to  
13          us through United, is that they have subject  
14          matter experts there who can work, if the  
15          primary issue is med/surg, work with that case  
16          manager, if those behavioral health needs are  
17          something that case manager is unfamiliar  
18          with.

19                      And then, they also provide as  
20          much family and social support as they  
21          possibly can, since we clearly understand that  
22          these injuries and illnesses impact the entire

1 family. And they also have specialized  
2 behavioral health medical directors at United  
3 Healthcare that they work with when there is  
4 uncertainty in the cases or they need the  
5 medical director to weigh-in on an issue.

6 The next case or next slide -- I'm  
7 sorry -- is comparisons. There is a question  
8 about how does the program or process differ.  
9 I think it is a tough question to answer  
10 because each of those programs, the non-  
11 medical case managers, medical case managers,  
12 RCCs, FRCs, Army WTUs, et cetera, are all  
13 unique.

14 So, I think that one thing to keep  
15 in mind is that there's a lot of coordination  
16 and collaboration amongst whichever one of  
17 those different entities is involved in the  
18 case or if there's multiple. And care  
19 conferences can occur where it is done  
20 telephonically where all of those different  
21 people are all on the phone coordinating  
22 everything that is going on with the Service

1 members.

2 And I think what is unique, that's  
3 different for what happens in the Military  
4 Treatment Facilities, is that active-duty  
5 Service members are required to get  
6 authorization for any care that is provided to  
7 them out in the civilian community, in the  
8 network. So, the contractor has visibility of  
9 that probably much more easily than the MTF  
10 does. There, it has to be a referral to that  
11 care, but, then, the contractor has the  
12 visibility of the very finer details of that  
13 data. And that gives them the ability to do  
14 those types of screenings and see who might be  
15 a candidate for case management or any other  
16 type of service that they can offer.

17 Next slide.

18 And then, also, United has been  
19 able to refer to other Recovering Warrior  
20 resource programs, and Recovering Care  
21 Coordinators, they have referred one case;  
22 FRCs, five with two pending; Army Wounded

1 Warrior Advocates, AW2, they have referred  
2 one. And then, for VHA, OIF, OEF, O&D program  
3 referrals, they have referred six with two  
4 pending. So, you can see there is a lot of  
5 collaboration on the United side with those  
6 resources.

7 And the next slide, please.

8 When United, and much like I think  
9 the other contractors, was developing this  
10 program, they were very deliberate in  
11 designing to collaborate with all of those  
12 other entities. And again, the Warrior  
13 Advocate Program offers consultation only. It  
14 could be one-time co-management with other  
15 case managers, the example at the VA, or it  
16 can be with a Military Treatment Facility  
17 medical case manager or with a primary care  
18 provider. And they are also actively  
19 participating in the DoD/VA Clinical Case  
20 Conferences.

21 Probably in closing, I think that  
22 the West Region is unique. We're more rural.

1           We have a lot of WTUs and CBWTUs. Our  
2           Hawaiian/Alaska markets are very unique, in  
3           that Alaska being very isolated and Hawaii  
4           with the islands, transportation/provider  
5           issues can be more challenging because of  
6           those difficulties, especially out on the  
7           islands getting to Oahu, where the specialty  
8           care is more available; the same thing in  
9           Alaska.

10                           And I think that --

11                           CO-CHAIR CROCKETT-JONES: We have  
12           a question from one our members, if you can  
13           hold on a sec.

14                           MS. REILLY: Sure.

15                           MEMBER REHBEIN: Yes, if we can  
16           back up I think one slide --

17                           MS. REILLY: Yes.

18                           MEMBER REHBEIN: -- where United  
19           initiated referrals, am I to take that to mean  
20           that there were some people that either  
21           needed/deserved an RCC or an FRC that didn't  
22           have one until they got to you?

1 MS. REILLY: I'll let Yvonne  
2 answer.

3 MS. HARRINGTON: Correct. There  
4 are times when some of the case managers at  
5 the MTF may or may not have been involved or  
6 may not have recognized that one of these  
7 cases meet criteria for one of these programs.  
8 And at that point, we would definitely assist  
9 or place a referral on their behalf, as is the  
10 example with these cases listed here.

11 MEMBER REHBEIN: Interesting.  
12 Thank you.

13 MS. REILLY: So, the --

14 CO-CHAIR CROCKETT-JONES: And I  
15 actually also have a question. Looking at  
16 your numbers, do you have the single case  
17 manager for the workload, making that  
18 caseload, if my numbers are correct, around  
19 20?

20 MS. REILLY: Correct. The number  
21 right now is 20 active cases that are  
22 currently in the Warrior Advocate Program that

1 Yvonne is case managing.

2 So, that 201 total is the total  
3 number from the beginning of April, when the  
4 start of healthcare delivery here in the West  
5 Region and when United started up that  
6 program.

7 CO-CHAIR CROCKETT-JONES: And just  
8 so I'm clear, this is the contracted program?  
9 This is not value-added? This was specified  
10 within the contract, that this case management  
11 be made available?

12 MS. REILLY: It's specified in the  
13 contract language that the contractor can  
14 provide services, case management services, to  
15 the MTF -- and I'm going to go back to my  
16 notes, so I don't misquote myself -- that  
17 "allows the Managed Care Support Contractor to  
18 work collaboratively with the Military  
19 Treatment Facilities to manage active-duty  
20 Service members whose care is projected to  
21 occur in whole or in part in the civilian  
22 sector."

1                   It doesn't specify a unique  
2                   program particularly for what is referred to  
3                   as Recovering Warriors or Wounded Warriors,  
4                   that kind of thing. So, that program that  
5                   they have developed, I would say, yes, it is  
6                   value-added, because it is very specific and  
7                   unique to that population.

8                   CO-CHAIR CROCKETT-JONES: Okay.  
9                   Well, thank you. I think that we have asked  
10                  all our questions.

11                  Anything else you want to add for  
12                  us?

13                  MS. REILLY: I think there was one  
14                  other question about customer satisfaction,  
15                  and I'm at the third-to-the-last slide, which  
16                  is just that the baseline that United has for  
17                  their standard for care coordination  
18                  interactions is to develop a process. It is  
19                  developing a process to ask Recovering  
20                  Warriors on feedback, on how the program has  
21                  been supporting them and their satisfaction  
22                  with services.

1                   But, currently, there is not a  
2                   tool that is being used to measured that, but  
3                   that is in development, as well as United is  
4                   also working with their compliance officer to  
5                   see if there is an ability for them to do some  
6                   kind of annual survey. I think Brandi  
7                   mentioned that they're prohibited from doing  
8                   surveys. So, that goes through a whole other  
9                   channel before surveys are allowed, and that  
10                  is why they are working with their compliance  
11                  officer to see what they can and can't do.

12                  And then, the next slide is just  
13                  all of us, our points of contact, myself,  
14                  Trish Reilly; Shari Erickson; Terry Pierce,  
15                  the Director, and Yvonne Harrington, who is  
16                  the Lead Warrior Advocate Case Manager.

17                  And then, if there are any other  
18                  questions, we'll go ahead and take those now.

19                  DIRECTOR DAILEY: Yes, I do.

20                  So, you did mention -- can you  
21                  talk to us a little bit about your  
22                  interaction? You said in one of your slides

1           that you are working and participating in all  
2           the clinical case management focus groups, or  
3           not focus groups but conference calls. And  
4           can you talk to us about -- I can't remember  
5           where that bullet is -- but you did say you  
6           are participating --

7                       MS. REILLY: Yes, that they are  
8           actively participating in the DoD/VA Clinical  
9           Case Conferences --

10                      DIRECTOR DAILEY: Yes, that's it.

11                      MS. REILLY: -- for transitioning  
12           Service members.

13                      DIRECTOR DAILEY: Yes.

14                      MS. REILLY: And I will let United  
15           answer that question.

16                      MS. HARRINGTON: This is Yvonne  
17           Harrington again.

18                      Especially when we have very  
19           complex, catastrophic injuries, and the  
20           beneficiary is either moving areas,  
21           transitioning to different levels of care, or  
22           separating from active service, we will

1 definitely work with the MTF and the VA during  
2 their clinical conferences in case there are  
3 any network needs, especially authorization  
4 for care, making sure that care is not only  
5 set up, but maintained for the duration of  
6 their active-duty timeframe. And so, we  
7 definitely participate to make sure that the  
8 treatment plan directed by the MTF and  
9 requested by the VA is executed without  
10 barriers on the authorization side.

11 DIRECTOR DAILEY: Okay. And I did  
12 find my bullet here. It's under the page that  
13 says, "Coordination with CBWTUs and Recovering  
14 Warriors". It's that last bullet.

15 MS. HARRINGTON: Uh-hum.

16 DIRECTOR DAILEY: It says,  
17 "Actively participates in DoD/VA Clinical Case  
18 Conferences for transitioning Service  
19 members." Okay, so that's individual cases  
20 moving between DoD/VA. Participation in the  
21 DoD/VA clinical case management policy  
22 development, participation in efforts to

1 deconflict roles, are you involved with that  
2 at all, IC3?

3 I know our briefer, Brenda, talked  
4 al little bit about you would be participating  
5 in the future in these interagency --

6 MS. HARRINGTON: Yes.

7 DIRECTOR DAILEY: -- policy-level  
8 activities, not case, not the smaller -- not  
9 to minimize a case --

10 MS. REILLY: Right.

11 DIRECTOR DAILEY: -- but at the  
12 higher policy levels.

13 MS. REILLY: This is Trish, and I  
14 will respond to that question.

15 The contractor would not  
16 necessarily be involved in that level of  
17 discussion unless invited. But, at the TRO  
18 level, yes, we recently found out about the  
19 IC3 group and are working to be able to  
20 participate in that and contribute to that.  
21 So, I think that's what you're talking about,  
22 is the higher-level policy setting.

1                   DIRECTOR DAILEY:  Yes, exactly.

2                   MS. REILLY:  As well as, you know,  
3                   we have a variety of roles here, and we work  
4                   on a variety of different work groups, all  
5                   involved, that touch on many of the different  
6                   TRICARE benefits.  And some are specific to  
7                   dependent care, like the ADA programs that are  
8                   in a constant state of evolution within  
9                   TRICARE.

10                   But I think the IC3 is the one  
11                   that comes to my mind that is specific to the  
12                   veterans and the coordination of efforts.  And  
13                   that was news to us this week.  I found out  
14                   about it this week.  So, we are excited to be  
15                   a part of that.

16                   CO-CHAIR CROCKETT-JONES:  Okay.  
17                   Well, thank you very much.  I think the  
18                   members have gotten all their questions out,  
19                   and we appreciate your bringing this to us  
20                   today.

21                   MS. REILLY:  Thank you.

22                   CO-CHAIR CROCKETT-JONES:  We are

1 going into a break and be back at 3:15 for our  
2 nonprofits panel.

3 (Whereupon, the foregoing matter  
4 went off the record at 2:59 p.m. and went back  
5 on the record at 3:14 p.m.)

6 CO-CHAIR CROCKETT-JONES: Okay,  
7 welcome back.

8 Joining us this afternoon are  
9 members of our nonprofit panel. We have Mr.  
10 John Hanson, the Senior Vice President for the  
11 USO's Warrior and Family Care Program. And we  
12 have Mr. Ken Falke, Founder and Chairman for  
13 the Boulder Crest Retreat for Wounded  
14 Warriors. And we also have Mr. Jim Lorraine,  
15 President and Chief Executive Officer for the  
16 Augusta Warrior Project.

17 Panelists will provide us with an  
18 overview of their respective organizations,  
19 their work with the Recovering Warriors, their  
20 input on Recovering Warrior transitions to  
21 civilian life. We have briefings under tab N  
22 for their information.

1                   And are we going to start with  
2                   you, Mr. Hanson?

3                   MR. HANSON:    Yes.

4                   CO-CHAIR CROCKETT-JONES:  Well,  
5                   then, let me turn it over to you.

6                   MR. HANSON:  Thank you very much.

7                   Good afternoon, everyone.

8                   These are the questions.  You have  
9                   seen those.  You don't need me to read to you  
10                  on the screen.  So, we'll get going.

11                  There's a little known law:  every  
12                  USO presentation has to start with a picture  
13                  of Bob Hope.  I don't want to break the law.  
14                  So, there's Bob Hope.

15                  (Laughter.)

16                  About 100 percent of what a lot of  
17                  people know of the USO is our entertainment  
18                  program.  Since 1941, it has consistently been  
19                  about 12 percent of what we do.  But, because  
20                  of his great work, people know that we  
21                  entertain troops, and we are proud of doing  
22                  it.  But it is a big 12 percent of what we do.

1                   We have been around since 1941.  
2                   We're the only group we know of that has  
3                   access to troops from the moment they enter  
4                   the Service, in most places through their  
5                   deployments, and on their way home, and to the  
6                   time they transition. They're going to be  
7                   touched by the USO somewhere.

8                   We have an array of programs for  
9                   wounded, ill, and injured troops. We always  
10                  have. And we are just facilitators. We don't  
11                  provide care. We don't have caregivers. We  
12                  provide help for caregivers in any way we can.

13                  After World War II, our  
14                  representatives were at VA and military  
15                  hospitals around the country. Anybody who has  
16                  been at the former Walter Reed or out at  
17                  Bethesda, you've seen the USO presence there  
18                  probably. We are there because troops and  
19                  families need to know that the public supports  
20                  them, and that's what we do.

21                  We continue to change to meet the  
22                  changing needs of troops and families. We

1 reach out with caregivers' conferences.  
2 Currently, we're doing two caregivers'  
3 conferences a year. These conferences are  
4 facilitated by experts, but they are run by  
5 the caregivers. These are places where  
6 caregivers learn they're not alone.

7 Last year there were 150  
8 participants. This year we anticipate there  
9 will be more. But it is an opportunity for  
10 caregivers to find out they're not the only  
11 person with a particular problem they have in  
12 their household.

13 We have employment transition  
14 events. We work with a group out of Georgia  
15 called Hire Heroes USA. We have been working  
16 with them, I think, since 2012. Since we  
17 began, 1600 troops have found jobs. Last year  
18 we had 1300 participants in programs, about 80  
19 programs last year. This year we look to have  
20 127 programs around the country. We had two  
21 last week.

22 These are high-impact, high-touch

1 events. They're not jobs fairs. They're  
2 places where people learn how to -- they are  
3 run by former Marines, one of whom is a former  
4 martial arts specialist. So, he gets people's  
5 attention and teaches them how to do their  
6 resume to where it makes sense to a civilian  
7 employer, how to go into an interview. And  
8 then, we put these folks together the next day  
9 with employers who are ready to hire.

10 It's a confidence-builder, and we  
11 know that in many cases they're not getting  
12 the job they are going to have the rest of  
13 their lives, but they get their foot in the  
14 door and they learn what it is like to be a  
15 civilian employee.

16 Last year we had 23 families  
17 strengthening workshops, primarily ones done  
18 with our ally, Stronger Families. The  
19 workshops are called "Oxygen for Your  
20 Relationships". There were 350 people who  
21 went through those, most of whom had suffered  
22 some of the consequences of frequent and

1           lengthy deployments and they are just trying  
2           to get their relationships back on track. So,  
3           we facilitate those kinds of activities.

4                       And I think you know we work with  
5           TAPS and have for years. We sponsor a lot of  
6           their Good Grief Camps for children and family  
7           members who have lost a family member. Last  
8           year there were 1,000 participants in the Good  
9           Grief Camps that we sponsored around the  
10          country.

11                      These testimonies are in your  
12          folder. I'm not going to read them for you.  
13          But the important thing is we get  
14          testimonials, and we get them because we look  
15          for, we survey every single person who goes  
16          through every single iteration of every single  
17          program.

18                      We have about 58 discrete  
19          programs, some of which have dozens of  
20          iterations all year long. So, it gets  
21          complicated, but we encourage every  
22          participant to let us know what we're doing

1 right, what we're doing wrong, and what we  
2 could do better.

3 We look for outcomes, not just  
4 outputs. It is important to do that. We  
5 didn't know how important that was. It was  
6 important to us. But we have since found that  
7 a lot of the charity evaluators in a couple of  
8 years are going to be changing the way they  
9 evaluate charities, and much of what they look  
10 for is the impact of what nonprofits do.

11 We have way too much information  
12 to share with these evaluators. So, we have  
13 to figure out how to winnow it down. But, for  
14 the past couple of years, we have been able to  
15 get a lot of input from participants in our  
16 programs, to learn what the programs meant to  
17 them.

18 You all know this. About 44  
19 percent of the troops who served in Iraq and  
20 Afghanistan have had some sort of readjustment  
21 issue, sometimes from complex medical issues,  
22 sometimes for other reasons that aren't all

1           that surprising.

2                         Our focus, though, is on active-  
3           duty wounded, ill, and injured troops. We are  
4           not a veterans' group; we don't want to be.  
5           We don't pretend to be. We couldn't be if we  
6           wanted to be.

7                         What we try to do is help these  
8           troops as they are transitioning plan for  
9           whatever comes next in their lives. We do  
10          that at all of our centers, and I will talk a  
11          little bit more about two of the main efforts  
12          we have in this area.

13                        But every year around Veterans Day  
14          our CEO produces an op-ed piece around  
15          Veterans Day. Just because we are not a  
16          veterans' organization doesn't mean we have to  
17          be quiet. And the theme of those op-ed pieces  
18          is to educate the public, to remind them that  
19          these troops are coming home, that there has  
20          to be a national community of care there. We  
21          want them welcomed into schools, welcomed into  
22          their houses of worship. Find them jobs.

1           Make them a part of the fabric of the  
2           community.

3                         Our job, we think one of our jobs  
4           is to hand off troops as they go home and to  
5           remind the public that we all have a role in  
6           making their transition successful.

7                         The central features of our  
8           Warrior and Family Care Program are our  
9           Warrior and Family Centers. The first one  
10          -- and it is the one on the left -- opened at  
11          Ft. Belvoir just about exactly a year ago.  
12          Our birthday is next Tuesday, and we opened it  
13          on our birthday last year.

14                        It is the biggest USO center in  
15          the world, 20,500 square feet, two levels.  
16          There are dozens of rooms in there, large  
17          rooms, small rooms, a music room, art room.  
18          There's an outdoor patio. There's even a golf  
19          simulator.

20                        It's on what used to be part of a  
21          former golf course at Ft. Belvoir. So, we are  
22          trying to simulate the golf course in the golf

1 simulator.

2 But it is a USO Center that is  
3 aimed at needs for wounded, ill, and injured  
4 troops and the whole Ft. Belvoir community.  
5 Since it opened last February, through the end  
6 of December, 115,000 visits. We imagine by  
7 the end of this month, by the end of the first  
8 year, year-over-year, probably 150,000 visits  
9 to that Center.

10 On April 1st, no kidding, we'll be  
11 opening the next Warrior and Family Center at  
12 Bethesda. It is the drawing on the right. It  
13 is a one-level affair. It will be the second-  
14 largest USO Center in the world, about 17,000  
15 square feet.

16 It will lean heavily toward the  
17 troops who are recovering out at the National  
18 Military Medical Center in Bethesda, their  
19 families, and everyone who passes through  
20 Bethesda.

21 Now all of our locations offer  
22 something for troops with issues or troops who

1 are transitioning. A lot of it is ad hoc. We  
2 say that our folks at USOs around the world  
3 solve problems every day they didn't see the  
4 day before, and they know that they can find,  
5 they can access people to do that.

6 We touch troops and family members  
7 30,000 times every single day -- that's about 9  
8 million times a year -- around the world. So,  
9 if we weren't taking advantage of our scope  
10 and our scale and our presence around the  
11 world, we wouldn't be doing our job.

12 So, we try to do more than just  
13 give them coffee and donuts. In Afghanistan  
14 we offer them free phone calls home, which is  
15 great, but we try to do more than that. We  
16 are a representative of our donors' intent to  
17 serve, to lift the spirits of troops and  
18 family members, and we do everything we can.  
19 We try to fill gaps.

20 We have a great deal of trust with  
21 the Department of Defense and the VA. We  
22 build on that trust every day, and we try to

1           augment their programs any way we can.

2                         There is a question about what  
3           might be interfering. I don't think anybody  
4           in this room is interfering with anything. If  
5           the question is, can VA and DoD a better job,  
6           sure, they're the two largest bureaucracies on  
7           the face of the earth probably, and they have  
8           a lot of moving parts.

9                         Sharing medical records is a good  
10          way to begin. Sharing information about  
11          disability benefits wouldn't be a bad place to  
12          look at, either. And I know that both  
13          Departments are trying to do that.

14                        Secretary Hagel used to be at VA,  
15          used to be at the USO. He understands this  
16          problem, and I think he and Secretary Shinseki  
17          are working to do a better at transitioning.

18                        We can all do a better job of  
19          reminding citizens that troops are coming  
20          home. We think -- and we don't have any  
21          evidence of this -- but we think there is  
22          almost a perfect sine wave for us of support

1 from war and peace. When war breaks out,  
2 people come to us and they give us money  
3 because they know we'll try to take care of  
4 the troops. When wars are over, people forget  
5 that there are people still in the military or  
6 that there were people in the military.

7 So, our job is to try, one of our  
8 jobs is to make sure that people understand  
9 that troops are coming home. They are going  
10 to be joining their communities. They are  
11 going to be looking for work. And we want to  
12 be able to help everybody we can.

13 I used to be VA spokesperson. I'm  
14 no longer that person, thank goodness. But  
15 when I was at VA, one of the challenges we had  
16 was that veterans, many, many veterans didn't  
17 know what benefits they had coming to them.  
18 And we could all do a better job.

19 Now what can DoD do better? Our  
20 relationship is rock solid with the  
21 Department. We work together. I don't know  
22 today what efforts. Only I come to briefings

1           like this and I hear of efforts that the  
2           Department and the Services go through to make  
3           people who are out processing aware of the  
4           services that they're due.

5                        I do know that VA is trying to  
6           produce or has produced a messaging platform  
7           to let veterans know what programs are  
8           available for them to try to drive use up for  
9           those programs. Both Departments owe it to  
10          the people on active duty and those who are  
11          recently off of active duty to know that.

12                       I want to go back to our Centers.  
13          We have made our Centers available to the VA  
14          because they're already on DoD facilities. We  
15          have told the VA and we have told the  
16          veterans' service organizations that, if they  
17          want a place for intake, for lack of a better  
18          word, to go out and teach people, make them  
19          aware of benefits coming up, they can use our  
20          Centers. We don't charge anything for it.  
21          They just have to schedule it.

22                       We think they can come up with a

1 battle rhythm that makes sense to regularly  
2 tell troops and family members. More  
3 important than that, than telling troops, I  
4 think, is making family members aware of what  
5 benefits are available to reinforce the  
6 message. So, that is one way we are trying to  
7 augment.

8 This is, how will we change post-  
9 war? The USO has been dealing with this since  
10 August of 1945. You might not know that in  
11 1947 Harry Truman issued an Honorable  
12 Discharge to the USO.

13 There were USO Centers during  
14 World War II at just about every railroad  
15 station. Starting in 1946, those Centers  
16 started closing down. There was no need for  
17 a lot of them. They remained in large cities.  
18 They remained near large military bases. But  
19 the need for a USO was dwindling.

20 So, starting in 1947, the USO  
21 started closing up its books. And then,  
22 spring of 1950 came along and we haven't been

1 out of business since.

2 The tradition of our being or  
3 changing to meet changing needs, we're already  
4 in Australia. We have already set up a small  
5 USO Center at Darwin, and we are enlarging  
6 that. We are across the Pacific. We have  
7 activities in Jordan and around the Middle  
8 East for troops who might be going in and out  
9 of there. We will be in Kuwait for a while.  
10 We will be in Afghanistan for a while. But  
11 when we don't need to be there, we'll be out  
12 of there.

13 But we have done this movement  
14 recently in Europe. When the military posture  
15 in Europe changed, we moved where the military  
16 was going. The same thing happened in Korea  
17 a couple of years ago.

18 We are used to responding to the  
19 military. We are not interested in operating  
20 a Center at an empty base. So, wherever the  
21 military goes, we will be there. At our cost,  
22 we will be there to support troops wherever

1           they are.

2                       The challenge will continue to be  
3           to keep the public engaged in this because we  
4           are not a government agency. We rely on the  
5           kindness of strangers, like all nonprofits do,  
6           and making the case for what we do will be  
7           primary in what we do.

8                       I think during peacetime -- I  
9           don't mean this to sound pejorative in any way  
10          -- but I think the military tends to be  
11          treated like cops and firemen during  
12          peacetime. You're glad they're there. You're  
13          happy to know they're there. If you don't  
14          need them, you don't really think about them  
15          until you need them, and then, you hope you  
16          have been supporting them all along.

17                      Our challenge will be to dampen-  
18          down what we anticipate will be a decrease in  
19          the public's attention on the need to support  
20          troops and families, and to make them aware  
21          that somewhere somebody is walking the wire,  
22          serving their interests around the world.

1           They might not be in combat, but it is a  
2           dangerous job and there are a few people out  
3           there willing to do it.

4                        So, our job is to remain with them  
5           and to keep the public engaged. Right now, we  
6           have a couple million dedicated individual  
7           donors, some great corporate partners, and we  
8           are going to be letting them know over and  
9           over again that the USO is still there.

10                      We hope we have set the standards  
11           since 1941 in showing America how to support  
12           the troops. And it is not always through us.  
13           We know what we can't do, and that is why we  
14           look for partners like TAPS and Hire Heroes  
15           USA and Stronger Families and Ride to  
16           Recovery, and other nonprofits, we support to  
17           provide direct services because we don't have  
18           any interest in doing what we don't do well.  
19           We have an interest in making it easier for  
20           troops to have access to programs that serve  
21           their needs.

22                      I don't know if we're taking

1           questions individually or as a group. That is  
2           it for me.

3                           CO-CHAIR CROCKETT-JONES: I would  
4           just like to ask you, how do you identify --  
5           I know when I have had encounters with USO,  
6           they generally wanted to see my ID card and  
7           that kind of thing. What about family  
8           members? I know the Services try to get  
9           family members who are going to be involved  
10          bedside an ID card. But if you have any  
11          insight on how you deal with that kind of  
12          issue? And just generally, if you would say  
13          a bit more about how the USO feels about  
14          caregivers and the current level of caregiver  
15          support that is inherent in the DoD system?

16                          MR. HANSON: There are actually a  
17          couple of different dimensions to the family  
18          member. The family members who have  
19          identification, they are welcome in USO  
20          Centers. The biggest illustration is our  
21          airport centers. People who are traveling can  
22          go to the airport centers and wait. Those

1 centers, if you have been to them, are small.

2 What we have encouraged -- and we  
3 don't operate every USO Center in the country.  
4 Some are independent and they have their own  
5 -- they get our brand; we give them standards.  
6 We give them a little funding occasionally.  
7 But some of them raise their own money and  
8 have their own Boards. But they carry our  
9 brand. So, we try to use persuasion wherever  
10 we can.

11 The best example is the USO Center  
12 in Atlanta at Hartsfield. It is a tiny USO  
13 Center. It is really overused. And  
14 occasionally, veterans will want to go in  
15 there because everything is free, and they're  
16 welcome, unless it's full of troops. And  
17 then, the people there say, "Well, you can see  
18 we've got a deployment going on and we've got  
19 people coming out of basic or going to basic.  
20 So, come back a little later, if you don't  
21 mind."

22 We are trying to change that now

1           and encourage anybody who wants to go to the  
2           USO Center to be able to stick their head in  
3           at least and go in and at least be able to see  
4           what we offer there, family members, people  
5           who aren't associated with the military, just  
6           to see what goes on there, with the  
7           understanding that if the Center is full of  
8           troops, they may not be able to be treated  
9           with as much attention as we might like.

10                       Our model is the Families of the  
11           Fallen Center at Dover. When the dignified  
12           returns were opened to the public and to  
13           family members, there really wasn't a place  
14           for family members to go. The Air Force had  
15           to catch up.

16                       As it turns out, my boss, my  
17           current boss, was up there one day and saw  
18           what happened. There was a mother and a  
19           sister of someone who was coming home for the  
20           last time, and there was no place for them to  
21           prepare themselves for standing on the tarmac  
22           to watch the remains come off.

1                   So, we offered an architect. We  
2                   offered money, but we offered an architect.  
3                   And the Air Force answered by coming up with  
4                   the funding to build the Families of the  
5                   Fallen Center. We augment it with volunteers  
6                   from the two USO Centers we have at Dover, as  
7                   a place that is not a USO Center, but it feels  
8                   like a place of comfort and care.

9                   There are two USO Centers at  
10                  Dover. One is pointed directly at the people  
11                  at the port mortuary, the volunteers who work  
12                  there and the troops who work there, because  
13                  it is a really stressful job and they need a  
14                  place to catch their breath. And then, there  
15                  is a USO there for the rest of the base. It  
16                  doesn't matter who goes where, but each one of  
17                  those Centers has its own mission.

18                  So, we are trying to expand access  
19                  as well as we can, understanding that, if a  
20                  Center is full, a Center is full and the  
21                  primary purpose is to serve troops and family  
22                  members.

1                   That will not be a challenge at  
2                   either Bethesda or Belvoir. These are  
3                   gigantic institutions. These are huge  
4                   buildings.

5                   If you haven't seen our Center at  
6                   Belvoir, you ought to go. It's spectacular.  
7                   It is an easy post to get onto. Go look at  
8                   it. And you can see, you might get an idea of  
9                   the kinds of things we're offering.

10                  What we have found is that the  
11                  care being provided on the base sometimes  
12                  lacks facilities where that care can be given  
13                  effectively or the facility might be full.  
14                  So, we can be an overflow.

15                  We have had a discussion at  
16                  Bethesda already about arts therapy at the USO  
17                  to supplement the art therapy that the NICOE  
18                  is going to be offering. We already are going  
19                  to have an arts area there anyway. In both  
20                  places we have a big room. Big rooms are rare  
21                  on military installations. So, they can be  
22                  there for transition briefings, for medal

1 presentations, for any other kinds of  
2 presentations. So, we are there really to  
3 supplement.

4 The reason we offer caregivers'  
5 conferences is because we saw a need. We had  
6 caregivers coming to us asking questions that  
7 we couldn't answer. And we made an enormous  
8 mistake with the first one. We did it in El  
9 Paso, one of the most inaccessible places in  
10 the United States. And we found out right  
11 away that these were sessions that couldn't go  
12 beyond 2:00 or 2:30 in the afternoon because  
13 these caregivers had kids to pick up at  
14 school.

15 And we learned an awful lot. We  
16 learned that no number of experts who came in  
17 to offer advice were going to be as compelling  
18 or as interesting as the caregivers themselves  
19 telling their own stories, supplemented by  
20 facilitators, not by speakers.

21 So now, our caregivers'  
22 conferences tend to last a couple of days, a

1 couple of half-days, and they are driven by  
2 people who have gone through dealing with  
3 someone who has had to deal with any number of  
4 issues from potential suicide to "How do I  
5 take care of someone who is just depressed all  
6 the time?" And occasionally, we bring in the  
7 family member, the Service member as well,  
8 just as a learning experience.

9 Now, when you do two a year, you  
10 can't really touch a lot of people. So, if we  
11 get 300 or 400 a year, we're doing that much.  
12 I hope that what the Department is doing is  
13 bigger. And if there is something we can do  
14 in concert, then we can have a conversation.  
15 Maybe we can have four or five a year. But we  
16 are doing this out of hide. So, we're trying  
17 to do that.

18 Sorry to take so long, but these  
19 are complicated things.

20 CO-CHAIR CROCKETT-JONES: Thank  
21 you.

22 MR. HANSON: Thank you.

1 CO-CHAIR CROCKETT-JONES: And I  
2 think next we have Mr. Ken Falke.

3 MR. FALKE: Falke.

4 CO-CHAIR CROCKETT-JONES: Falke.

5 MR. FALKE: While the slides are  
6 coming up, I'll just give you my quick  
7 background. My bio is in your book.

8 I got into the Wounded Warrior  
9 care business, if you will -- in 2004, I  
10 retired from the Navy as a Master Chief Petty  
11 Officer in the EOD Tech. And the first EOD  
12 troops that were injured in Iraq, my best  
13 friend, who was killed later that year in  
14 Iraq, was a Sergeant Major of the 52nd  
15 Ordnance Group, and called me and said, "I've  
16 got an EOD troop coming to Walter Reed. I  
17 know you're in the D.C. area. Could you meet  
18 them at the hospital?"

19 So, my wife and I said we would be  
20 honored to. We got to the hospital. A young  
21 man was laying there with no legs, with no  
22 mom, no wife, et cetera, et cetera.

1                   I said, "Where's your mom?  
2                   Where's your wife?" He said, "I'm not  
3                   married. My mom's in Kentucky. She is trying  
4                   to get somebody to watch her dog. Can't  
5                   afford a plane ticket. She's driving. She'll  
6                   be here in three days."

7                   So, we took my wallet and my cell  
8                   phone. We called the mother, got her on an  
9                   airplane and brought her to the hospital.

10                  Quite frankly, because I was in  
11                  the first Gulf War and in Bosnia, I thought  
12                  that that would be the first and the last time  
13                  I did that. I did it 11 more times before it  
14                  started stressing my wallet out, and my wife  
15                  and I started what was called the Wounded EOD  
16                  Warrior Foundation. Today it is the EOD  
17                  Warrior Foundation.

18                  I sold a company in 2008 that I  
19                  left in 2010 and went back to school at  
20                  Georgetown to do a master's degree in public  
21                  policy. And it just so happened to be the  
22                  worst year for EOD troops in Afghanistan. We

1 had 71 amputees between I think April of '10  
2 and May of '11. When I was in school, I was  
3 on one end of Wisconsin Avenue. So, in the  
4 evenings, I would drive up and spend time with  
5 the families.

6 For those of you that don't know,  
7 on average, the inpatient Wounded Warrior,  
8 physically Wounded Warrior, at Bethesda will  
9 stay in the hospital for about three months  
10 and an outpatient for a year. I've got some  
11 that have been there for four.

12 We, being my wife and myself, and  
13 now my Board -- our foundation is much larger  
14 today than it ever has been on the EOD side --  
15 started bringing these families out to our  
16 home. We have an estate, a 200-acre estate in  
17 Bluemont, Virginia, a 100-year-old farmhouse,  
18 and 37 acres of the property we never really  
19 used, other than take the hay off of the  
20 property for a local horse rescue farm.

21 We were lucky that our property  
22 subdivided by tax parcels. We went to the

1 County. Thank God, one of our County  
2 Supervisors was a retired Air Force Colonel.  
3 We told him what we would like to do with the  
4 property. We wanted to peel 37 acres off and  
5 build a retreat for Wounded Warriors and their  
6 families to be able to come away from the  
7 hospital and just basically get R&R away from  
8 the hospital facilities.

9 We also saw that, you know, when  
10 you are in a hospital for a year and you're  
11 eating hospital food for a year, and that is  
12 miserable as well. So, we found that getting  
13 families out, getting them something healthier  
14 to eat was very powerful.

15 One of my first honorary Board  
16 members is General Hugh Shelton, who served on  
17 my for-profit company. I called General  
18 Shelton. We initially were going to do this  
19 for EOD and Special Forces troops only.

20 It just so happened to be one  
21 night, as I was leaving the hospital, there  
22 was a young soldier laying in his room by

1           himself. I popped in to talk to him -- it was  
2           Christmas Eve -- to find out that he had no  
3           family, no wife, no special 501(c)(3), the  
4           Green Beret Foundation, the EOD Foundation,  
5           any of the Special Operations kind of  
6           foundations to help him. And he was sitting  
7           there by himself and feeling pretty sad and  
8           lonely.

9                           And as I was driving home, I  
10           called General Shelton and I said, "You know,  
11           I think we really ought to open this up to all  
12           Wounded Warriors and their families, not just  
13           focus on this community." And he agreed.

14                           I spent, as an EOD guy, about 10  
15           years of my career supporting Special Ops, and  
16           that's where the connection to that community  
17           was.

18                           So, real quick, I'll run you  
19           through the mission. We have built a first-  
20           class retreat. It literally is a first-class  
21           retreat for Wounded Warriors and their  
22           families to come and rest and reconnect

1           together.

2                         It's in Bluemont, Virginia.

3           That's one hour west of the city, straight out  
4           Route 7 between Leesburg and Winchester.

5                         We serve any -- we have a very  
6           gray area, which I'm proud of -- we serve any  
7           military or served veteran, serving, active-  
8           duty or veteran, suffering from combat stress.  
9           And we do not distinguish between combat -- or  
10          we do distinguish between combat stress and  
11          PTSD or PTS in the sense that we also know  
12          that some people are much more resilient than  
13          others, and sometimes it is a family member  
14          suffering with stress of combat. And we  
15          welcome them, if that is the case. So, we are  
16          very open in that gray area.

17                        We focus our programs around  
18          couples, families, male and female  
19          independently, Wounded Warrior population. We  
20          have a caregiver program. We have just hosted  
21          a couples program. And also, military sexual  
22          trauma survivors. We're hosting a one-week

1 program this week, and we hosted the first-  
2 ever male MST program late last year through  
3 a nonprofit called Artemis Rising.

4 We thought we would serve about  
5 250 to 500 families a year, and I think that  
6 number is probably still accurate. What I  
7 will say is in total people -- we opened up  
8 last September; the Vice Chairman was our  
9 guest speaker, flew out to the facility via  
10 helicopter. It was a great day. But we  
11 opened up September 6th. And September 6th to  
12 December 31st, we had over 300 people in the  
13 facility. Now that is family members and  
14 everybody. So, we think it is going to be  
15 about 1,000 people a year.

16 We provide accommodations. We  
17 have non-traditional therapies from equine  
18 therapy, EMDR, meditation programs, both  
19 mindfulness and transcendental meditation,  
20 yoga, all non-traditional. We will look at  
21 anything that is focused non-traditional.

22 And then, we also have recreation

1 therapy. We are at the foot of the first Blue  
2 Ridge Mountain range. On the Blue Ridge  
3 Mountain range is the Appalachian Trail. Just  
4 over the mountain about a mile and a half from  
5 us is the Shenandoah River. So, we do  
6 kayaking. We do fishing in the Shenandoah,  
7 hikes along the Appalachian Trail, those types  
8 of programs.

9 The next few pictures are  
10 literally just pictures. This is our lodge.  
11 It is about 11,000 square feet. Everything  
12 out there is timber frame construction. This  
13 is all private money. There is no federal  
14 government money for the project.

15 I will tell you that most of the  
16 healing that is going on out here is going on  
17 around those fire pits. I'm glad my  
18 landscaper talked us into two of them. It's  
19 amazing what people will do sometimes when  
20 you're not looking them in the eye in the  
21 evening and what they will say, even in that  
22 little bit of darkness.

1                   The next picture is the Great  
2                   Room, which is the upstairs room of the lodge.  
3                   We reconfigure it for everything from yoga to  
4                   meetings. We held our first -- JPMorgan Chase  
5                   gave us some money to host an employment  
6                   seminar, a very focused seminar. We had 25  
7                   people. We had three CEOs come in from  
8                   different organizations Saturday, this past  
9                   Saturday, and actually talk to transitioning  
10                  active-duty military personnel. It was a  
11                  great program. We're going to host four of  
12                  those, I think, this year. But we can do  
13                  anything from host day-like programs to do a  
14                  yoga class in there.

15                  Downstairs this building includes  
16                  a kitchen, courtesy of General Electric,  
17                  provided all the appliances. In addition to  
18                  raising a lot of private money, we had a lot  
19                  of in-kind donations. General Electric was  
20                  one of our big donors.

21                  Again, that is the kitchen/dining  
22                  area. Music, art therapy on the other side of

1 the kitchen downstairs. Some of the retreats  
2 we host we actually do journaling and creative  
3 writing and those types of programs, kind of  
4 going in that relaxed living-room-like  
5 facility.

6 The fire pits are huge. I think  
7 they are 6-foot across, and you can get  
8 probably comfortably 20 people around them.

9 We have four cabins. One of my  
10 Board members, Ike Skelton, honorary Board  
11 members, who was our first honorary Board  
12 member, passed away late last year.

13 Ike Skelton had polio and he grew  
14 up in camps in the summer. When we went into  
15 this project because we have 37 acres, some of  
16 the Board members wanted us to build more  
17 cabins. My personal opinion is that I think  
18 a lot of nonprofits try to do too much for too  
19 many. Our motto is healing heroes one family  
20 at a time, very high-touch, high-impact.

21 We said if it was successful and  
22 we could perfect it, that maybe we would look

1 at going out and raising more money and  
2 building a handful of these around the country  
3 in high-veteran population areas.

4 That's an upfront picture of the  
5 cabin. They're beautiful cabins. You'll see  
6 some pictures inside. They're not small  
7 cabins. They're set up for a family of six  
8 inside.

9 We had no intentions of putting  
10 granite on the kitchen countertops, but the  
11 local support in the community embracing of  
12 this project has been unbelievable. From the  
13 gravel on the roads, the guy that owns the  
14 quarries in Virginia, Charles Luck, is a VMI  
15 graduate. He came out and said he wanted  
16 granite in the kitchens and we got granite  
17 countertops in the kitchen.

18 The flooring came from Lumber  
19 Liquidators. The Trex decks, the CEO of Trex  
20 put the decks on the facility as well. All  
21 the furniture in there is from a company in  
22 Kentucky.

1                   I have an Air Force triple amputee  
2                   EOD guy and another Air Force single-leg  
3                   amputee. I flew out to the furniture in  
4                   Kentucky. We wanted not to be only ADA-  
5                   compliant, but ADA-friendly. So, everything  
6                   in here you can transfer from wheelchair to  
7                   bed easily. The shower in the main bathroom  
8                   was designed by a Marine Corps triple amputee.  
9                   So, it is very, very handicapped-friendly.

10                   Every one of the beds has endless  
11                   numbers of quilts. The quilting community  
12                   gathered around this project like you wouldn't  
13                   believe, and some beautiful quilts on all the  
14                   beds. And that has been a blessing as well.

15                   So, we've got a king-sized bed in  
16                   one room, a queen-sized bed in the other room,  
17                   and a set of bunk beds for the kids and some  
18                   of the Wounded Warriors as well in the fourth  
19                   or third bedroom.

20                   Nice big decks on the back of all  
21                   the buildings, and that's what they look like.  
22                   And they're all done by Trex and all lit.

1                   We have an archery range and a  
2                   labyrinth in the back field. A labyrinth is  
3                   a form of walking meditation. We have an  
4                   archery range that has been a big hit. And  
5                   that was just one photograph that I was real  
6                   happy with. The guy pulling the string back  
7                   was shot seven times in the arm with an AK-47,  
8                   can't move his left arm. The guy on the right  
9                   lost his right arm. The guy on the back is a  
10                  quiver. So, it's teamwork on one of the first  
11                  retreats we hosted.

12                 So, I think we had some questions  
13                 to answer for you. The first one was long-  
14                 term services that are needed. The data that  
15                 we know indicates that approximately half of  
16                 the veteran population does not seek services  
17                 from the VA. We know that stigma very well.  
18                 We're trying to make sure that that's not the  
19                 case. We're very open to this gray area of  
20                 combat stress.

21                 The gap in the services continues  
22                 to be needed. There's no shortage -- I think

1           somebody said 45,000 nonprofits. I would love  
2           to see that list. I've heard anything from  
3           200 to 45. My personal opinion is it may not  
4           be enough. Some people think it is too many.  
5           And I know some people want to control them  
6           all, but at the end of the day it is amazing  
7           the work that's going in this country by  
8           people. Whether it is a single therapy dog a  
9           year or the USO, it's amazing what is going on  
10          in this country on private money.

11                        What we offer is rest and  
12          reconnection time. Sometimes families want to  
13          come out and they just don't want to do  
14          anything, and I love that.

15                        You know, my wife and I have been  
16          married 31 years. In the military they say,  
17          "EOD stands for everyone is divorced." The  
18          Special Ops community, it's 95-percent divorce  
19          rate. And I know that you can get through it  
20          and get through the ups and downs of life if  
21          you have quality time as a couple, and that's  
22          kind of what we do.

1                   So, we provide this rest and  
2                   reconnection. We stay clear of any  
3                   pharmaceutical solutions. We're not in the  
4                   business of medical or pharmaceutical  
5                   solutions. We're looking at those alternative  
6                   therapies and modalities that are focused.

7                   The one thing we haven't built  
8                   yet, and we're still looking for a donor, is  
9                   the walled garden. We are going to build a  
10                  fully-accessible walled garden, not only to  
11                  bring food into the kitchen for some of the  
12                  cooking classes and things that we do, but  
13                  also as a place of therapy.

14                  The next question was, how  
15                  prepared are the DoD and VA? I have watched  
16                  this since the beginning with my EOD  
17                  foundation. I think the progress is  
18                  remarkable, I guess is probably what I would  
19                  say, from the facilities, from what used to be  
20                  at the Malone House to Building 62, the  
21                  facilities in general, but just the services  
22                  I think have been much, much better.

1                   I have been saying for about 10  
2                   years now that, as these physical injuries  
3                   wind down, I think the Post Traumatic Stress  
4                   injuries will wind up. We all know the  
5                   stigma. I think everybody agrees to the  
6                   stigma. I think as the war winds down, the  
7                   downsizing occurs, I think you're going to see  
8                   a lot more PTSD claims, and we are trying to  
9                   prepare for that.

10                   We serve not only severely-  
11                   injured, but, obviously, the combat stress as  
12                   well. And we see that as a big gap because a  
13                   lot of people that are in this business --  
14                   there are a lot of organizations that stay  
15                   really focused on one type of injury. Maybe  
16                   it is a physical injury. You have to have an  
17                   amputation if you go skiing on this trip in  
18                   Aspen. We don't look at it that way. We look  
19                   at this whole community and try to see where  
20                   the real gaps are.

21                   What we really see is an  
22                   opportunity to perfect these non-traditional

1 modalities. And I know we have talked -- and  
2 Gen and I sat here yesterday and listened to  
3 the discussion on evidence-based therapies.  
4 Although I'm a firm believer in it, I'm also  
5 a firm believer in paralysis or analysis and  
6 paralysis by analysis, whatever you want to  
7 call it. But, you know, long-term studies --  
8 there's a lot of people that are in need of  
9 help -- I think long-term studies are going to  
10 just make for a lot more backlog.

11 So, we are willing to try  
12 anything. It is amazing what a day on an  
13 archery, it is amazing what a day kayaking  
14 will do. And I know that recreational therapy  
15 has a lot of evidence-based research, but at  
16 the end of day it is amazing what that will  
17 do.

18 I told somebody once, and I had a  
19 psychiatrist, and he looked at me like I had  
20 three eyes, that I'm not as sure -- I think  
21 one of the big mistakes we have made in DoD  
22 and the VA is combining TBI and PTSD in the

1 same language. There's no doubt that TBI  
2 complicates PTSD, but I'm almost of the  
3 mindset, after watching the people come  
4 through our facility, that PTSD is more of a  
5 disease of the heart than the brain. And I  
6 can tell you a lot more about that.

7 The trauma that we see processed,  
8 it goes way back. It is not just military  
9 trauma. So, when you see real severe PTSD  
10 cases, the trauma probably started a long time  
11 ago.

12 And I'll just give you one  
13 example. We hosted six men who had been raped  
14 on active duty, the MST program. Four of the  
15 six had been raped since they were six years  
16 old. So, it is just a really interesting  
17 dilemma of what type of trauma is in these  
18 folks before we even get them in the military.  
19 And we've got some thoughts on that as well.

20 One of the things that we think is  
21 there's a way of leveraging existing  
22 infrastructure rather than building high-

1           dollar facilities like this. You know, the  
2           VFW and the American Legion have some great  
3           infrastructure. I'm a lifetime member of the  
4           VFW. We have a million-dollar facility in  
5           Berryville, Virginia. Right now, the  
6           population is primarily Vietnam vets. There  
7           are some Korean War vets and one or two World  
8           War II vets left in our post. But I think, as  
9           time transitions, I think figuring out a way  
10          of leveraging some of this infrastructure  
11          could be very interesting for this new  
12          generation of war-fighters that suffer. And  
13          that is something we are really interested in.

14                        We also, like I said, are very  
15          interested in looking at some what I would  
16          call revolutionary-based private/public  
17          partnerships. And I don't think that has been  
18          explored enough yet. Because when you look at  
19          the amount of money spent on healthcare and  
20          you look at the amount of money spent for us  
21          to take a family in, which is 200 bucks a day,  
22          I think for a little bit of public money, we

1           could do a whole lot more work. And that is  
2           something that we are exploring.

3                       The next slide, the question was,  
4           what interferes with transition? We said  
5           there's not much interfering with access to  
6           Boulder Crest. To get a reservation at our  
7           facility, you literally just go online like  
8           you would a hotel. And then, our community  
9           outreach person and reservations person at the  
10          facility will work with the family to ensure  
11          that we understand that they do have, in fact,  
12          combat deployments. And if that is a DD-214  
13          that is provided, if it is a letter from a  
14          Base Commander or a supervisor, we're okay  
15          with that.

16                      We have debate over and over  
17          again: is anybody going to rip us off and  
18          come there and say that they had combat time?  
19          We probably think so, but at the end of the  
20          day, if one person slips through or one family  
21          a year, we are not going to worry about it.

22                      There's no cost to the individual

1 warrior or family. If the retreats are fully  
2 paid for, the family R&R stays, all they have  
3 to do is get there and pay for food. And even  
4 sometimes the food is provided.

5 We had four families over the  
6 holidays, Christmas Eve. And a friend of  
7 mine's wife is a pastry chef in D.C. She  
8 brought a bunch of chef friends out and they  
9 cooked a breakfast for free. So, those are  
10 the kinds of things that are going on with the  
11 community.

12 The one thing that we think in  
13 transitioning or using our facility is an  
14 obstacle is the awareness. We haven't done a  
15 great job of -- it has mostly been word of  
16 mouth. So, we are working harder this year,  
17 because we just opened last year, to let  
18 people know we're here.

19 And I think the second-to-last  
20 question was, how can DoD improve transition?  
21 I have transitioned. I never looked back. I  
22 started a company. It went from 50 to 500

1 employees in a couple of years. I hired 300  
2 transitioning veterans into a company of 500,  
3 personally sat through 300 interviews of 300  
4 people that we hired, mostly EOD and Special  
5 Forces MOSes in my company. And so, I have a  
6 little bit of experience. I'm probably not an  
7 expert.

8 I do think one of the challenges  
9 in the VSO world, MSO world, we keep hearing  
10 over and over, how do I know what resources  
11 are available? So, if I transition back to  
12 Bluemont, Virginia or Loudoun County, Virginia  
13 or Martinsburg, West Virginia, what are the  
14 nonprofits that are in the area that are  
15 available? And I don't think anybody has done  
16 a good job.

17 I mean, I have literally heard the  
18 number 45,000 VSO/MSOs to 250,000. And I'm  
19 still not sure anybody got the list. I've  
20 listened to Dave Sutherland say those numbers  
21 for probably four or five years now. So, I  
22 mean, I would love to see the list myself,

1 just to really see what we have and, then,  
2 figure out how to catalog it.

3 And along those lines, we thought  
4 maybe creating some kind of a catalog, you  
5 know, like the Veterans Job Network, where all  
6 these VSOs are listed in there. There are a  
7 couple of things, the National Resource  
8 Directory, some of these databases that are  
9 pretty full, but not everybody is in them. I  
10 have gone through them.

11 The challenge, by the way, of  
12 getting your VSO or your MSO into the National  
13 Resource Directory is not easy. So, maybe  
14 making that access easier for organizations  
15 could be good.

16 And then, how do you publicize  
17 that, which is always a big challenge? How do  
18 you get out to a 22-million-person population  
19 and say, "Here's the websites" or "Here's the  
20 portal."? Not that I think we need a single  
21 portal, but I do think we need better  
22 information on what is out there.

1                   The last question you posed to us  
2                   was, will your activities change? We don't  
3                   think so. I will tell you that, when we  
4                   started planning this retreat facility in  
5                   2010, I thought that the majority of our  
6                   guests would be amputees from Walter Reed and  
7                   Bethesda. That has not been the case. We  
8                   have had as many active-duty as we have had  
9                   veterans, and we have had more families  
10                  suffering with the effects of combat stress  
11                  than we have had amputees. So, that is  
12                  probably what we think will continue to  
13                  happen. So, we don't expect anything to go.

14                   We expect to continue our mission.  
15                  And obviously, we will get better and smarter  
16                  as we continue to run the facility.

17                   And finally, we really hope to  
18                  serve as a model. We probably get, without  
19                  exaggerating, we probably get two phone calls  
20                  a week on people who have been given property  
21                  or have a similar idea. I tell everybody,  
22                  "Don't do it yet." At least I don't want to

1 provide advice because I'm not sure we've got  
2 it right yet. I think we will be the leader  
3 in this space, specifically on the therapeutic  
4 side, but I do think there will be a lot more  
5 facilities as far as the recreational therapy,  
6 families who own anything from timeshares to  
7 family estates who will donate them and allow  
8 people to come stay for free.

9 I do know of one wealthy guy in  
10 Idaho, up in Sun Valley, Idaho, who just gave  
11 away a fairly-substantial piece of real estate  
12 for Wounded Warriors only. There's another  
13 guy in New Hampshire right now working on  
14 something. There's another guy not far from  
15 our facility who has been in the newspaper  
16 recently that's trying to build something.

17 So, I do think this will be  
18 something more, but at the end of the day it  
19 is not just about R&R. And I don't want you  
20 to take away that this is a free vacation  
21 place for veterans because the therapy that is  
22 going on out here is world class.

1                   And when I say "world class," I  
2                   know what it is because I spent, as an  
3                   executive, I spent 10 years going to the Mayo  
4                   Clinic and getting executive physicals. If  
5                   you have never done that and you can afford  
6                   it, go do it because you will never have a  
7                   medical experience like that again in your  
8                   life.

9                   What we are offering out here is  
10                  world class. We have got therapists that I  
11                  don't think would want to be working inside of  
12                  a bureaucracy. And that is no disrespect to  
13                  military medicine. But I am telling you, the  
14                  people that are delivering therapies out here  
15                  are unbelievably talented.

16                 I would never in my life have  
17                 believed that somebody suffering with  
18                 something as dark as sexual trauma would walk  
19                 away from this facility in three weeks and say  
20                 it was life-changing, and not only say it was  
21                 life-changing, but to see it in their faces.

22                 So, thanks again for having us

1 here, and I'm happy to answer any questions.

2 MEMBER REHBEIN: Sir, a few months  
3 ago, on one of our visits we were in Park  
4 City, Utah at the National Ability Center.  
5 Some of what you talk about reminds me very  
6 much of some of the things that they are doing  
7 out there. Is there any conversation that  
8 goes on between existing facility to trade  
9 knowledge and best practices, what works, what  
10 doesn't? Is there anything organized along  
11 those lines, experience that can be drawn on?

12 MR. FALKE: I was going to say  
13 yes, until you said "organized".

14 (Laughter.)"

15 I do think there is a lot of great  
16 discussion going on. And funny enough, where  
17 a lot of the great feedback and knowledge-  
18 sharing goes is from the Wounded Warriors who  
19 attend these things. So, the guy who is  
20 skiing out there or cycling with Race Across  
21 America, or whatever the event is, when they  
22 come to different facilities, they will make

1           recommendations.

2                           The one thing about our military  
3           and veteran population, they're not shy. So,  
4           we do get a lot of great feedback. And then,  
5           the caregivers, I mean, the caregiver side of  
6           what we do and the caregiver retreats  
7           specifically, I mean, they are not shy. They  
8           will tell you exactly what you need to do to  
9           get better and what you can do.

10                          I think the major adaptive sports  
11           centers do collaborate a lot. We collaborate  
12           with certain modalities that we work. So,  
13           like equine therapy, we have had a bunch of  
14           people that are in the equine therapy business  
15           that we have had discussions with. We don't  
16           ride. So, there is a difference between  
17           therapeutic riding -- sometimes when you say  
18           "equine," people just think they're getting on  
19           a horse's back and going for a ride.

20                          We do something called HIGH, which  
21           is Horse-Inspired Growth and Healing, which is  
22           work that is done with the animal on the

1 ground. It builds a level of confidence when  
2 you are working with a 2,000-pound animal on  
3 the ground, not much different than dogs other  
4 than the size really, but very, very  
5 therapeutic.

6 I had a Delta IV Sergeant Major --  
7 and I'll just tell this one story because of  
8 how important these modalities can be. This  
9 guy walked in, and a typical Delta IV Sergeant  
10 Major; he wasn't sure who was in the room. He  
11 had his back to the wall. He had his rucksack  
12 on his shoulder and he never looked up. He  
13 looked at the floor. And this guy is  
14 suffering from, I think, 13 deployments to  
15 Afghanistan and Iraq, and definitely suffering  
16 with Post Traumatic Stress, and never looked  
17 up off the floor.

18 And we took him -- and I've got  
19 the picture on my phone, if anybody wants to  
20 see it -- I took him to the equine. And  
21 within 10 minutes, his demeanor changed like  
22 that. And if somebody would have told me

1           petting a horse was going to change a Delta IV  
2           Sergeant Major's demeanor 10 years ago, I  
3           would have called you a liar, but it was  
4           amazing, an amazing response from what's going  
5           on with these non-traditional therapies.

6                        I don't know if that answered your  
7           question, sir. But if I could say one thing  
8           about these things, it is be careful in  
9           looking for that evidence because it is a  
10          smile, a handshake, and a hug that makes a big  
11          darn difference.

12                       CO-CHAIR CROCKETT-JONES: Thank  
13          you very much.

14                       Let's move on to Mr. Jim Lorraine.

15                       MR. LORRAINE: Hi there. Just as  
16          my colleague did earlier, my bio is in the  
17          book. But my background is United States  
18          Special Operations Command. I stood up the  
19          CARE Coalition. Kevin McDonnell took my  
20          place, followed me there. Before I left, I  
21          worked for the Chairman as a Special  
22          Assistant.

1                   Left both of those jobs because I  
2                   was a military caregiver. My wife is active-  
3                   duty Air Force, got real sick, and I had to  
4                   leave both jobs to take care of her. So, my  
5                   perspective is from active-duty military, ran  
6                   a program like this, became a caregiver, left  
7                   my job, moved back home to her family, so that  
8                   I could press forward going forward. So, that  
9                   is my perspective.

10                   I want to thank my colleagues  
11                   here. Great programs. I'm going to get you  
12                   afterwards and we're going to fill your place  
13                   with Augusta.

14                   But our program is a little bit  
15                   different. We are a community-based program.  
16                   Our mission is to improve the quality of life  
17                   of warriors and their families that live in  
18                   the central Savannah River area. To get an  
19                   idea, as it says at the bottom, it's 13  
20                   counties around Augusta, Georgia. Nine  
21                   counties are in Georgia; four counties are in  
22                   South Carolina.

1                   So, when I deal with a  
2                   bureaucracy, I deal with seven municipalities,  
3                   13 counties, and two states. So, what is the  
4                   issue in South Carolina isn't the same issue  
5                   in Georgia. So, we balance that.

6                   And again, when I say "warriors,"  
7                   our definition of warriors comes straight out  
8                   of the dictionary. A warrior is somebody who  
9                   is either engaged or experienced in warfare.  
10                  That's either a military or a veteran and  
11                  their caregivers. So, that's where our focus  
12                  comes from that effort.

13                  All eras, World War II to a kid  
14                  who just gets out of the military today. So,  
15                  it's all eras.

16                  These are the numbers, and they  
17                  are in the ball park. So, if anybody has a  
18                  dispute over the exact number, they are in the  
19                  ball park.

20                  What we are focused on in Augusta  
21                  is the 66,000 veterans who live in the CSRA  
22                  and the 8700 post-9/11 vets that live in the

1 CSRA. Our mission is honestly to find them  
2 all and to identify who they are.

3 This is the system to a kid  
4 getting out of the military today. It is just  
5 a puzzle. They come out of a great TAP glass  
6 and GPS, and all the other programs out of  
7 Camp Pendleton, and it was taught at Camp  
8 Pendleton.

9 And then, they fly home and they  
10 end up in Augusta, Georgia. And everything  
11 that they learned at Camp Pendleton, the  
12 concepts are the same, but the contexts are  
13 completely different.

14 If you live in South Carolina,  
15 you're getting your healthcare from the VA in  
16 Georgia, but you're filing your claim in South  
17 Carolina. The Vet Center is in Georgia. You  
18 can be in South Carolina. You have to  
19 register. It just doesn't make any sense.

20 So, what our effort is, our effort  
21 is to take that puzzle and put it together.  
22 And the way we do it is four steps. It is

1 connect, educate, advocate, and collaborate.

2 The connect, our goal is to find  
3 and build a relationship with every veteran in  
4 our community. In the 18 months that we have  
5 really made a forced effort at that, we are at  
6 4,000. Most of the veterans -- I spoke at a  
7 MOAA event, sat at a table. Vietnam era  
8 veterans, medically service-connected  
9 disabilities, sitting around the table, four  
10 of them; none of them were enrolled in the VA,  
11 none of them.

12 So, what we did was we went back  
13 to the next meeting with the VA and enrolled  
14 every single eligible veteran in the VA. We  
15 said, "Hey, we're going to bring it to you  
16 rather than us bringing it to them."

17 And then, the next ask is, "I want  
18 you to find five more and bring them to us,  
19 and we're going to help you connect."

20 Educate. It's really about how do  
21 you -- you come into a community or you go  
22 through TAP or you go through another program,

1           and what's available to you on the outside?  
2           Unless you know the system, you don't have a  
3           clue. And it may be case-specific.

4                        So, what we do is we educate the  
5           warrior on what's available to him and their  
6           caregiver about what's available to them not  
7           only in their community, but within the state  
8           and nationally. It is our job to know what is  
9           available, where it is, and how to access it.

10                      And then, advocate. If they hit a  
11           roadblock, we advocate on their behalf to  
12           bypass that roadblock and to move it along,  
13           press it along. Our focus is results. We  
14           don't want to sit and have a discussion. We  
15           want the results and get to the endstate to  
16           have a positive outcome overall.

17                      And collaboration is important.  
18           We collaborate with everybody. We don't have  
19           any MOUs. We work closely with other  
20           partners. Our job is we'll find your  
21           customers and we'll bring them to you, but you  
22           have to provide the service. If you don't

1 provide the service, we'll go to somebody  
2 else, and then, they'll provide the service.

3 And what we found is, when I came  
4 to Augusta about two-and-a-half years ago,  
5 there were about 20 nonprofits -- I think  
6 there are 45,000 -- there were about 20  
7 nonprofits in our area that were in this  
8 space. And they were local; some were  
9 regional. Ten of those nonprofits are now  
10 gone because they just couldn't provide any  
11 service. It was either they didn't provide  
12 service or they were more focused on  
13 fundraising than providing the service. So,  
14 we just bypassed them. Because it was about  
15 how are you going to contribute to the  
16 endstate and the goal.

17 How we do it is that we build a  
18 relationship with all these community  
19 programs. It is sort of an eye chart there,  
20 and it is in your slides. But we look at  
21 school, healthcare, VA, the VA services,  
22 housing, all the service providers, and then,

1 jobs.

2 We build a relationship with  
3 employers, with the Georgia and South Carolina  
4 Department of Labor, but, more importantly,  
5 with the employers. Because what we want to  
6 do is we go into the employers and we say, "I  
7 want to help your veterans that are here.  
8 Most of them are eligible for the GI bill. I  
9 want to help them go to school, so that they  
10 can become a better employee."

11 The other thing is, when the  
12 government shutdown happened -- we have a lot  
13 of federal jobs -- the Department of Energy  
14 had to furlough a number of people, and the  
15 contractors fell into the same thing. We had  
16 a relationship built with the companies. So,  
17 instead of sending them over to the South  
18 Carolina Department of Labor, all the veterans  
19 came to us, and we rolled them in to make sure  
20 that they had their healthcare, made sure that  
21 their families were taken care of, got them  
22 into education services that they could use

1 while they were over the shutdown, which for  
2 some of them lasted about four months. Used  
3 federal and non-federal programs, and then,  
4 got them back into the employment.

5 The benefit was the employers  
6 said, "If you're going to do that for my  
7 employees, I want more of them." And so,  
8 then, they came back to us with a requisition  
9 when the money kicked back in at October.  
10 They came back to us and said, "We're going to  
11 up our staffing by 20. I want 20 of them, 20  
12 more vets."

13 This is our biggest problem, is  
14 finding them. And we're doing it through  
15 branding, through commercials. Our  
16 commercials that run on television in our  
17 local area say, "If you wore the uniform or  
18 your nation and served your country, and swore  
19 to defend against the Constitution, against  
20 all enemies, foreign and domestic, we want to  
21 know who you are. You earned services that  
22 you're entitled to. Please let us know who

1           you are and we'll help you." Even if they  
2           don't need help right away, we just want them  
3           to know that in the back of their head, that  
4           they can call us and that we'll help them.

5                        This is how we do it. So, we just  
6           don't focus on -- I'm sorry, I'm completely  
7           blowing this in terms of where the button is  
8           -- so, we don't focus on one piece. Our focus  
9           is the center, which is quality of life.

10                      So, if someone comes to us and  
11           they say, "Hey, I'm having a housing problem,"  
12           I guarantee you their issue isn't housing.  
13           It's probably education. It's probably  
14           employment. It's probably their access to  
15           healthcare, Post Traumatic Stress, TBI.  
16           Whatever the contributor is, their issue is  
17           not housing. The symptom is housing, but not  
18           the core issue.

19                      So, everyone we meet, we say, "So,  
20           how are you doing?"

21                      You see the spirituality piece  
22           there. In Augusta and in the area that we

1 live in, churches are a big thing and they  
2 have an enormous amount of resources,  
3 resources that on a national level, the  
4 TRICARE groups, they would never know that  
5 they existed there, but they provide a vast  
6 amount of counseling.

7 I can tell you that our social  
8 workers don't run into a lack of counseling  
9 services in our community. People can get  
10 right in, whether it is through the spiritual,  
11 through the VA healthcare, through the  
12 community programs, through the Georgia  
13 Regents University, which is our medical  
14 research center. It's you've got to know  
15 what's in the community and what they're  
16 offering, and then, plug the people in. Plug  
17 the people in.

18 So, we focus holistically, and you  
19 see our name wrapped around the outside with  
20 our community partners. But we don't provide  
21 any direct services at all. We are truly  
22 navigators of the system. Understand what the

1 issue is with the veteran and navigate through  
2 it.

3 So, quickly, I'll run through  
4 this. Process and action. A warrior comes to  
5 us with a question or a life issue. We  
6 understand it. We know the warrior. We know  
7 the question and the issue. And what we do is  
8 we develop a plan. Then, we turn that plan  
9 down to our partners, the community partners.  
10 And some are national partners.

11 So, if someone would benefit from  
12 a retreat, I'm going to call you and say,  
13 "Hey" -- there's a couple of things that have  
14 to happen first, but one of the steps in the  
15 process of success would be to go to Boulder  
16 Retreat.

17 I don't mean to keep poking you.

18 So, we bring this down to the  
19 community. We sort of synchronize the  
20 approach. We say, "Okay, you're first, you're  
21 second, you're third, you're fourth. Here's  
22 what I need you to provide." They go, "Roger

1           that," and then, they provide the service in  
2           that order to the warrior.

3                       And then, we do another thing. We  
4           follow up with both. We follow up with the  
5           warrior to say, "Hey, is everything on track?  
6           Okay, did you clear that first step, that  
7           first gate? Now let's move to the next one."

8                       And then, we go back. If they  
9           say, "Yes, I'm good to go," we go back to our  
10          partner and say, "Hey, thanks a lot. You did  
11          a great job." If they say, "Do you know what?  
12          Nobody called me back," we circle back to that  
13          nonprofit and say, "Did we communicate wrong?  
14          Is there something going on here? You need to  
15          provide this. Let's step in and do it."

16                      I thought this was cute.

17                      So, anyway, in the endstate, you  
18          bring it all together, bring all the puzzle  
19          together. The warrior is happy.

20                      Our work locations, we go to where  
21          the veteran is, the warrior is. So, we work  
22          out of the Salvation Army, which is the Kroc

1 Center. It is like a one-stop in Augusta.  
2 And that is where we launch from. But we have  
3 folks who work at Aiken Technical College, the  
4 University of South Carolina, Aiken; out of  
5 the Goodwills; Ft. Gordon, we have two seats  
6 at Ft. Gordon working for the Garrison  
7 Commander there. The local VA uses us also.  
8 Again, it's 13 counties, a pretty big area to  
9 cover. We have the tyranny of distance for  
10 us.

11 These are our partners, national  
12 and local. We are not restricted. We will  
13 work with anybody.

14 So, we worked with the USO and the  
15 Gary Sinise Foundation to bring Gary Sinise to  
16 Ft. Gordon to perform for the troops that  
17 ended up getting stuck there. There was a  
18 heat spell and they closed down the post.  
19 Everybody was ticked. They couldn't go  
20 outside. They couldn't do a lot of things.  
21 We got Gary to come out to play. The USO  
22 helped us to do it. We worked with the

1 foundation. The troops came out at night. He  
2 performed, had a great time, almost got blown  
3 off the stage from a tornado, but that is  
4 beside the point.

5 Anyway, we work with everyone. In  
6 terms of VSOs, we're not a VSO. We work with  
7 VSOs to do claims/benefits.

8 Here's our results since February  
9 of 2012. We have virtually eliminated veteran  
10 homelessness from Augusta, Georgia. We had  
11 195 homeless veterans. The official count  
12 today is six.

13 In that time, in that period, we  
14 worked and got 220 -- when I say they're  
15 permanently housed, they're paying their own  
16 rent. I just had one of our folks who we  
17 engaged with 18 months ago who purchased her  
18 own house through a VA loan because she went  
19 from homelessness. We got her into school.  
20 She got a job. We got her to a consumer  
21 credit counseling service, a local one,  
22 cleaned up her credit, got her rating above

1 where the VA could give her a home loan. She  
2 bought a house. She was the first person in  
3 her family, a female veteran, Desert  
4 Shield/Storm. Desert Shield/Storm, not post-  
5 9/11.

6 And I will tell you, at a  
7 community level, when a post-9/11 veteran  
8 comes into us, they are easy because they have  
9 so many services and so many programs that are  
10 targeted toward them. But, once you cross  
11 that bridge, if you got out in 2000, God help  
12 you; there's not as many resources and  
13 services that are available. I see Ron  
14 shaking his head. You know exactly.

15 Five hundred and thirty-six  
16 enrolled in colleges and training. Remember  
17 back to our mission. Our mission was focused  
18 on improving the quality of life within the  
19 community.

20 So, the message to the warrior is,  
21 "Hey, we want to take care of you because it's  
22 the right thing to do." The message to the

1 community is, "Veterans are economically-  
2 smart. So, if have 20,000 post-9/11 veterans  
3 come to our community and use their GI bill,  
4 that's \$500 million a year in federal GI bill  
5 funds that come into my community. Why  
6 wouldn't I take care of them? Why wouldn't I  
7 take care of them?"

8 And that doesn't count disability  
9 benefits and voc rehab and all the other  
10 pieces. That's just the GI bill.

11 So, we tell the community leaders  
12 and our businesses, "Doing this is smart for  
13 the community." We tell everyone else, "It's  
14 also the right thing to do. It's also the  
15 right thing to do."

16 Unemployment, 195 unemployed  
17 warriors employed. Again, it is because it is  
18 a personal relationship with a business at the  
19 local area. This is not the 100,000 Jobs  
20 Initiatives, because I can tell you in  
21 Augusta, Georgia, JPMorgan and these major  
22 companies are not there. It is a mom-and-pop,

1           small business. I always say, "Who's the  
2           biggest employer in the United States?" Small  
3           business, and they're in Augusta and they're  
4           in my region. And they are where the veterans  
5           want to live. You just have to find the  
6           opportunity for them.

7                         We increased the VA enrollment.  
8           One of our policies is, of the 3800, everyone  
9           we meet, 100-percent enrollment in money  
10          benefits, 100-percent enrollment if you're  
11          eligible in VA healthcare, 100-percent, if  
12          you're eligible, enrollment in the Wounded  
13          Warrior Project. They are one of the main  
14          programs that we use.

15                        We are going to leverage all the  
16          resources we can to help you.

17                        I know I'm running out of time.  
18          I'm running over. So, just bear with me here  
19          one second.

20                        And again, 3800, our number is  
21          now, since I sent this to you, we're over  
22          4,000 now. We had a big push.

1                   So, this is our national outreach.  
2                   The Wounded Warrior Project came to us and  
3                   said, "Hey, we really like how you're doing  
4                   business. Can you replicate this in five  
5                   communities this year, five communities next  
6                   year, five communities going forward?"

7                   And so, our goals are pretty tough  
8                   in this program. Because of the Wounded  
9                   Warrior Project, we bring the funds to the  
10                  community, so that they can focus on doing the  
11                  work and not necessarily doing the  
12                  fundraising. We want them to get results that  
13                  resonate within the community, so the  
14                  community, then, can resource and fund them.

15                  But if you look at the measures  
16                  here, we want to find, in 36 months we want  
17                  them to have a personal relationship with  
18                  80,000 or 80 percent -- 80,000? -- 80 percent  
19                  of the post-9/11 vets.

20                  In Tacoma, Washington, where we  
21                  just engaged with, that is 20,000 troops that  
22                  this organization will get to know.

1                   Ninety percent graduation rate.

2                   It is not important that they go to school.

3                   It's good, but it is important to graduate.

4                   So, whatever gets in their way of graduation,

5                   childcare, transportation, whatever the

6                   reason, tell us and we'll fix it. Just stay

7                   in school. Just graduate.

8                   We also look at optimizing the use

9                   of the GI bill. So, we advise the warriors on

10                  how to best use their GI bill so they don't

11                  burn through it and end up not completing the

12                  degree. We sort of pace it out.

13                  We had a VetCorps volunteer that

14                  worked for me that did a great paper on that

15                  and showed the benefit, the economic benefit,

16                  too, to the schools, why it was smart.

17                  Reduced homelessness by 70

18                  percent. You can see the unemployment.

19                  And then, what we think is that

20                  this year we will touch 40,000 post-9/11

21                  veterans in the community, in the country,

22                  through this. The next year we look to double

1           that.

2                           The model that we have is as  
3           applicable to little Clinton, New York, where  
4           I grew up, which has got 2400 people in it, as  
5           it is to Boston, Massachusetts. It just  
6           works. It is somebody who is the honest  
7           broker in a community who can connect people  
8           to resources.

9                           In terms of the questions you had,  
10          I wrote them out and I didn't include them on  
11          the slides. But what type of services will  
12          the current generation need long-term? In my  
13          opinion, understanding of opportunities,  
14          because they don't know what they don't know;  
15          navigation of the system, because it's not  
16          what you know; it's who you know, and access  
17          to the services. How do we increase the  
18          access?

19                          No. 3, how prepared is DoD and the  
20          VA to care? What I see locally, it breaks my  
21          heart. When I see a family and they have to  
22          uproot themselves to move to San Antonio or to

1           move to Washington, D.C. or to move to a site  
2           where they can get DoD or VA care, when they  
3           could actually fee-for-service, they could  
4           stay in Augusta and get it at the Medical  
5           College of Georgia or the facilities that are  
6           there.

7                       Basically -- and I'm a nurse by  
8           trade -- I always believe that the best care  
9           is provided by the family. If you can keep  
10          them close to their family, that is almost as  
11          good as having good quality care.

12                      And then, what could our community  
13          organization do? The same thing that we do at  
14          colleges and universities. Hospitals can take  
15          care of them. We'll take care of all the  
16          other stuff in the area.

17                      What interferes with  
18          transitioning? And I'm going to read this.  
19          "The blind limitation of the joint ethics  
20          regulation. The joint ethics regulation  
21          provides little room for JAG interpretation  
22          when a Commander seeks gray area, and when

1           gray area is identified."

2                       So, when gray area is identified,  
3           programs are inconsistent across the Services.  
4           What happens is, if I go to Tacoma, they have  
5           a different interpretation than if I'm at Ft.  
6           Gordon, than if I am at Charleston Air Force  
7           Base.

8                       And the Commanders, while they  
9           want to work with you, they look to their JAG.  
10          And if the JAG can't find any interpretation,  
11          it's not happening.

12                      Our goal as a community is to  
13          improve Ft. Gordon, is to improve the services  
14          that they provide, to make them better. It's  
15          to make the VA better. But I can't do it  
16          without partnering with them.

17                      And the joint ethics regulation  
18          prohibits me from partnering with a federal  
19          entity. And so, I would say that is probably  
20          the biggest obstacle that we face that I have  
21          seen.

22                      How can DoD improve the transition

1 services? Communicate with community  
2 programs.

3 And I will tell you, I sat through  
4 the TRO brief. I didn't even know that they  
5 existed. But we could leverage our community  
6 resources extensively if we just could  
7 communicate with the people who provide the  
8 services. It becomes so stovepiped. The one  
9 group that we can't collaborate with, DoD and  
10 the VA, because it is a very closed system.  
11 Figure out how we can open it up.

12 And then, how are our activities  
13 going to change? They're not going to change  
14 a bit. We're going to keep doing what we do.  
15 We support all services, as I said.

16 Any questions?

17 CO-CHAIR CROCKETT-JONES: I think  
18 we're good.

19 Denise, anything?

20 Okay. Well, thank you very much.  
21 It has been very helpful, and I think that  
22 you've really got a handle on the real

1 population. So, thank you very much.

2 DIRECTOR DAILEY: Thank you,  
3 gentlemen.

4 This concludes the Task Force's  
5 activities for this business meeting. We will  
6 see you again in February, late February, and  
7 we'll be in touch between now and then for  
8 your installation visits.

9 Thank you.

10 (Whereupon, at 4:30 p.m., the  
11 meeting 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: January Business Meeting

Before: Task Force on Recovering Wounded

Date: 01-28-14

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*  
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Court Reporter

**NEAL R. GROSS**

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