

DEPARTMENT OF DEFENSE

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

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BUSINESS MEETING

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THURSDAY  
APRIL 17, 2014

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The Task Force met in the  
DoubleTree by Hilton Hotel Washington D.C.-  
Crystal City, Washington Ballroom, 300 Army  
Navy Drive, Arlington, Virginia, at 8:30 a.m.,  
MG Richard Mustion, DoD Co-Chair, and Suzanne  
Crockett-Jones, Non-DoD Co-Chair, presiding.

PRESENT

MG RICHARD P. MUSTION, DoD Co-Chair  
SUZANNE CROCKETT-JONES, Non-DoD Co-Chair  
CSM STEVEN D. DEJONG, Member  
RONALD DRACH, Member  
TSGT ALEX T. EUDY, Member  
LTCOL SEAN P.K. KEANE, Member  
DAVID REHBEIN, Member  
CAPT ROBERT SANDERS, Member  
RICHARD A. STONE, Member  
LTCOL THEODORE WONG, Member

ALSO PRESENT

DENISE F. DAILEY, Executive Director  
MICHAEL PARKER, Wounded Warrior Advocate  
BRENDON GEHRKE, Veterans of Foreign Wars  
MERRISSA LARSON, Department of the Navy  
ROBERT POWERS, Department of the Navy  
CAPT BRENT BREINING, Department of the Navy  
CDR MICHAEL CHARISSIS, Department of the  
Navy  
KENDALL HILLIER, Department of the Navy  
HORACE LARRY, Air Force Services  
COL TODD POINDEXTER, Air Force Medical  
Support Agency  
TIM TOWNES, Air Force Survivor Assistance  
Program  
LT COL. MARK MEERSMAN, Air Force Medical  
Support Agency  
COL WILLARD A. BUHL, Marine Corps Wounded  
Warrior Regiment  
PAUL WILLIAMSON, Marine Corps Wounded  
Warrior Regiment  
APRIL PETERSON, Marine Corps Wounded Warrior  
Regiment  
JOHN KUNZ, Research Director  
SUZANNE LEDERER, Deputy Research Director  
AMBER BAKEMAN, Research Team  
ASHLEIGH DAVIS, Research Team  
MATTHEW MCDONOUGH, Research Team  
ASHLEY SCHAAD, Research Team  
JOHN BOOTON, Staff  
LAKIA BROCKENBERRY, Staff  
STEPHEN LU, Staff  
DAVID C. MCKELVIN, Staff  
HEATHER JANE MOORE, Staff  
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P-R-O-C-E-E-D-I-N-G-S

(8:33 a.m.)

CO-CHAIR CROCKETT-JONES: We have a little open time and so I would like to get the members to introduce themselves again. And then we some discussion time for the document I think you all have a copy of with the consolidated observations.

So, let me start with introductions. And as usual, Mr. Drach would you start us? Give us an introduction and we will go around the table.

MR. DRACH: Yes, I'm Ron Drach. I have been on the committee since the beginning and one of non-DoD members.

LT COL WONG: Good morning. I am Lieutenant Colonel Wong. I am the Marine Corps representative. I am recently a new member of the Recovery Task Force.

CSM DE JONG: Command Sergeant Major Steve DeJong. I represent National Guard Bureau.

1                   MR. REHBEIN: Dave Rehbein, one of  
2 the original members, research scientist, past  
3 national commander for the American Legion.

4                   CO-CHAIR MUSTION: Rick Mustion. I  
5 represent the United States Army.

6                   CO-CHAIR CROCKETT-JONES: Suzanne  
7 Crockett-Jones. I am the spouse of a  
8 recovering warrior and I am civilian co-chair.

9                   DR. STONE: Rich Stone, non-DoD  
10 member.

11                   LTCOL KEANE: Lieutenant Colonel  
12 Sean Keane. I have a member of the Task Force  
13 since the inception and I am the Reserve  
14 member.

15                   TSGT EUDY: Technical Sergeant  
16 Alex Eudy, representing both the Air Force and  
17 Special Operations Command.

18                   CAPT SANDERS: Captain Rob  
19 Sanders. I am a new member of the Task Force  
20 and I represent the Navy in my other capacity.  
21 I was the Commanding Officer of the Navy  
22 Marine Corps PEB attorneys.

1                   CO-CHAIR CROCKETT-JONES: Okay,  
2 Denise, if you would like to walk us through  
3 the observation so that we can get some  
4 discussion going.

5                   MS. DAILEY: Good morning, ladies  
6 and gentlemen. We talked briefly yesterday  
7 about a framework and here, I just want to  
8 spend a little bit of time talking about the  
9 observations that we have gathered from you  
10 all over this last year. And you have the  
11 Navy and the Marine Corps this afternoon  
12 information briefing. And so I assume that is  
13 going to generate some more thought process  
14 and some more ideas. So, Tuesday we are going  
15 to have -- I want to kind of give you a  
16 deadline for good ideas for what is jelling  
17 for you and what is not jelling. So, I will  
18 send out a reminder.

19                   But this is the thought document.  
20 It is called Members' Consolidated  
21 Observations. And I just want to spend some  
22 time going through it. And again, it is in

1 the same framework that Dr. Phillips gave us  
2 in the early fall for kind of looking at where  
3 the gaps are.

4 All right, so over this last year  
5 you all have talked about a strategic  
6 observation about the holistic reform of IDES.  
7 And we have pinged, let's say, the services on  
8 this question in an effort to gather some  
9 data, together their opinions. Believe it or  
10 not, ladies and gentlemen, no one really wants  
11 to talk about the holistic reform of IDES.  
12 They do send back, push back a little bit and  
13 say not really my lane. You should pitch that  
14 up to OSD, WCP. But sometimes, they will  
15 weigh in and sometimes they will give us some  
16 thoughts from a service perspective. But on  
17 the whole when we have been trying to gather  
18 ideas from the services, it has been talk to  
19 OSD.

20 That is about right, Suzanne and  
21 my research team back here. We don't have a  
22 lot of feedback from the services on holistic

1 reform, although we tried to ping them  
2 throughout the year. All right, so I think we  
3 are going to really be looking at secondary  
4 research to flesh this one out for you.

5 So, the next one is we have this  
6 harmonization across DoD, VA, the private  
7 sector. And I tell you, this one is, if you  
8 go with this one as a framework for a  
9 recommendation or a recommendation, this one  
10 is very well fleshed out. We have lots of  
11 good examples from Tampa to San Antonio to San  
12 Diego of communities that are bringing  
13 together all these services. So, this one, I  
14 think, will tell a good story for you, if you  
15 want to go in this direction. So, we have a  
16 lot of data on this one.

17 Let's go to the next page. And  
18 ladies and gentlemen, right now next May's  
19 agenda is going to look like these major topic  
20 area, where I have these bold prints,  
21 strategic observations related to holistic  
22 reform. That is the first agenda item you all



1 will be looking at in May.

2 Strategic observations related to  
3 harmonization across DoD/VA, that is the next  
4 hour of your May agenda. So again, we have  
5 got a lot of material on the strategic  
6 observations related to harmonization.

7 Number three, slide down a little  
8 bit more, would you please? There we go.

9 Number three, to promote inter-agency  
10 healthcare collaboration in harmonizing  
11 components of DoD/VA and civilian IT systems.  
12 So, this A, B, and C under this one are some  
13 of the directions we would go. These are some  
14 of the data points that we have and could  
15 possibly flesh out at this point.

16 And then we also, on a four, want  
17 to look at under this framework, we are going  
18 to spend some time, and we have it on the  
19 agenda to talk about PTSD care and harmonizing  
20 it across all sectors. Again, you want to  
21 think holistically here on these  
22 recommendations. You want to tell a story

1 about the resources available. You want it to  
2 be patient-centered. So, we are kind of  
3 breaking out IT for you, PTSD for you.

4 And then number five is the  
5 transfer. It is the IC3. It is the  
6 transition between these services and  
7 communities. You have talked -- it is the  
8 seamless nature and how are you going to break  
9 down silos and make the transition between  
10 them smoother.

11 And we have a number of items that  
12 we have seen on this, number one being, and  
13 this is a very good observation and we heard  
14 a little bit about it yesterday but 5(a) is an  
15 inter-agency policy. Inter-agency policy. It  
16 is not an MOA, MOU here, and a MOU here. And  
17 you heard IC3 talk about it. And then  
18 subsequent downward flowing DoDIs and service  
19 regulations. It is a document that transcends  
20 both services.

21 Some of the work the research team  
22 has done is -- or even I did some searches,

1 what documents like that are in our federal  
2 agencies. How do we set up Health and Human  
3 Services -- excuse me. How do we set up the  
4 Homeland Security? Right after the financial  
5 crisis, a number of inter-agency documents  
6 were published to bring together the financial  
7 federal agencies and to synchronize their  
8 oversight of the financial picture to avoid  
9 the financial crisis we had.

10 So, there might be some documents  
11 to support an inter-agency, overarching inter-  
12 agency policy document. But right now they  
13 are in MOU here, MOU DoD, subsequent service  
14 DoDIs and regulations.

15 So, we go down and we talk about  
16 the recovery teams on this one. A lot of this  
17 might be either findings or part of the  
18 recommendation.

19 Six, are going to be family care  
20 givers, integration of family care givers on  
21 this one. And we have -- yes, roll all the  
22 way down to the bottom. There you go. So,

1 your final opportunity to, if you want to,  
2 work care givers again this year. You have  
3 done a lot of work over the last few years on  
4 care givers but we have pulled together a lot  
5 of information on care givers and what would  
6 make a possible recommendation or the findings  
7 for the recommendation.

8 And then down to the bottom,  
9 observations related to military services. We  
10 get a little more tactical starting about  
11 here, ladies and gentlemen. And these are,  
12 you know, you might recognize, for example,  
13 eight, minimize remotely located legal  
14 services for IDES. We ran across this with  
15 the Marines in San Antonio who are getting  
16 legal services from Corpus Christi. And I  
17 think the Marines in Hawaii are getting legal  
18 services from the battalion on West Coast.

19 So, again, you know what do you  
20 want to say? Or these are good points, good  
21 places for you to look at it and say we don't  
22 want to go this small. We don't need to make

1 a recommendation that tells them again, put  
2 legal services where they need to be, close to  
3 the service member. So, at some point in time  
4 not only are you going to want to advocate for  
5 some of these but I need you to kind of sort  
6 out which ones you want to pitch. This is not  
7 the same and the place and you are going to  
8 whittle down.

9 And Sergeant Eudy, you would  
10 recognize number nine, which is to put a  
11 uniformed body at the warrior care policy  
12 office. All civilians are contractors right  
13 now.

14 All right. We have  
15 recommendations for the CoEs again. These  
16 come from the briefings they give us. They  
17 come from the discussions you have had.

18 And 14, we have had this  
19 recommendation about screening practices. We  
20 really are looking at psychological health  
21 from start, from induction to being a veteran.  
22 And if we want to really look at our

1       psychological health environment, these are  
2       not a place to start with who we are bringing  
3       in the military and how we are screening them  
4       for psychological health issue.

5                       We have some observations that are  
6       related to IDES here. These are more tactical  
7       again. You know your decision process has to  
8       be worked through on which ones you all are  
9       going to take on this year, whether they be  
10      big or little. Here are some of the more  
11      tactical ones.

12                      Reserve component, we spent a lot  
13      of time with the reserve component this year.  
14      So, when that happens, we see a lot of  
15      observations that you are bringing to our  
16      attention, that you have in discussions, that  
17      you talk about on the site visits, being down  
18      in Tampa, seeing the reserve component sell  
19      there. The SMSC shutting down generated a lot  
20      of interest with you all. And you gave us a  
21      lot of ideas for recommendations.

22                      I recently sent out a packet of

1 information on what the Army is doing to  
2 continue their reserve component initiatives  
3 in moving their RC members through the system,  
4 even in the absence of the facility at Tampa.

5 So, good reading material for you  
6 on that one. Again, is it something you want  
7 to take on this year?

8 And overall on the last page,  
9 vocational and employment services. We have  
10 built a lot of employment services into the  
11 harmonization observations because, again, if  
12 you are trying to integrate all these  
13 activities and capitalize on the non-profits  
14 and the companies out there that are hiring,  
15 employment needs to be part of that overall  
16 strategic picture. You need employment,  
17 quality of life, education are kind of the end  
18 state, the outcome that you want. So, we have  
19 some tactical recommendations on employment  
20 here but we have also built more strategic  
21 employment recommendations as part of the  
22 holistic picture into your big strategic

1 recommendations.

2                   And then the last one are some  
3 miscellaneous observations that you have  
4 brought forward. And again, these are either  
5 -- and I think like 28, Tech Sergeant Eudy,  
6 you gave us the information we can build some  
7 data and some findings on up on the adaptive  
8 technology, DoDI, the community of adaptive  
9 technology out in the -- that is servicing  
10 wounded, ill, and injured. We haven't been  
11 down that road but Tech Sergeant Eudy gave us  
12 some good data. If you want to go down this  
13 road, if you want to stake a flag in the  
14 ground on an area we have not talked about in  
15 the past, this is one that Tech Sergeant Eudy  
16 has brought to our attention.

17                   All right, so again, just  
18 refreshing you on what you have brought to us  
19 over the last six or eight months. And what  
20 next month is going to look like. Again, by  
21 Tuesday, good ideas and if you feel you want  
22 to whittle one out and you have done circle X,



1 circle X, fax it to me, email it to me. What  
2 you want to spend your time on because there  
3 is 28 here and I have got them all built in to  
4 two days. But if you want to expand some of  
5 those areas for discussion, I will take them  
6 off the agenda and you can spend more time in  
7 other places.

8 Okay. Any other questions? Thank  
9 you.

10 CO-CHAIR CROCKETT-JONES: We have  
11 ten minutes until our public forum begins.  
12 So, I would just like to give us a little  
13 break until that time.

14 So, we will convene again at 9:00.

15 (Whereupon, the foregoing meeting  
16 went off the record at 8:50 a.m. and went back  
17 on the record at 9:01 a.m.)

18 CO-CHAIR CROCKETT-JONES: Good  
19 morning. We have three oral statements for  
20 the public forum, possibly. We definitely  
21 have two.

22 Our first statement comes from Mr.

1 Michael Parker, a retired lieutenant colonel  
2 and Wounded Warrior advocate. We have his  
3 information under Tab I.

4 Welcome back, Mr. Parker. I'm  
5 going to turn it over to you.

6 MR. PARKER: Thank you and good  
7 morning. Last month, DoD released a report  
8 outlining concepts for modernizing the  
9 military retirement system. A critical  
10 section of this report focused on reform of  
11 DoD's disability compensation system.

12 A key sentence in this report  
13 states, "The current DoD disability benefit  
14 does not fully compensate service members for  
15 the expected value of a lost military career  
16 for either enlisted personnel or officers."

17 This statement hits the nail on  
18 the head and the recommendations in DoD's  
19 report help ensure wounded warriors who are  
20 forced to leave service due to disability are  
21 properly compensated for the economic loss of  
22 their career.

1                   DoD's recommendation to fix the  
2 DoD disability system closely echo  
3 recommendations made in the 2007 Dole-Shalala  
4 report and past legislative proposals. In its  
5 report, DoD states that VA compensation should  
6 not offset DoD disability benefits.

7                   This is a very critical aspect  
8 reforming the DoD - of reforming the DoD  
9 disability system as it ensures the lost  
10 career is actually compensated separately from  
11 the earnings impact of service connected  
12 disabilities.

13                   DoD's report also recommends  
14 modifying the current disability system by  
15 ensuring those who serve at least 12 years  
16 receive disability retirement regardless of  
17 the rating of their unfitting condition as the  
18 loss of the - a lost career is a lost career.

19                   This is a good but incomplete step  
20 forward as it fails to grant disability  
21 retirement to all those whose careers are  
22 terminated by service connected disability

1       regardless of time served.

2                   At a minimum, disability severance  
3       should be also protected from offset by VA  
4       compensation. I also believe wounded warriors  
5       should be able to roll over the disability  
6       severance payments into a tax-deferred  
7       retirement plan, much like a 401K plan can be  
8       rolled over when one changes employment.

9                   I still recommend elimination of  
10       the TDRL program in favor of a disability  
11       retirement system with payments based on  
12       length of service for all deemed unfit for  
13       continuing military service due to a service  
14       connected condition.

15                   Those who feel they have recovered  
16       enough to return to service can apply for  
17       reentry. However, if disability severance and  
18       - excuse me - however, if disability severance  
19       on a TDRL type system continue, DoD's TDRL  
20       recommendation in this report makes a critical  
21       needed improvement to the system by allowing  
22       those rated less than 30 percent for unstable

1 and unfitting condition to be placed on the  
2 TDRL until their condition stabilizes.

3           Currently, a wounded warrior is  
4 given disability severance if their unfitting  
5 condition - unfitting disability is currently  
6 rated less than 30 percent, even if it's known  
7 that their disability will get much worse or  
8 even fatal in the future.

9           I must admit I am confused as to  
10 why DoD recommends continuing a TDRL program  
11 if those deemed unfit are compensated based on  
12 their years of service rather than the rating  
13 of their unfitting condition.

14           All that matters under such a  
15 system is if the condition is unfitting. The  
16 actual disability rating would be moot for DoD  
17 purposes.

18           Certainly, if the VA compensation  
19 continues to be - to offset disability  
20 retirement or disability severance is still in  
21 effect then a TDRL type system has value to  
22 ensure stability of a condition prior to

1 making the final disability - DoD disability  
2 determination.

3 I ask that the recovering warrior  
4 task force study the disability benefits  
5 reforms made in DoD's report and that the Task  
6 Force reinforce these concepts and  
7 recommendations in their FY 2014 report to DoD  
8 and Congress.

9 I'll answer any questions that you  
10 may have.

11 DR. STONE: Mr. Parker, you hit a  
12 fair number of subjects in a fairly short  
13 time. DoD has a disability compensation  
14 system for what reason?

15 MR. PARKER: Well, if you look at  
16 the details they say that DoD disability is to  
17 compensate for a lost career. However, the  
18 system is structured that it usually doesn't  
19 do that, that it's based on the degree of  
20 disability or in the case of those rated under  
21 30 percent.

22 DR. STONE: So why as an employer

1       should DoD be different than every other  
2       employer in America? Every other employer in  
3       America - if you go back to the early 20th  
4       century when disability compensation started  
5       during the Great Depression, wasn't fully  
6       implemented, lots of fraudulent problems with  
7       it, really matured after World War II.

8               Social Security disability started  
9       in 1956. This is a fairly recent last 60-,  
10       65-year process. The average American  
11       employer has long-term disability insurance to  
12       protect that employer and its business from  
13       adjudication of lifetime claims.

14               Why should DoD operate such a  
15       dramatically different system than every other  
16       employer in America?

17               MR. PARKER: Well, I think you hit  
18       the nail on the head. The current system from  
19       the 1947 Career Compensation Act I think at  
20       the time was probably leading edge.

21               But the civilian community was  
22       still catching up on, you know, people who

1       lose their career, particular people who lose  
2       their career for a non-job related illness or  
3       injury, and I think they've been kind of  
4       overlapped now.

5                       Now, one of the reasons I think  
6       DoD needs such a disability program is that a  
7       military member cannot go to Aflac and say I'd  
8       like disability coverage in case I'm working  
9       and get hurt. They will not compensate or  
10      cover folks who are in a high-risk occupation.  
11      So -

12                     DR. STONE: No, but DoD is large  
13      enough and the American government is large  
14      enough to have a self-insured program.

15                     MR. PARKER: Oh, absolutely.

16                     DR. STONE: And that self-insured  
17      program could go to a fairly standardized  
18      short-term disability. You just stay on your  
19      - on your pay for the first year and if you  
20      can't return to your work after the first year  
21      then your long-term disability kicks in.

22                     MR. PARKER: Right, and I would



1 think -

2 DR. STONE: And that's the same as  
3 every other employer in America.

4 MR. PARKER: And I would tell you  
5 that DoD has a program that echoes the  
6 civilian program if you look at the DoD's  
7 civilian or even the federal service - civil  
8 service.

9 If they're deemed unfit for their  
10 job it very much closely echoes how somebody  
11 in the civilian sector is treated.

12 DR. STONE: So why -

13 MR. PARKER: It's the military  
14 that's somewhat of an antiquated system.

15 DR. STONE: Absolutely. So you  
16 are a step ahead of me in that why not adopt  
17 the civilian employee disability system for  
18 the uniformed military and abandon this system  
19 that is so truncated that it's impossible for  
20 anyone to be - have a feeling of fairness when  
21 they're dealt with as they move through this?

22 MR. PARKER: Well, and I agree. I

1 think the key cornerstone issue is  
2 compensating for that lost career - that  
3 career equity. If I work for IBM and I get  
4 hit by a bus, I'm taking - not only am I going  
5 to get compensated for the impact of that  
6 disability through that disability program but  
7 I'm keeping my 401K plan as well.

8           So that career retirement equity  
9 that I've earned in the military all too often  
10 evaporates when you go through the disability  
11 evaluation system and you're rated for 30  
12 percent or they say it's EPTS or a hundred  
13 other reasons why they, you know, are not  
14 totally or even compensated at all.

15           DR. STONE: So you would support  
16 the concept of moving to a federal civilian  
17 employee type long-term disability system for  
18 the uniformed military with the understanding  
19 that there needs to be some additional caveats  
20 of accumulation of retirement benefits as well  
21 as the fact that we'd have to adjudicate the  
22 fact that current civilian employment is not

1 100 percent compensable if you're on long-term  
2 disability? On average, it's 60 to 80  
3 percent.

4 MR. PARKER: Right, which - you  
5 know, in the military, see, if I'm in the  
6 civilian - a civilian employee in the Army and  
7 I become disabled they're going to - I think  
8 it's 60 percent for the first year of my base  
9 pay or my compensation and 40 percent  
10 thereafter.

11 On the DoD side, though, bear in  
12 mind that my retirement or my disability  
13 benefits is based on my base pay only. It  
14 doesn't include my housing allowance, my food  
15 allowance and all the other specialty pays and  
16 things that I might get.

17 So it's already kind of like that  
18 because they're only looking at two-thirds of  
19 my pay and giving me two-thirds of two-thirds,  
20 so to speak. So to a large degree that's  
21 already factored in.

22 DR. STONE: But, again, I ask you

1 would support that basic structure, realizing  
2 all the caveats we'd have to work our way  
3 through?

4 MR. PARKER: I certainly support  
5 any program that actually and fairly  
6 compensates for the career lost and I believe  
7 the Dole-Shalala type plan does that.

8 If I do 12 years in, my  
9 compensation is based on 12 years. Twenty  
10 years, 20 years. Fifteen years, five years,  
11 whatever it is it gets compensated based on  
12 that and that's just for the career equity.

13 Separately, the VA rates me for  
14 the impact of that disability on my future  
15 earnings capacity and then that covers both  
16 sides of the equation.

17 DR. STONE: Thank you very much.

18 MR. PARKER: All right.

19 CO-CHAIR CROCKETT-JONES: Thank  
20 you, Mr. Parker.

21 MR. PARKER: Okay. Thank you very  
22 much.

1 CO-CHAIR CROCKETT-JONES: Oh, I'm  
2 sorry.

3 CAPT SANDERS: Yeah. Just one  
4 quick question. Is that largely different  
5 from the way firefighters and police are  
6 compensated in their high-risk jobs?

7 MR. PARKER: The DoD system? The  
8 military system?

9 CAPT SANDERS: No. The system you  
10 advocate moving toward.

11 MR. PARKER: Well, I couldn't - I  
12 don't know all the details but I think most  
13 fire departments - I mean, the Veterans  
14 Disability Benefit Commission did kind of use  
15 police officers and firefighters as their - as  
16 a kind of a data point as to how people in  
17 high-risk jobs get compensated, and from what  
18 I understand of the - of those type of  
19 systems, yes, they do.

20 If they can't serve as a police  
21 officer or a firefighter then they're going to  
22 get a disability retirement.

1                   Unlike the military, where it  
2 depends on, you know, how - you know, what's  
3 deemed unfitting and how is it rated and other  
4 factors such as EPTS considerations.

5                   CAPT SANDERS: But there's no VA  
6 for the firefighter or policeman to add that  
7 secondary level of income.

8                   MR. PARKER: I couldn't speak for  
9 the - I mean, you've got a gazillion different  
10 municipalities out there and I'm sure they all  
11 have different type of programs, and I guess  
12 the bottom line would be total compensation,  
13 however you flavor it as career compensation  
14 or earnings impact compensation.

15                   You'd probably have to dissect it  
16 and find out how does that - you know, what's  
17 the total compensation packet look like in  
18 comparison.

19                   So I think there's - it's probably  
20 something that would have to be thoroughly  
21 dissected to find out exactly how much  
22 compensation is involved and for what that

1 compensation is provided for.

2 CSM DEJONG: But in - if I may, in  
3 the public sector the biggest difference is  
4 that it has to be deemed whether it was in  
5 line of duty or whether it was not, and based  
6 off of whether it was a line of duty  
7 disability or whether it was not a line of  
8 duty disability it is based off of and then  
9 each one has their own standard of when you  
10 have an off-duty disability. So each one is  
11 different.

12 There's three separate - I've been  
13 in the public sector for 15 years so each one  
14 is - each one is very different in how it  
15 lines out and what your benefits package will  
16 be - so whether you're insured for life or  
17 whether you're not, whether you just get a  
18 stipend and you move on.

19 MR. PARKER: There is a workman's  
20 compensation type program that is specifically  
21 for getting hurt at or injured at work.

22 CSM DEJONG: Correct.

1                   MR. PARKER: That's separate and  
2                   distinct from disability type - when I retired  
3                   from the military and worked - went into work  
4                   in the civilian world, one of the benefits I  
5                   got was disability protection.

6                   If I get hit by a bus, have a  
7                   heart attack that had nothing to do with  
8                   whether I'm at work or not they pay me, you  
9                   know, five times my annual salary or, you  
10                  know, it was basically insurance that they had  
11                  gotten from a private insurance company like  
12                  Aflac and it was provided as a benefit of my  
13                  service.

14                 CSM DEJONG: Okay. The public  
15                 sector does not offer that. You as a public  
16                 employee can elect to have that and you pay  
17                 for that out of your pocket.

18                 MR. PARKER: Well, in my case it  
19                 was - you know, it was part of the  
20                 compensation package so you can look at it  
21                 either way.

22                 CSM DEJONG: And each pension



1 system is slightly different based off of  
2 where the pension is funded and how it's  
3 funded.

4 But it also - you have to link it  
5 into whether it was a line of duty disability  
6 or a non-line of duty disability. Just  
7 because you're at work and something happens -  
8 as a firefighter I can be in the station and  
9 fall and break my back.

10 If I was not on an actual  
11 emergency call it is not considered a line of  
12 duty disability. I am just there at work. So  
13 -

14 MR. PARKER: I'm going to have to  
15 disagree. From my perspective -

16 CSM DEJONG: - you got to - you  
17 got to dissect a little bit deeper and then if  
18 you really want to take the federal side to  
19 that then you have to come up with a  
20 definition of what are they going to consider  
21 line of duty and what are they not.

22 DR. STONE: See, now you begin to

1 return to the system we have today. If I'm on  
2 active duty and on a Sunday I'm crawling on a  
3 ladder to clean out an eaves trough, fall off  
4 the ladder and become a quadriplegic, I am  
5 disabled. I have lost my ability to perform  
6 my military MOS.

7 Now, if I'm in Reserve component  
8 and that happens then there's a discussion of  
9 well, was I in a duty status or what kind of  
10 duty status.

11 What I'm suggesting is that as a  
12 condition of employment as part of the  
13 compensation package we have long-term  
14 disability insurance. If I lose the ability  
15 to perform my MOS then I am compensated for  
16 that to the terms of whatever the policy is.

17 It's a very simple system and gets  
18 rid of the entire LOD process. You just get  
19 rid of it, just like we've done for the active  
20 component already.

21 Now, if there is malfeasance in my  
22 behavior in some manner - you know, if I'm

1 drunk and fall into a swimming pool and become  
2 a quadriplegic that can be compensated  
3 differently, maybe. But I think we can debate  
4 all of that. I think we can debate all of  
5 that discussion.

6 The question is to move to a very  
7 simple straightforward system that's been  
8 proven over and over again in every employer  
9 in America with the exception of various  
10 public employers that still are in this LOD/  
11 non-LOD.

12 CSM DEJONG: Don't take the public  
13 sector model for that. I would - because it  
14 gets more complicated.

15 MR. PARKER: Right. And I would  
16 just like to reemphasize that if I'm in the  
17 public sector and my job does not provide  
18 disability coverage I can go to Aflac and buy  
19 disability coverage to protect my family from  
20 such an economic situation.

21 I cannot do that as an active duty  
22 military member. They will not cover - I

1 can't call and say I'm about ready to deploy  
2 to Afghanistan - can I get some disability  
3 coverage. You know, click buzz is what I'm  
4 going to hear.

5 You probably could get it but it's  
6 going to probably cost you three-quarters of  
7 your base pay to begin with. It's going to be  
8 completely unaffordable.

9 So that's why DoD has to step up  
10 and provide disability coverage regardless of  
11 whether it's line of duty or not.

12 DR. STONE: You know, I think we  
13 hear you very clearly. This should be a  
14 portion of the compensation package -  
15 shouldn't be self-funded.

16 And as DoD examines options in the  
17 retirement system in a participatory status,  
18 I hear you very clearly this should be part of  
19 the compensation package, not self-funded by  
20 the employee.

21 MR. PARKER: Appreciate it.

22 CO-CHAIR CROCKETT-JONES: Thank

1       you, Mr. Parker.

2                       MR. PARKER: All right. Thank  
3       you.

4                       CO-CHAIR CROCKETT-JONES: Our next  
5       statement comes from Mr. Brendan Gehrke, a  
6       senior legislative associate with the Veterans  
7       of Foreign Wars. Please find his information  
8       also in Tab I, a page back, and I'm turning it  
9       over to you.

10                      MR. GEHRKE: Thank you. On behalf  
11       of the men and women of the Veterans of  
12       Foreign Wars, I thank you for the opportunity  
13       to discuss our concerns with the task force  
14       regarding the issue of improperly diagnosing  
15       service members with false psychiatric  
16       disorders for the purpose of expediting their  
17       discharge.

18                      Defense Department data shows that  
19       more than 32,000 military members were  
20       discharged from the military with a  
21       personality or adjustment disorder from 2001  
22       to 2010.

1                   By reviewing the cases the  
2                   Government Accountability Office estimated  
3                   that thousands of improper PD or AD discharges  
4                   occurred.

5                   GAO found that military branches  
6                   were failing to abide by their own directives  
7                   for diagnosing and discharging veterans with  
8                   PD or by DoD's own directives. We've talked  
9                   with multiple service members who were  
10                  discharged with PD after they were deployed to  
11                  a combat zone or experienced military sexual  
12                  trauma.

13                  Instead of properly diagnosing  
14                  these troops with PTSD or at least sending  
15                  them to the MEB to be evaluated, the service  
16                  members received an expeditious discharge with  
17                  a PD designation.

18                  The VFW is concerned that vets who  
19                  were improperly discharged with a false  
20                  psychiatric diagnosis but who actually suffer  
21                  from PTSD may have a difficult time  
22                  reintegrating into society without the access

1 in curative benefits they have earned and  
2 need.

3 The current process for  
4 overturning a wrongful diagnosis or improper  
5 discharge is very arduous and decisions  
6 rendered by the Board of Correction of  
7 Military Records have been described as  
8 arbitrary.

9 The boards that evaluate these  
10 members do not have mental health care  
11 professionals as members of the board or even  
12 do they always consult with a mental health  
13 care professional nor are they required to  
14 give due deference to the outside clinical -  
15 to outside clinical evidence such as VA  
16 records or private medical evidence.

17 The VFW believes that veterans  
18 discharged with PD or AD deserve due process  
19 and we believe that they should be entitled to  
20 appeal to the board - to the Physical  
21 Disability Board of Review. More so when  
22 reviewing mental health cases it is necessary

1 to have an independent mental health care  
2 professional who has experienced treating PTSD  
3 survivors.

4 We stand ready to work with the  
5 task force to ensure that veterans suffering  
6 from PTSD receive the treatment and the care  
7 they deserve and need.

8 This concludes my remarks and I am  
9 open for any questions.

10 MR. REHBEIN: Sir, just for  
11 clarity in my own mind, personality disorder,  
12 adjustment disorder - am I clear in your  
13 statement that someone that's diagnosed with  
14 adjustment disorder still receives benefits?

15 MR. GEHRKE: So they were supposed  
16 - they are supposed to. That is on the VASRD  
17 where they would receive benefits if they go  
18 through the evaluation process properly.  
19 However, if they have a personality disorder  
20 they do not receive benefits.

21 In 2010, Congress put a lot of  
22 emphasis on these type of discharges, pushed



1 the DoD to reform. DoD did make notable  
2 reforms.

3                   However, at the same time that you  
4 saw a decrease in personality disorders you  
5 saw an uptick in adjustment disorders. So I  
6 think that warrants current evaluation to see  
7 if they are connected and how they are  
8 connected.

9                   MR. REHBEIN: Okay. I'm clear  
10 that, you know, personality disorders if they  
11 - if they were given wrongly and denied  
12 benefits what the benefit would be to the - to  
13 the service - to the former service member by  
14 that adjustment or change in their - in their  
15 discharge status.

16                   I guess I'm still unclear a little  
17 bit what would the gain for someone that was  
18 discharged with an adjustment disorder if  
19 they're receiving benefits - putting them  
20 through this process what would the potential  
21 gain for them be.

22                   MR. GEHRKE: So I think the

1 question you have to evaluate is whether they  
2 were really experiencing adjustment disorder  
3 or whether they were experiencing post-  
4 traumatic stress disorder.

5 If they were experiencing PTSD  
6 then their benefits would be dramatically  
7 different under the law that DoD is forced to  
8 give them a 50 percent rating or above, which  
9 entitles them to Tricare and health care for  
10 life for their families, which is not related  
11 to adjustment disorder.

12 DR. STONE: So what evidence do  
13 you have that either personality disorder or  
14 chronic adjustment disorder is being  
15 misdiagnosed in preference over PTSD?

16 MR. GEHRKE: So, first, I think  
17 you have evidence that in a lot of these cases  
18 they were so expeditiously done that the DoD  
19 did not follow their own directives.

20 And so you want to make sure that  
21 the Department of Defense is following their  
22 directives in doing that. However, we have

1 spoken with many veterans who were discharged  
2 with PD who later went and received a PTSD  
3 diagnosis from the VA or some outside private  
4 clinician - a psychiatrist.

5 I think one stark example is a  
6 veteran came home after combat. Within that  
7 year - and he received a Bronze Star for his  
8 actions in theater - he came home. He  
9 attempted suicide.

10 The service then discharged him  
11 within a matter of weeks with a PD discharge -  
12 no disability evaluation process.

13 Even though he did see a  
14 psychiatrist after the suicide attempt the  
15 psychiatrist said he probably did have PTSD.  
16 There was medical evidence suggesting that.

17 However, he was discharged with a  
18 PD. When he went to appeal the discharge with  
19 the Board of Correction of Military Records he  
20 brought a VA diagnosis and said look, I have  
21 PTSD - I would like to be upgraded from a  
22 general discharge to a honorable discharge and

1 with this PD removed from my discharge papers.

2 They essentially ignored the VA  
3 clinical evidence. They brought in a doctor  
4 who was not a psychiatrist or a psychologist  
5 to be a member of the board and to vote on the  
6 board. I believe, and I could be wrong, he  
7 was an orthopedic surgeon.

8 He said in the correction process  
9 review - clearly stated that he had no  
10 expertise in diagnosing PTSD or treating PTSD.

11 He was just there from a medical  
12 perspective because that's what was required  
13 of him or required on the board. And so  
14 you're seeing a lot of these cases that aren't  
15 being handled properly.

16 DR. STONE: So Dave, going back to  
17 your question, the VA for a long time, number  
18 of years, has compensated chronic adjustment  
19 disorder.

20 The congressional concern that  
21 resulted in the 2010 law was that DoD was not  
22 aligned to the VA benefit system and therefore

1 DoD was ordered under the law to develop  
2 chronic adjustment disorder compensation-based  
3 process.

4 MR. GEHRKE: That's correct.

5 DR. STONE: And that's been the  
6 evolution that you refer to.

7 MR. GEHRKE: Yes.

8 DR. STONE: You know, look, all of  
9 us come home with acute adjustment issues and  
10 then go through a period of time that we sort  
11 of fall into civilian society in an effective  
12 manner.

13 The question is what are - what's  
14 going on chronically that it disables us in  
15 some manner.

16 And so it has aligned somewhat,  
17 but the concept of preexisting conditions that  
18 precede your service in the military has  
19 created great difficulty trying to understand  
20 either a worsening of those preexisting  
21 conditions, those personality disorders,  
22 because of stressful service.

1                   And I'm respectful of the position  
2                   you take and I understand that you cannot - it  
3                   is too hard to get sort of real data on this.  
4                   Most of it's anecdotal until you start to  
5                   really pull it apart.

6                   Are you suggesting that the  
7                   previous work that was ordered under the 2010  
8                   law in which the secretaries responded to by  
9                   asking for additional studies and bringing  
10                  people back - is that inadequate in order to  
11                  work through this?

12                  MR. GEHRKE: Two things. One, we  
13                  feel that the changes were made were good  
14                  changes and we are happy to see the Department  
15                  of Defense making progress in that order.

16                  However, they have not released  
17                  the latest numbers since 2010 in how many PD  
18                  discharges there were. So I think it's  
19                  important to evaluate whether that is  
20                  decreasing or not.

21                  And second, nothing has really  
22                  been done to significantly change any wrong

1 that was done to previous people who were  
2 discharged with PD and which we feel needs to  
3 be evaluated and looked at. I think there was  
4 a -

5 DR. STONE: And you have submitted  
6 a FOIA request for that information?

7 MR. GEHRKE: Say that again.

8 DR. STONE: You have submitted a  
9 Freedom of Information request for that -

10 MR. GEHRKE: The Vietnam Veterans  
11 of America have submitted that and to my  
12 knowledge have not received that data as of  
13 yet, and I believe they submitted it two years  
14 ago.

15 So I believe the Vietnam Veterans  
16 of America are actually in a lawsuit over that  
17 FOIA request to get that information.

18 LTCOL WONG: Mr. Gehrke, are you  
19 familiar with - you did mention some of the  
20 changes that have gone on since this report.  
21 As I understand, the Navy published a policy  
22 for review and the Marine Corps has done a

1 review of all PD and AD discharges during that  
2 period to do a review, contact those veterans  
3 and give them a process for a re-review.

4 In addition, there is also a Navy  
5 policy letter to the - on the medical side for  
6 all commanders - Marine Corps and Navy  
7 commanders - to look at before they do an  
8 administrative separation to ensure that it's  
9 not - it could be an injury that's not a  
10 disability, ensure that if it could be brought  
11 through the MEB DES process that it is in  
12 terms of going forward with that  
13 administrative discharge.

14 MR. GEHRKE: So we have not  
15 received any results from that review. We  
16 were told that they were conducting that  
17 review. Nor are we aware that the Marine  
18 Corps or Navy has reached out to those  
19 veterans and allow - notified them of their  
20 right to seek a formal review either at the  
21 Board of Correction of Military Records or  
22 Physical Disability Board of Review, which we



1 would suggest that they do.

2 And when they're eligible we would  
3 suggest that they allow them to go to the  
4 Physical Disability Board of Review rather  
5 than the Board of Correction of Military  
6 Records.

7 From everything that we've  
8 noticed, the Physical Disability Board of  
9 Review gives a more fair review to the veteran  
10 and the process favors the veteran as opposed  
11 to the Board of Correction of Military  
12 Records, which a veteran really has the  
13 obligation or the burden of proof to prove  
14 that there was some sort of administrative  
15 error in their discharge.

16 The review that we are currently  
17 aware of that the Army is conducting, I  
18 believe, is DoD wide does not look  
19 specifically at the personality disorder  
20 discharges.

21 They look at discharges where the  
22 person was going through - the MEB was given

1 a PTSD diagnosis and then it was lowered to a  
2 personality disorder or adjustment disorder.

3 But in that review they are  
4 required to have started the MEB process and  
5 what we've noticed is a lot of these people  
6 never started the MEB process in the first  
7 place.

8 CO-CHAIR CROCKETT-JONES: Okay.  
9 Thank you.

10 MR. GEHRKE: Thank you for your  
11 time.

12 CO-CHAIR CROCKETT-JONES: Is Dr.  
13 Sidonson available or - okay.

14 CO-CHAIR MUSTION: Okay, this  
15 morning we welcome members of the Department  
16 of Navy staff. Joining us we Ms. Merissa  
17 Larson, Mr. Robert Powers, Commander Green-  
18 McRae, and Captain Brent Breining.

19 The panel will brief us on the  
20 response, or brief the panel on the response  
21 to the status of the 2013 recommendations that  
22 apply to the Navy, specifically

1 recommendations 5, 13, 15, 16, 18, 19, 20 and  
2 21.

3 Captain Breining will also brief  
4 us on the safe harbor, Navy Safe Harbor  
5 Program and metrics. Please find the  
6 biographies and presentations at Tab J.

7 CDR CHARISSIS: Good morning,  
8 everybody. My name is Mike Charissis. I am  
9 a Navy Commander. I work at BUMED and I am  
10 here today to brief some of the information  
11 specifically relating to the Navy Medicine's  
12 response to the Recovering Warrior Task Force.

13 The way I would like to start is  
14 with specific recommendations made to the DoD  
15 by the Task Force and review BUMED's response  
16 to those. The first recommendation number 5  
17 pertains to medical documentation of medical  
18 conditions for folks going through the MEB  
19 process. Again, DoD ensuring that all the  
20 medical conditions are documented by MEBs and  
21 that information is a true representation of  
22 the members' conditions and that facilitate

1 timely and accurate decisions by the PEB and  
2 also provides information so that the VA can  
3 make their own assessment accurately.

4 In response, BUMED is supporting  
5 the DoD Office of Warrior Care Policy in its  
6 efforts to implement a quality assurance  
7 program.

8 This is a different presentation.  
9 I need the BUMED response. Forward three  
10 slides, okay. There we go. Okay, sorry about  
11 that.

12 So again, this is the  
13 recommendation that I was speaking about.  
14 Again, we are working to implement that  
15 quality assurance program.

16 The other thing I will say is that  
17 as somebody that has worked with the PEB,  
18 given the packet that is generated from the  
19 MEBs and from the VA containing the VA's  
20 compensation and pension examination, those  
21 packages do get a full look. And so,  
22 basically, every piece of information that is

1 in there pertaining to every medical condition  
2 that is discovered, not only on the MEB side  
3 but the VA side gets a full look.

4 Our next recommendation is number  
5 18. Again, services must supply locations  
6 that have difficulty recruiting civilian staff  
7 with those resources to provide adequate  
8 access to care for our wounded warriors.

9 While the DoD has previously non-  
10 concurred with this recommendation, are  
11 preferring to use TeleHealth initiatives, we  
12 at BUMED have actually taken steps to increase  
13 the number of uniformed providers at places  
14 that have difficulty sourcing civilian  
15 employees.

16 As the results of the Navy  
17 Medicine's CONUS Hospital Study, we have done  
18 some shifting of billets, which has freed up  
19 an ability to staff up places like Camp  
20 Lejeune, which historically has some  
21 difficulty filling civilian provider billets,  
22 putting uniformed provider billets there so

1 that we can get our uniformed providers there,  
2 which we anticipate will result in significant  
3 improvements and access to care for our folks  
4 down in Camp Lejeune.

5 CAPT SANDERS: What type of  
6 providers are you putting in place there,  
7 nurses, doctors?

8 CDR CHARISSIS: My understanding  
9 is preliminary -- I'm sorry -- primarily  
10 physicians, healthcare providers. I don't  
11 have the -- basically, I don't have the  
12 specific identity of the types of providers  
13 there. But uniformed providers, whether they  
14 are psychiatrists or nurse practitioners, I  
15 don't have that, the granularity of that  
16 information.

17 CAPT SANDERS: I think that is  
18 part of the critical thing you need to figure  
19 out, what providers. Providers are not  
20 generic. I think there is probably a need  
21 that generated a certain type of provider.  
22 And are you actually filling that need, as

1       opposed to just filling bodies and stopping.

2                   CDR CHARISSIS:  Yes, sir, I  
3 understand that.  I do think that has been  
4 addressed.

5                   CO-CHAIR CROCKETT-JONES:  I think  
6 to explain how the Task Force created this  
7 recommendation, this started, this was an  
8 issue that we saw in several places but then  
9 really it came to a culmination of need when  
10 we went to Alaska.  In places where the local  
11 pool of contract providers is near zero and  
12 extremely expensive, leaving open slots for  
13 extended periods of time when there was very  
14 little hope they were going to be filled did  
15 not make sense.

16                   And although when you know that  
17 there are locations say in the Capital Region  
18 that are heavier with uniformed providers that  
19 didn't balance.  It is easy to happen but it  
20 should constantly be reviewed to say the  
21 places -- some places there are plenty of  
22 local available professionals to fill a

1 contract and the contract compensation is  
2 reasonable. But in some places, like in  
3 Alaska, it doesn't matter how much money you  
4 are offering, there aren't any providers for  
5 a lot of those slots.

6           Rather than leaving things open,  
7 which we had, the Task Force had, seen  
8 extended periods where providers were not  
9 available and people were being shipped back  
10 or just going without care. And so, we just  
11 wanted every service just kind of take a look  
12 and push their uniforms to the places where  
13 they either had no success at filling provider  
14 slots with contract positions, keep  
15 reevaluating that balance.

16           So, that was the genesis of our  
17 recommendation. And I think the fact that the  
18 Navy Medicine did the hospital study to get a  
19 sense of where their people were and where  
20 that actually happened was probably more in  
21 line with what we were looking for than even  
22 just the movement but just on the



1 understanding of where your needs were. So,  
2 I just want to throw that out there so we  
3 understand why we made this recommendation.

4 CDR CHARISSIS: And I think that  
5 there are two separate issues here. There is  
6 the billets and then there is the type of work  
7 that needs to be done. And I think that it  
8 was very plain by the difficulty in hiring  
9 specific providers in certain regions is that  
10 when those billets were shifted around that  
11 the goal was to get a uniformed provider that  
12 matched that task at Camp Lejeune and other  
13 places that weren't served.

14 LT COL WONG: Excuse me before you  
15 go forward. On this hospital study, do you  
16 have the data for that? Was it just MTS or  
17 did you also look at the clinics and was it  
18 looked at the services that are not being  
19 served there, that there was a potential need  
20 that you were contracting for and unable to  
21 fill? Do you have like the completion rate or  
22 ability to fill that gap rate after completing

1 this study?

2 CDR CHARISSIS: I don't have that  
3 information with me. I believe that the  
4 intent of the study was to figure out we have  
5 these people at our facilities. Where is  
6 there an unmet need? And where is there  
7 basically an excess of people without really  
8 a need to serve?

9 So, and it was not only  
10 identifying the places that were going without  
11 but the places that were overstaffed, had  
12 excess capacity for a need that really wasn't  
13 present anymore.

14 LT COL WONG: And does it show a  
15 metric of what percentage of the need is now  
16 met? Was it previously 60 percent across the  
17 board and now it is eight and now it is even,  
18 the bandwidth has evened out to 80 or 90?

19 CDR CHARISSIS: I'm not sure  
20 whether we have that follow-on data yet. I  
21 think that, again, the study was done to kind  
22 of a snapshot or two identify where the over

1 and under capacity was. I think it would  
2 probably require another look, once the shifts  
3 have been made to see whether we are now where  
4 we want to be or whether further adjustment is  
5 necessary.

6 LT COL WONG: Thank you.

7 CDR CHARISSIS: The third  
8 recommendation I am going to speak to you  
9 today also pertains to the IDES process.  
10 Basically, the need for family member  
11 involvement in the recovery process and also  
12 to make family members aware of the resources  
13 available to folks going through the  
14 disability evaluation process.

15 Again, the idea is that we have  
16 100 percent outreach to family members for in-  
17 processing in IDES orientation. Again, 100  
18 percent outreach defined as positive contact,  
19 two-way communication. And our response is  
20 that, again, this requirement has been in  
21 existence for quite some time and we task our  
22 PEB liaison officers to perform this outreach

1 and to document that this is occurring in the  
2 member's case file. We have done case file  
3 reviews during site visits and we have  
4 confirmed that these steps are being taken.  
5 I think that the next step would be to move  
6 forward and collect this information  
7 enterprise-wide and essentially start  
8 maintaining a metric of the completion rate to  
9 ensure that what we are finding on  
10 intermittent site visit is truly and  
11 consistently at the level that is mandated.

12 I am going to switch gears now and  
13 just talk about some numbers, in terms of  
14 diagnoses across the Navy and the Marine Corps  
15 from 2011 to 2014. This first slide, I  
16 apologize, is a little bit busy but it  
17 contains a lot of information. If you can't  
18 see it up top, basically this slide contains  
19 information about the incidence rate per  
20 100,000 service members that have various  
21 behavioral health diagnoses.

22 At the top, behavioral health

1 overall we broke down by Navy and Marine  
2 Corps. We also break it down by depressive  
3 disorder, PTSD, and then our substance use and  
4 alcohol use disorder diagnoses are down below.

5 Again, incidence rate basically  
6 covers when the number of people that have  
7 received this particular diagnosis within that  
8 year. And overall, I think what you will see  
9 if you look at the is that from 2011 to 2012  
10 to 2013, across the board in all of these  
11 categories what we see is a slight uptick in  
12 2012 and then a decrease in 2013.

13 And basically this is a graphical  
14 representation of those, basically the totals  
15 for the active duty Navy and active duty  
16 Marines.

17 CAPT SANDERS: Before you move on,  
18 did you do any correlation with the JAG  
19 community to see how many of these people  
20 actually ended up being discharged for these  
21 diagnoses or after these incidents?

22 CDR CHARISSIS: After having been

1 diagnosed?

2 CAPT SANDERS: Correct.

3 CDR CHARISSIS: Not that I am  
4 aware of. Is there a particular concern you  
5 hard regarding that?

6 CAPT SANDERS: Well, you have an  
7 incident in the previous speaker from the  
8 Veterans of Foreign Wars made an accusation  
9 about how we are mistreating and misdiagnosing  
10 people and diagnosing them and discharging in  
11 a process where they are not getting their  
12 full benefit packages.

13 And we have a great number of  
14 diagnoses here and no information about what  
15 happened to them afterwards. I am just  
16 curious if there is any correlation.

17 CDR CHARISSIS: I mean, I think  
18 that it would be moving from incidence rates,  
19 it would require a pretty intensive review to  
20 figure out where, ultimately, these people,  
21 these folks ended up. And I think I share  
22 that concern and we would want to ensure that

1 if people are receiving diagnoses that they  
2 are receiving treatment. And I think that the  
3 prevalence and encounter slide speak to the  
4 fact that folks that are receiving these  
5 diagnoses are actually receiving treatment and  
6 are still in our system.

7 MR. REHBEIN: Not being a medical  
8 professional, I am not sure whether my  
9 impression here is correct. But in looking  
10 through the numbers, there appear to be about  
11 a thousand cellulars that are being diagnosed  
12 with other behavioral health diagnoses. I  
13 will leave that to the medical professionals  
14 on the panel with me but is that a high  
15 number, based on the force level that we have  
16 in the U.S. Navy?

17 DR. STONE: Sir, the American  
18 adult population has an incidence of  
19 behavioral health problems in any given year  
20 of about 24 to 26 percent, of which one-third  
21 are severe so, about eight percent.

22 The uniformed military has pretty

1 much aligned with that incidence. So, you  
2 would expect about 8,000 behavioral health  
3 diagnoses per 100,000 population that would be  
4 severe. I am assuming that is what you are  
5 portraying. You are portraying numbers quite  
6 a bit lower than that. That either means that  
7 the Navy is on a behavioral health basis  
8 healthier than the rest of the American  
9 population, Navy and Marine Corps or you have  
10 undercounted in some manner. You are not  
11 capturing the full population. My suspicion  
12 is it is the latter because when we took a  
13 hard look at Army, Army pretty much aligned to  
14 the American population and reflected, as did  
15 the Air Force.

16 CDR CHARISSIS: I think speaking  
17 to maybe part of the question that you had is  
18 that if you look at the, let's say for 2013  
19 the 10,242 that the various -- the depressive  
20 disorder, PTSD, alcohol and substance abuse  
21 disorders don't add up. These are, I think,  
22 diagnoses that have captured a lot of our



1 attention and rightly so. But there are a lot  
2 of other diagnostic categories that are not  
3 necessarily captured here, in terms anxiety  
4 disorders, thought disorders. So, they just  
5 have different types of disorders that aren't  
6 captured in these categories that we have  
7 specifically picked out.

8 So, this slide is prevalence rates  
9 and these are basically in any given calendar  
10 year everybody who carries this diagnosis.  
11 Again, this is where we see more pronounced  
12 the up-tick in numbers of diagnoses in 2012  
13 and then a decrease down in 2013.

14 And again, the diagnoses that are  
15 most numerous are the depressive disorders.  
16 And again, here, the scale on the y axis  
17 probably distorts the curve a little bit but,  
18 again, there is a slight uptick in 2012 and  
19 then down in 2013.

20 And this is the encounter burden,  
21 basically the number of encounters for these  
22 categories of diagnoses from 2011 to 2013.

1 And again, all of these are per 100,000  
2 service members.

3 In terms of the long-range vision  
4 BUMED has for behavioral health, again, we are  
5 encouraged that there has been some decline in  
6 diagnoses but we know that by no means is the  
7 demand going away in a significant way anytime  
8 soon or when hostilities end. We understand  
9 that we will have an elevated need for  
10 psychological health and TBI services and it  
11 will continue for some time.

12 So with that in mind, what our  
13 imperatives are are to really focus on  
14 evidence-based care and, as a start, make sure  
15 that when service members are coming in to get  
16 the treatment as they are getting evidence-  
17 based care and it is being implemented  
18 according to the best practices that we are  
19 aware of in the present time and to ensure  
20 that we are continuing to do this is to  
21 monitor outcome measures for our care to make  
22 sure that when we are using these practices,

1 that we are reaping the benefit that is  
2 warranted.

3 Also, one of our imperatives is to  
4 look at all the programs that we are running  
5 for wounded warriors and to expand the  
6 programs that are clearly benefiting our  
7 service members while either re-scoping or  
8 eliminating the ones that have not.

9 One example that is showing  
10 potential benefit is OASIS, which is a project  
11 out in San Diego that is helping treat some of  
12 our more difficult refractory PTSD cases.

13 Also continuing realizing that in  
14 this environment involvement of multiple  
15 disciplines in the treatment of individuals.  
16 It tends to give us the most benefit is we are  
17 emphasizing programs that do provide  
18 interdisciplinary care and relies on the  
19 knowledge that is present in different  
20 communities to assist in recovery.

21 Again, Navy Medicine, we have  
22 launched a more systematic effort to measure

1 the use of Clinical Practice Guidelines. We  
2 have focused, again, on PTSD and Depression  
3 because we see those diagnoses popping up as  
4 most significant in our incidence and  
5 prevalence rates. And we are encouraged by  
6 our initial numbers but we know we can always  
7 do better and make sure that we get those  
8 numbers up.

9 We are also in the process of  
10 implementing the Army's Behavioral Health Data  
11 Portal at all our mental health clinics. And  
12 what BHDP does is provides information on that  
13 the clinical practice guidelines and standards  
14 of care, measures outcomes, and puts that  
15 information all in a very user-friendly  
16 dashboard, so that our providers can know what  
17 they are doing, how they are doing it, and  
18 what they need to do in order to improve.

19 We have NICoE satellite up and  
20 running at Camp Lejeune and personnel in place  
21 at Camp Pendleton out west.

22 And also continuing to operate

1 several best practice programs identified  
2 through the defense center of excellence  
3 psychological health effectiveness initiative.  
4 MORE is My On-going Recovery Experience, which  
5 is for folks with substance use disorders.  
6 And FOCUS is Families Overcoming Under Stress  
7 and that is more geared towards assisting  
8 family members, as well as a service member  
9 coping with readjustment with stress with  
10 interpersonal family issues and we have seen  
11 good results with that and that is actually a  
12 very well-regarded program with documented  
13 results.

14 DR. STONE: Could you discuss,  
15 before you go on, you bring up the NICoE  
16 satellite, have you expanded your patient  
17 population beyond closed-head injury?

18 CDR CHARISSIS: At the NICoE?  
19 Well, there is -- it is for psychological  
20 health and traumatic brain injury.

21 DR. STONE: And what psychological  
22 health diagnoses are you accepting? And do

1 you require a closed-head injury by history in  
2 order to be admitted?

3 CDR CHARISSIS: Not from my  
4 understanding, no. That is not a hard  
5 requirement.

6 DR. STONE: Okay.

7 CDR CHARISSIS: Those are all my  
8 prepared remarks. If anybody has any other  
9 questions -- thank you very much.

10 CAPT BREINING: Good morning,  
11 everyone. I am Captain Brent Breining. I am  
12 the new Director of the Navy Wounded Warrior  
13 Safe Harbor Program. I also have Ms. Merissa  
14 Larson, my Deputy Director at the table, as  
15 well as Ms. Kendall Hillier, who is our  
16 Department Head for QA and Inspections.

17 I want to thank the Task Force for  
18 this opportunity to update you on the progress  
19 of Navy Safe Harbor since the last time we  
20 briefed you. And we are excited to show what  
21 we have done in the past year and delivering  
22 non-medical services to our Navy and Coast

1 Guard seriously wounded and injured  
2 population.

3 I would like to begin with  
4 addressing recommendation 16, which is  
5 optimized SCAADL implementation. This had to  
6 do with the recommendation for proposed  
7 legislative change to exempt SCAADL from  
8 income taxes. The Navy partially concurs. We  
9 just want to make sure, we think overall that  
10 this will be good for the program but we want  
11 to make sure that the wording is correct.

12 There has been some concern from our  
13 recovering service members and caregivers  
14 about the potential for if it is just tax free  
15 on the front and of kicking them into a higher  
16 tax bracket. So, we want to make sure that it  
17 is treated similarly to like the BAH housing  
18 benefit of where it would be nontaxable income  
19 that comes in and not have that effect. And  
20 we, obviously, need to message that after it  
21 goes out to ensure that everyone is aware that  
22 that is not going to affect them.

1                   Yes, sir?

2                   DR. STONE:  It is it non-taxable,  
3                   how does that take them into a higher tax  
4                   bracket?

5                   CAPT BREINING:  Well, I think that  
6                   goes back to the messaging of making sure that  
7                   everyone who is eligible understands that that  
8                   will not affect them.

9                   DR. STONE:  So, the Navy would  
10                  concur, based upon appropriate educational  
11                  tools being given to those receiving the  
12                  SCAADL benefit.  Is that correct?

13                  CAPT BREINING:  Correct.  Yes,  
14                  sir.

15                  And then going to our enhanced  
16                  marketing to the population.  We have  
17                  developed a fact sheet which we will  
18                  distribute as soon as the OSD program changes  
19                  take effect.  We are tracking very heavily our  
20                  CAT III patients, making sure that everyone  
21                  who is eligible that we discussed the benefit  
22                  with them and that we put an enrollment



1 request out to ensure that they receive the  
2 benefit.

3 As far as the electronic  
4 application process for AHLTA, we non-concur  
5 because the Navy does not use this process or  
6 this database for the non-medical care  
7 purposes. For our execution for SCAADL, we do  
8 point to point between my senior medical  
9 advisor and the primary care manager. And it  
10 is handled that way. It does not go through  
11 the AHLTA database. So, this would not be a  
12 benefit for our executional program. Perhaps  
13 the other services have a different view on  
14 that.

15 So, I would like to update you on  
16 the business process improvements. We will  
17 take you through the metrics, our inspections,  
18 and our restructuring. The benefits, I will  
19 go into a little bit more depth in how we are  
20 executing and administering the SCAADL  
21 program. And our initiatives for '14, which  
22 includes looking at our enduring mission, what

1 happens as we scale back from Afghanistan and  
2 move forward with the program, along with  
3 strategic communications, the Recovery Care  
4 Program, and Our Transition Initiative.

5 Overall, this past year has been a  
6 year of transformation and standardization.  
7 It has been our focus in serving our wounded  
8 warrior population.

9 Here is a snapshot from February  
10 of our metrics that we have been gathering.  
11 The overall goal is develop an enterprise-wide  
12 metric system that we administer through our  
13 regions and establish standardized data  
14 reporting requirements to meet congressional  
15 mandates and validate non-medical care.

16 Up to this point, it has actually  
17 been five months with the data that we have  
18 collected. And we have expanded the criteria  
19 that we are collecting to include the FY13  
20 NDAA recommendations for metrics. So, we have  
21 just started gathering that data this last  
22 month and we will also incorporate that as we

1 move forward with our data collection.

2 Our focus is on the 40:1  
3 congressionally mandated case ratio. As you  
4 can see, we have mostly met that and we do  
5 have POM16 initiatives in effect, assuming  
6 that they are adopted, to bring our ratios  
7 even lower.

8 Our internal target, though, is  
9 for the non-medical care managers to be at  
10 20:1 ratio and the recovery care coordinators  
11 should be at 30:1 ratio. We feel that that is  
12 a better cure for our enrolled population and  
13 we have the smaller ratios, so those are our  
14 targets.

15 Here is an example of one of our  
16 metrics that we gather. You can see down at  
17 the bottom left-hand corner these are the  
18 Comprehensive Recovery Plans. Our Region N95s  
19 are responsible for each of our teams out in  
20 our seven regions and they certify the plans  
21 when they go up. So you are going to see that  
22 is our progress. That is probably the

1 snapshot back in February. So, we have a  
2 little bit of work to do there but we are  
3 getting better in that regard.

4 And then making sure that the CRPs  
5 are actually signed and entered into the data  
6 base, according to the guidance that the  
7 warrior care policy is enforcing with respect  
8 to our DoD instruction and guidance. So  
9 again, that is an area that we are working  
10 hard to improve on. What this does is give us  
11 a snapshot in the areas of improvement that we  
12 need to make so that when we go out into the  
13 field with our inspection teams, we can assist  
14 and focus on these areas.

15 MS. DAILEY: Captain Breining, can  
16 I get you get you to go back? Because I  
17 looked at this a couple of times.

18 CAPT BREINING: Yes, ma'am.

19 MS. DAILEY: So, if the dots all  
20 line up on the dashed lines around the outer  
21 edge, that is 100 percent compliance or you  
22 are closer to your goal.

1                   CAPT BREINING: Correct.

2                   MS. DAILEY: The more congested in  
3 the middle they are, the farther away from  
4 your goals you are.

5                   CAPT BREINING: Thank you for  
6 explaining that because it does get a little  
7 confusing when you are just looking at this  
8 for the first time.

9                   So, we are trying to move  
10 everything outward. Our goal is 90 percent --  
11 why it is not 100 percent, we have constantly  
12 new enrollees coming in. So, we are being  
13 realistic we will never reach 100 percent.  
14 There is always going to be a little a bit of  
15 a delta as we go through the process of  
16 enrollment in assessing the cases of whether  
17 they meet the criteria for enrollment.

18                   And then, obviously, we want 100  
19 percent signed. So this is part of our  
20 documentation effort to make sure that our  
21 people out in the field, their energy to get  
22 these CRPs done and implemented, we don't

1 forget to do the basics, such as signatures,  
2 and making sure they are filed in our  
3 database.

4 So, thank you.

5 MS. DAILEY: And we are  
6 appreciative of that. As we have gone out and  
7 talked with Navy members, we know your non-  
8 medical case managers are very tuned in to  
9 your CRPs. They work them aggressively but  
10 they are not well-marketed to your service  
11 member. When we say CRP, we get a blank look.

12 So, thank you for trying to create  
13 that branding, basically branding it down with  
14 your service members. I think that will be  
15 very helpful for them.

16 CAPT BREINING: That is our goal.  
17 Any other questions on this chart?

18 This next slide is a look at how  
19 we have done on our transition programs. For  
20 our transitioning service members, these will  
21 be the numbers that leave the active service  
22 either under medical retirement or they are

1 separated.

2 In the case of separation,  
3 typically we will continue to assist that  
4 person. And most of our population will be on  
5 medical retirement and receiving their  
6 benefits that way.

7 So, some of the education in 2013,  
8 this is for the calendar year 2013, we  
9 assisted 320 enrollees in employment education  
10 assistance, education being helping them  
11 navigate through the whole process of enacting  
12 their GI bill benefits, helping them with the  
13 applications of the school, so on and so  
14 forth. And then, obviously, job assistance  
15 kind of speaks to itself there.

16 Another thing that we instituted  
17 was our Anchor Program. This has been very  
18 successful. We had 140 participants in 2013.  
19 We have over 160 for this year.

20 This is s the transitioning  
21 service member leaves the military and goes to  
22 civilian life, that is very -- even for

1 someone who is coming up on a 20-year career  
2 and retiring, that can be somewhat traumatic  
3 and then, add on the compounding effect of  
4 whatever medical issues that they are dealing  
5 with. It is nice to have a guide to help take  
6 them through that process, someone who is in  
7 the trenches with them.

8           So, what we do is pair up that  
9 service member with someone from a like rating  
10 so that they have that common identity. And  
11 we have used the reserve forces quite a bit  
12 for this because members may not relocate to  
13 fleet concentration areas. They may go to  
14 middle America where we don't have a heavy  
15 Navy presence, and that is where the reserves  
16 can really assist us. And we have about 90  
17 percent of the mentors in the Anchor Program  
18 are from the reserve side.

19           So it has been very successful.  
20 The idea is to have a commitment from the  
21 mentor for a year to go alongside this service  
22 member. What we found, as we are going into



1     our second year of this, those relationships  
2     develop and they continue well past that year.  
3     And it is a lot of the basic stuff of whether  
4     the services available to you in down. How do  
5     you get your child into daycare? Where is the  
6     VFW, that kind of thing? And then making sure  
7     if there is any issues, that they can tie that  
8     back to our teams and make sure that the  
9     issues are resolved.

10           DR. STONE: If you could just  
11     pause a second.

12           CAPT BREINING: Yes, sir.

13           DR. STONE: We asked the Army a  
14     question and Army has the AW2 Program --

15           CAPT BREINING: Right.

16           DR. STONE: -- that extends for  
17     thousands of individuals into the post-  
18     retirement phase. You can take this question  
19     for the record and respond, if you would like  
20     to. The Army did. Okay? And that is, what  
21     is it that the Navy perceives that is not  
22     being provided to veterans that the Navy needs

1 to stand up structure to reach into the post-  
2 retirement phase to do?

3 CAPT BREINING: It is a rather  
4 complex question. I would like to take that  
5 for the record, so we can get you a confidence  
6 response.

7 DR. STONE: I appreciate that.  
8 And we are deeply respectful and very pleased  
9 at all of the services reaching out into the  
10 post-retirement phase. But the Veterans  
11 Administration Exists for a reason. There are  
12 service advocacy organizations that exist for  
13 a reason. What is it that each of the  
14 services perceive to be the unmet need is  
15 where we are trying to get at some answer.

16 So, I appreciate you not only  
17 doing this work but also coming back to us and  
18 saying here is what we see as a gap.

19 CAPT BREINING: I would like to be  
20 able to respond in written form with some  
21 specifics. I think in just generalities,  
22 though, it can be very overwhelming to come

1 out of the military system where you are  
2 handheld. You usually have an NCO watching  
3 out for you. You have a company commander  
4 watching out for you. They make sure you get  
5 to your appointments; that you know exactly,  
6 because most of the services are organized on  
7 one post, where you need to go and who you  
8 need to talk to.

9 And since I have taken a couple of  
10 trips out to the field, the sense I get is it  
11 is almost like swimming in a very large pool  
12 sometimes to then be thrust into a situation  
13 where you are responsible for engaging with  
14 the VA. You need to find the touch points in  
15 a lot of cases. And especially if someone is  
16 dealing with some PTSD issues, where that can  
17 feel very overwhelming very quickly.

18 So, having an extra person in the  
19 mix in our Anchor Program to help navigate  
20 that, we are very tied into the federal  
21 recovery coordinators with the VA. In fact,  
22 they are, in San Diego, there is two of them

1 that are assigned to the medical center there  
2 that we work hand-in-hand with to get warm  
3 hand-offs, other files. But they develop over  
4 time of being with us a six month to a year  
5 period of how long it takes to get through the  
6 IDES process a relationship.

7           And you can't replace  
8 relationships, necessarily. I am giving you  
9 a very long answer to your question, sir. But  
10 there is a trust that forms, a bond that forms  
11 with our care managers so that that is the  
12 person that often they will turn back to and  
13 the transition coordinators, once we hand them  
14 off to that, if there is any issue with  
15 anything. And the CNOs commitment for a  
16 lifetime obligation to our service members, we  
17 want to uphold that and provide the resources  
18 so that if there is a question with the VA,  
19 they can come back to us and we can contact  
20 the right POC and the VA and do the hand-off  
21 and make sure that they are plugging in the  
22 right place, sir.

1                   Any other questions on that  
2                   portion?

3                   The 24/7 Call Center, this has  
4                   been very successful. So, we have a call  
5                   center we stood up in Wilmington, Tennessee.  
6                   This is how we really engage with our  
7                   outreach, especially as folks hit the  
8                   transition point. So, we follow up once a  
9                   month for that first year and then every six  
10                  months' thereafter.

11                  So we made 1630 calls throughout  
12                  the first year of operation. And again, this  
13                  is just showing that you are part of the Navy  
14                  family and we have an obligation to you for a  
15                  lifetime and we care about you.

16                  A lot of times, hey everything is  
17                  great, doing well, I'm going to school, no  
18                  issues. But every once in a while we will  
19                  come across that service member that did not  
20                  reach out and then we can pull them back in  
21                  and help with their need.

22                  CO-CHAIR CROCKETT-JONES: Can I --

1 I want to ask you a question about the Call  
2 Center.

3 CAPT BREINING: Yes, ma'am.

4 CO-CHAIR CROCKETT-JONES: The Call  
5 Center proactively makes calls and is  
6 available 24/7 for receiving calls.

7 CAPT BREINING: Correct. So, it  
8 is a two-phase. We pro-act them and then also  
9 we have cards and posters for 24/7 receipt of  
10 any needs or enrollment questions.

11 CO-CHAIR CROCKETT-JONES: Of that  
12 1630, how many were received calls and how  
13 many were dialed?

14 CAPT BREINING: Merissa, do you  
15 know the answer to that?

16 MS. LARSON: All outgoing calls.

17 CAPT BREINING: All outbound  
18 calls.

19 CO-CHAIR CROCKETT-JONES: They  
20 were all outbound calls. Okay.

21 CAPT BREINING: Would you like us  
22 to pull the data on received calls?

1                   CO-CHAIR CROCKETT-JONES: No, I am  
2 just -- my concern is that as budgets shrink  
3 and places which are proactively making calls  
4 without being high recipients, that basically  
5 the wheel gets reinvented to consolidate and  
6 having that done in a sort of a deliberate and  
7 thoughtful manner is, perhaps, better in a  
8 planning concept than just waiting until the  
9 service is no longer there and then it ends.  
10 And then the people who basically still have  
11 that card that says your number and it is no  
12 longer -- do you see what I am saying?

13                   CAPT BREINING: Absolutely.

14                   CO-CHAIR CROCKETT-JONES: I think  
15 this is an area where money is going to take  
16 a first hit for budget reasons.

17                   MS. LARSON: Just to address your  
18 question a little bit more with regards to the  
19 financial constraints. One great thing that  
20 we have realized with our realignment from  
21 OPNAV to CNIC is many synergies that have  
22 always currently available through a Commander

1 Navy installations command and this call  
2 center is actually one of them, we have  
3 married up within a pre-existing call center  
4 and it is actually the NGIS call center that  
5 the Navy has.

6 And so we utilized their  
7 infrastructure. And so it is very minimal  
8 cost to us to have these call representatives  
9 operating our call center, alongside the Navy  
10 Gateway Inns and Suites. So, we feel as  
11 though that has been a cost-realization that  
12 we have received.

13 CO-CHAIR CROCKETT-JONES: That is  
14 very good. That is exactly what I was looking  
15 for.

16 CAPT BREINING: And just a little  
17 bit more. So, for enrollees for an enrollment  
18 question, the call center is crucial for that.  
19 So, we have voice call-in referrals, self-  
20 referrals, as well as the email that we  
21 posted, not on posters, they may choose to use  
22 email. And then the third prong of that is



1 referrals to the chain of command, or if we  
2 see a casualty report come in. So, it is one  
3 of the three prongs that we use.

4 So, to your point, it is multi-  
5 use. And I think that is very important to  
6 justify that for our resources going forward.

7 Finally, is our adaptive  
8 athletics. This has been very, very helpful.  
9 So, the intent is to provide athletic  
10 reconditioning and recuperation. We do have  
11 the Warrior Games, which I am sure most of you  
12 are familiar with, which is a multi-service  
13 annual competition. It is a big competition.  
14 But really the whole purpose of the program is  
15 to expose our wounded, ill, and injured  
16 opportunities for mobility, perhaps get in the  
17 pool for the first time and, with a coach,  
18 learn how to navigate the pool or, using an  
19 adaptive bicycle to be able to bike if that  
20 was a passion of theirs. Or even to expose  
21 them to new sports opportunities that they  
22 were not even aware of through different

1 adaptive systems that we provide.

2 We provide the equipment. We  
3 have a contract with the coaches and the whole  
4 focus is the reconditioning portion as part of  
5 their comprehensive rehabilitation.

6 So, we have hosted 14 camps and  
7 clinics over 2013 and you can see the warrior  
8 game results pretty successful there. Again,  
9 you know that is just an added benefit to be  
10 able to reinvigorate that competitive nature  
11 that a lot of military have going into the  
12 service. But the recuperation is really where  
13 it is at.

14 So, any questions on this slide  
15 before we move on?

16 So, this next one is 2008 data to  
17 the present. This is kind of a snapshot of  
18 our support populations. I would like to draw  
19 your attention to the bottom.

20 About 15 percent officer and 85  
21 percent enlisted or thereabouts. Our combat  
22 to ill and injured population is around 20

1 percent of the population is combat warrior  
2 woundeds and the non-combat is approximately  
3 80 percent. And female to male about 20  
4 percent to 80 percent there.

5 And you can see the difference  
6 illness and injury types that we are looking  
7 at. About 50-50 between illness and injuries  
8 for the remainder of that 80 percent.

9 I would like to address our  
10 business process improvements. Our quality  
11 assurance and inspection team which Ms.  
12 Hillier runs has been in existence since 1  
13 October. So, we are just getting off the  
14 ground with our both our inspection criteria  
15 and our business throughout the region.

16 So, I have visited two regions  
17 since we have stood it up and we have a plan  
18 for the remainder of the FY to get out to all  
19 the regions. And this first year we are  
20 calling it a site assist really. So, we are  
21 not inspecting. This is kind of to just give  
22 a feel for how we are doing regionally with

1 our new regional construct and what areas of  
2 improvement we need. And the plan is for '14  
3 we will actually flow into a more formalized  
4 inspection process, where we report our  
5 results up to our three-star.

6 Three-person teams to out in the  
7 field. They are looking at standard inspection  
8 criteria. And we are going to use alignment  
9 with the word policy standards that they are  
10 inspecting us on. So, we have had, I believe  
11 one visit from WCP, so far this year.

12 They are getting around to the  
13 Eastern Seaboard this year. It is a two-year  
14 plan. It will probably rest next year. But  
15 we want to make sure that we are consistent in  
16 the application of the policy. It is not just  
17 coming from our level but we are looking up a  
18 level, too.

19 We also use customer satisfaction  
20 surveys to our enrollment population  
21 qualitative and quantitative, both recovering  
22 service members and their caregivers. And

1 this has been very helpful for us to judge  
2 whether we are being effective. Because we  
3 could have all the metrics in the world but if  
4 there is dissatisfaction from the people that  
5 we are trying to serve, then we are not doing  
6 business right.

7 And again, that is going to drive  
8 our training, our resourcing and, like I said,  
9 we have done two inspections so far.

10 CSM DE JONG: Sir, with your  
11 inspections, one of the things that we noticed  
12 was, obviously, Safe Harbor has very low  
13 numbers. So, one of the concerns that was out  
14 there when we were out on the West Coast was  
15 adaptive housing. How has Safe Harbor come  
16 along with that and do you have the adaptive  
17 housing?

18 CAPT BREINING: I am going to take  
19 that one for the record, because I don't have  
20 a specific answer to that. I know it is a  
21 problem, though, because a lot of their  
22 housing was built prior to those standards

1 being applied.

2 Why I know it is a problem is  
3 because when we do our warrior trials and we  
4 have to bring in, say 100 athletes into an  
5 area, we always have this back and forth with  
6 communities, maybe Navy Gateway Inns and  
7 Suites or the Navy Lodge to house them. And  
8 we don't seem to have enough to be able to  
9 address the need.

10 I think a lot of our new housing,  
11 we are getting a lot better but I don't have  
12 a specific answer for you in that regard. So,  
13 I would like to get back to you on that.

14 CSM DE JONG: Absolutely.

15 MS. LARSON: Just one other thing  
16 to add in regards to the housing. Where we  
17 land within CNIC under the N9 organization,  
18 our SES director also owns Navy housing. And  
19 so these issues and concerns are being raised  
20 to the highest level. So, we think we have a  
21 good partnership there to be able to move  
22 forward and individually address those housing

1 needs.

2 CSM DE JONG: Well, that is great  
3 news. It was just a concern of the Sailors  
4 and it was also a concern of ours when we saw  
5 that. But we also understand the difficulty  
6 and the burden of that when your numbers are  
7 very low. So, I just wanted to see where you  
8 all were. Thank you.

9 CAPT BREINING: I appreciate that  
10 question.

11 So here, our program restructure  
12 really came out of -- I have been with the CNO  
13 staff approximately -- a little over a year  
14 ago. And I went over to Commander Navy  
15 Installations Command. To Merissa's point, it  
16 was to increase those synergies where we  
17 execute and we have a lot of synergies with  
18 the family support. Being in the Navy  
19 Installation Command, we have direct press  
20 connections to the housing, to the MWR, all  
21 the enabling activities that we would need to  
22 coordinate with to be able to execute our

1 programs.

2 So, in our estimation, it has been  
3 a very successful partnership for this past  
4 year.

5 As we look into the headquarters  
6 structure, we were really focused when we were  
7 up at OPNAV on a day-to-day implementation of  
8 the program. So, we are very intentional on  
9 pushing a lot of our headquarters resources,  
10 especially some of our military billets out to  
11 the regions because that is the day-to-day  
12 touch point for this program. And that allows  
13 us, up at headquarters to focus on the policy  
14 and program improvements.

15 So, we modified some of the  
16 headquarter structure like I talked about. We  
17 have built some continuity into our department  
18 heads, my deputy director. And then went  
19 through a comprehensive billet scrub to make  
20 sure that we have the proper alignment both in  
21 headquarters and out in the field to best  
22 serve our wounded warrior ill and injured



1 population.

2                   Established four departments. You  
3 can see those up there, policy enrollment,  
4 quality assurance and inspections, pay and  
5 entitlements, and then cross-functional.  
6 Cross-functional is basically a our depth of  
7 athletics and our transition services that we  
8 provide.

9                   We have a program instruction that  
10 is going to be a CNIC instruction and final  
11 draft and review. This should basically  
12 formulate that policy for implementation. So,  
13 we have the OPNAV instruction, which gives us  
14 authority to execute the program on behalf of  
15 the CNO and this instruction will give us our  
16 actual execution criteria as we engage with  
17 our regional partners who make it happen.

18                   So our regionalization efforts, we  
19 basically conceived, planned, and executed all  
20 in one year on this, using a spiral  
21 implementation plan and then tested the  
22 regions as we roll it out to make sure it was

1 actually working.

2 So, some key initiatives that came  
3 along with this in separating out the NMCMS  
4 and the RCCs, making sure they understood  
5 their responsibilities. This is in compliance  
6 with the DoDI.

7 Establishing an on-site  
8 supervisor, which we called the N95, which is  
9 my counterpart on the regions that reports to  
10 the N9, which is in charge of the family  
11 services, the MWR, the housing, and then  
12 testing it to make sure it is working.

13 And like I said, we have seen a  
14 lot of synergies. That has been very  
15 beneficial to providing services to our  
16 enrollees.

17 We have also established a case  
18 flow process, so that everyone understands  
19 what their roles and responsibilities are.  
20 And then as we get out to each site, we are  
21 reinforcing that and messaging that and making  
22 sure everyone is adhering to that.

1                   This is how we are regionally  
2 aligned. So, we can see the big boxes over  
3 here. Those are all the region headquarters.  
4 And our personnel are actually assigned to the  
5 military treatment facility at that region.  
6 So, we are down here at the mid-Atlantic.  
7 That would be Portsmouth and so on and so  
8 forth.

9                   And then we have folks that are  
10 spread out in smaller groups, that some of the  
11 smaller MTFs, the VA polytraumas, and so on  
12 and so forth.

13                   CNIC is going to realign our  
14 Midwest Region here, beginning October first.  
15 So what is happening is Tennessee is going to  
16 come down here to the southeast. Everything  
17 else west of the Mississippi will go up to  
18 Northwest and then the remainder East of the  
19 Mississippi will go to Mid-Atlantic. So, a  
20 regional NMCM will be coming over here to Mid-  
21 Atlantic. And then we need an additional  
22 person out here in Hawaii. So, we are going

1 to take this enlisted E7 billet and push it  
2 out to Hawaii.

3 We have looked at the caseloads.  
4 We don't think there is going to be any  
5 excessive caseload being brought by any of the  
6 regions that they aren't equipped with the  
7 resources to address now. But like I said, in  
8 the 16POM Initiative, we do need more  
9 resources out in the field as we get our  
10 enrollment numbers up through our proactive  
11 outreach and we have asked for more resources  
12 going forward.

13 And you have seen that slide, so I  
14 am going to move on to SCAADL.

15 So how we implement and manage  
16 this for the Navy. I mentioned before that a  
17 doctor needs to complete the application.  
18 Typically, this is going to be the PCM for the  
19 service member. And then a Safe Harbor  
20 Medical Officer 05 assigned to my staff  
21 reviews that and makes sure it meets the  
22 criteria for assisted living.

1                   We track all Cat IIIs and make  
2                   sure that we don't miss anybody that is in the  
3                   Cat III status and make sure they understand  
4                   the opportunity to enroll in the benefits that  
5                   are available to them.

6                   And the Pay and Entitlement  
7                   Department down in BUPERS tracks and submits  
8                   all the SCAADL applications for submission.

9                   So looking over 2013, we had 84  
10                  wounded ill and injured have received SCAADL;  
11                  35 are currently receiving this benefit. The  
12                  average is 28. And you will see overall, our  
13                  average age for our enrollee population is  
14                  going to be higher than the other services.  
15                  And this is because our combat wounded are  
16                  generally lower than the other services just  
17                  be exposure.

18                  The average monthly payment,  
19                  \$1,436. And you can see some of the injuries  
20                  and illnesses up there that we are tracking.

21                  As I mentioned before about our  
22                  detailed SCAADL fact sheet, we are going to

1 post this on our website and make sure it gets  
2 out through social media. And we have Wounded  
3 Warrior Family Newsletters that go out once a  
4 quarter to all of our enrolled families. And  
5 this is a topic that we hit on that, too, so  
6 that they know the benefit if out there and we  
7 see if they are qualified.

8 MR. REHBEIN: Sir, if I may, for  
9 just a moment.

10 CAPT BREINING: Please.

11 MR. REHBEIN: Who makes the  
12 determination whether or not a Cat III Sailor  
13 should receive an application for SCAADL.

14 CAPT BREINING: I believe all Cat  
15 IIIs we look at vigorously to make sure. So,  
16 the specific criteria for activities of daily  
17 living, and that is why I have a doctor on my  
18 staff to be able to assess whether the  
19 disability or the illness would require that  
20 caregiver support. The concern is we have a  
21 fiduciary responsibility to our taxpayers to  
22 make sure that we are giving the benefit to

1 people that qualify.

2 MR. REHBEIN: Absolutely.

3 CAPT BREINING: And I think  
4 through messaging sometimes, I think, people  
5 see someone else getting it so, they think  
6 they automatically qualify. That is not  
7 always the case. Or deserve a benefit.  
8 Obviously, we need to make sure we do our due  
9 diligence.

10 MR. REHBEIN: What you are  
11 describing to me, though, is the process by  
12 which you make the determination after the  
13 application is received.

14 CAPT BREINING: Right.

15 MR. REHBEIN: What I would like to  
16 know is who makes the determination of which  
17 of the Cat IIIs received the application to be  
18 filled out. That was part of our earlier  
19 recommendation about the primary care manager  
20 because sometimes a PCM will see a person that  
21 maybe should be receiving SCAADL.

22 MS. HILLIER: Correct.

1                   MR. REHBEIN: So, that was the  
2 intent of our recommendation to put that  
3 application into AHLTA so that that primary  
4 care manager would have the ability to  
5 initiate the process. Not decide the process,  
6 but simply initiate the process.

7                   MS. HILLIER: And it is. It is  
8 initiated down with the PCM down at the NTF  
9 level. The nurse case manager, our non-  
10 medical care managers, when we get a Cat III  
11 in, they will review that case and then work  
12 with the nurse case manager down there, if it  
13 is warranted. And then those come up to  
14 headquarters and our physician at headquarters  
15 reviews those.

16                  MR. REHBEIN: Is there a process  
17 by which you are assuring yourselves that you  
18 have, if I may, 100 percent compliance that  
19 everyone that should be receiving an  
20 application is actually getting one?

21                  MS. HILLIER: I would say yes to  
22 that.



1                   CAPT BREINING: I mean that is  
2 part of our inspection.

3                   CO-CHAIR CROCKETT-JONES: That was  
4 really the genesis of our concern is that  
5 there seem to be an extra layer, an extra  
6 gateway that people were being dissuaded or  
7 prevented from application, based on a  
8 perception that is not made by the people who  
9 actually decide if they meet the criteria.

10                   And our feeling is that it is  
11 better for people to apply and be turned down  
12 than to have someone dissuaded from  
13 application who would have qualified. So,  
14 that was the genesis of this and it was not in  
15 any one particular service. This was sort of  
16 across the board there seemed to be these  
17 multiple gateways to apply before anyone was  
18 assessing, looking at the hard criteria,  
19 getting to the decision-maker. And so that  
20 was our concern.

21                   So, if you feel that you have  
22 removed any sort of obstacles to application,

1 that is fine but everybody's language seems to  
2 be this we decide who can apply and then we  
3 decide who gets it. And the answer is, why  
4 not have more people apply, even if you are  
5 going to have to say no, than sort of create  
6 a secondary layer of gatekeeping on this  
7 because the other perception from the Task  
8 Force members who have sort of gone around to  
9 various installations, certainly not just  
10 Navy, is that we are surprised a lot of the  
11 time by folks who have catastrophic illness  
12 and they have family members or caregivers who  
13 are talking about the enormous amount of work  
14 they are doing. And they weren't allowed to  
15 apply for SCAADL.

16 So, you know, we are seeing this  
17 kind of just one of those red flags that maybe  
18 they wouldn't have qualified for SCAADL.  
19 Maybe their perception of what they are doing  
20 is wrong. Maybe the need isn't there, so much  
21 as the desire. All those things are possible.  
22 But if they didn't apply, someone wasn't

1 making -- the decision process wasn't being  
2 made in a sort of deliberate and empirical  
3 way. It was being made in some sort of gate-  
4 keeping way prior to that.

5 So, that is one of the genesis of  
6 our recommendation that we just wanted to see  
7 this done in a more deliberate and sort of  
8 empirical way and less about this gatekeeping  
9 to the application process.

10 So, if you feel you have got a  
11 good system, I understand that and that is  
12 where we are going. But we are still hearing  
13 this language of we decide who can apply and  
14 then we decide who gets it. It makes it a  
15 little --

16 DR. STONE: How many active Cat  
17 IIIs do you have?

18 CAPT BREINING: Do we have an  
19 overall Cat III population?

20 MS. HILLIER: I do not. Not at  
21 this moment.

22 CAPT BREINING: And we got the

1 receiving benefit but we don't have anything  
2 to bounce it off.

3 DR. STONE: If you don't know your  
4 Cat III population, how do you know you are  
5 serving them well in SCAADL. How do you know  
6 35 is the right number? And why is the  
7 regional command inspection program the way to  
8 assess that? It seems to me that this is a  
9 headquarters issue.

10 MS. LARSON: Actually, SCAADL is  
11 executed and ran out of headquarters from our  
12 --

13 DR. STONE: But you do know how  
14 many Cat IIIs you have?

15 MS. LARSON: I can't tell you the  
16 number today off the top of my head but we do  
17 track that yes.

18 DR. STONE: I think this is,  
19 actually, you could get at this pretty  
20 quickly. If you have X number of Cat IIIs,  
21 you have 35 people and you know how many  
22 people you have turned down, then you pretty

1 much know how effectively you have penetrated  
2 this population.

3 It is my assumption that those  
4 people eligible for SCAADL are going to come  
5 exclusively from your Cat III injury.

6 MS. LARSON: Well we, also, too,  
7 through the awareness piece and the education  
8 tools that we have developed for SCAADL, we  
9 have seen an uptick in the application  
10 process. And so that is why we have created  
11 that direct relationship between our medical  
12 service officer and the regional medical  
13 providers as well, so that we can have those  
14 clear communication lines to ensure that those  
15 people who are properly eligible know that the  
16 catastrophic and the permanent disabilities  
17 are receiving that benefit.

18 So to your point, ma'am, we do not  
19 want to be a gatekeeper. And for those people  
20 who are able to apply and willing to apply, we  
21 want to receive those applications and we want  
22 to give them the proper review.

1 DR. STONE: How do we correlate  
2 that answer to your previous reference to  
3 fiduciary responsibility?

4 MS. LARSON: I think to the  
5 Captain's comment about fiduciary  
6 responsibility is since Navy Safe Harbor is  
7 the owner of the application, we want to make  
8 sure that we are on it ready as we prepare for  
9 OSD to come and do those annual audits. We  
10 need to make sure that the applications and  
11 the money flow properly.

12 DR. STONE: And in the seven  
13 criteria of audit-readiness -- you may not  
14 know the answer to this. In the seven  
15 criteria of audit-readiness that is, frankly,  
16 BUMED has done a great job with well ahead of  
17 the other services is the SCAADL program part  
18 of that audit readiness program?

19 MS. LARSON: I would have to  
20 double check, sir.

21 DR. STONE: Yes, I am not sure.

22 CAPT BREINING: I didn't mean to

1        imply, if it came out this way, that we were  
2        gatekeeping the applications. We take an  
3        extra look at the Cat IIIs just to make sure  
4        we are not missing anyone. We never  
5        discourage anyone from applying for a program.

6                    CO-CHAIR CROCKETT-JONES: You know  
7        I think this is more of our -- less from the  
8        wording. The wording just coincides when we  
9        hear this with what we have seen in the  
10       installations. I am not saying that this is  
11       your intention. Don't mistake me.

12                   CAPT BREINING: Absolutely.

13                   CAPT SANDERS: Does the fact sheet  
14        that you use as your marketing tool lay out an  
15        instant application, an access to an  
16        application for folks who want to apply?

17                   CAPT BREINING: It has all that  
18        information in it. Yes, sir.

19                   CAPT SANDERS: But there is no  
20        actual drop-down, where they could just apply  
21        from there. They would have to physically go  
22        in to an office some place and prepare an

1 application.

2 CAPT BREINING: Correct. And they  
3 would work with their care manager out in the  
4 field side by side through this whole process  
5 to say let's put an application. And my  
6 doctor up in the headquarters, to your point  
7 of executing up at headquarters, says hey,  
8 does it meet the criteria for the program or  
9 not. Not every Cat III will be eligible. The  
10 vast majority of them are but we just need to  
11 make sure that we are adhering to the  
12 standards and the policy that is in place,  
13 which we execute.

14 And certainly we can get back with  
15 those Cat III numbers for you, sir.

16 So, looking ahead to '14, looking  
17 for establishing a five-year strategic plan,  
18 maintaining a program visibility and relevance  
19 as we go forward in answer to that question  
20 "What now?" as we pull our forces back from  
21 Afghanistan, potentially. Where are all the  
22 Wounded Warrior Programs going within the DoD



1 and how do we fit into that niche?

2 We are looking to revamp our  
3 website, be more engaged in the regions on a  
4 traveling road show of our family symposiums  
5 that we do each year on the regions. That is  
6 a good inject point to touch a wide audience  
7 with the services we provide.

8 We are going to develop a series  
9 of educational webinars to the military and  
10 civilian community, to expand that outreach.

11 And finally, with the Recovery  
12 Care Program, improving enrollment. So,  
13 enrollment has been a continuous challenge.  
14 Everyone understands Navy Wounded Warrior Safe  
15 Harbor serves the wounded warrior population.  
16 We still have not been completely successful  
17 in getting out to the fleet the message that  
18 seriously ill and injured are also eligible  
19 for our programs.

20 So, we are working very hard at  
21 the deck plate level, working with the fleet  
22 commanders to set up roundtables and bringing

1 folks in from the ships and the units on the  
2 line to hear our sales pitch, you know this is  
3 what we can provide to your Sailors. And we  
4 are hopeful that once we do that, that they  
5 will be in tune so that when their Sailor has  
6 an issue, they will immediately pick up the  
7 phone and call us and make sure that the  
8 Sailor is put in touch with our program.

9 TSGT EUDY: Sir, is this  
10 information also being briefed out to any of  
11 the NCO professional development courses or  
12 standard officer training programs that exist?

13 CAPT BREINING: Yes. Yes, that is  
14 a great question. The Senior Enlisted Academy  
15 up in Newport, as well as the Commander  
16 Leadership School up there for the CEOs, XOs  
17 going through.

18 LTCOL KEANE: So, a follow-on  
19 question. But before I have that question,  
20 regarding SCAADL, of the 35 currently  
21 receiving, how many Coast Guardsmen are  
22 receiving SCAADL?

1                   CAPT BREINING: Do we that number?

2                   MS. HILLIER: Zero.

3                   LTCOL KEANE: Zero?

4                   MS. HILLIER: The Coast Guard does  
5 not have SCAADL.

6                   LTCOL KEANE: They don't have  
7 SCAADL?

8                   MS. HILLIER: They do not, sir.

9                   LTCOL KEANE: Thank you.

10                  CAPT SANDERS: Are you going to  
11 integrate the Call Center with your redesigned  
12 website so that there is an active integration  
13 between the two?

14                  CAPT BREINING: Do you want to  
15 take that one?

16                  MS. LARSON: Sir, that is a great  
17 recommendation. That is something actually we  
18 have been looking into to understand the cost  
19 associated with that. It is one of our wish  
20 lists.

21                  CAPT BREINING: So the enrollment  
22 challenge is also with the medical community

1 making sure the doctors and nurse care  
2 managers out there when they see patients come  
3 in, especially with a serious illness  
4 category, they understand what is the criteria  
5 for becoming a Safe Harbor enrollee and that  
6 they refer that service member to us.

7 So, we are looking at formalizing  
8 that through our MOU with BUMED to allow us  
9 greater access to that medical data and  
10 communication between our two organizations so  
11 we can synchronize the enrollments.

12 We are continuously tracking the  
13 caseloads and doing resource advocacy for our  
14 regions. And then finally we are going to  
15 migrate our database into the TWMS, which is  
16 our CNIC administrative human resources tool.  
17 And that is going to bring us a lot of  
18 enhancements, including automatic metric  
19 generation, which will keep us from sitting  
20 behind Excel spreadsheets and utilize our time  
21 with actually patient enrollee contact.

22 Finally, through our transition

1 initiatives, we are hiring transition  
2 coordinators, hopefully, if we get our 16POM  
3 Initiative approved to put transition  
4 coordinators out to each of the regions.  
5 Currently, we manage that from the  
6 headquarters and we have one out in the  
7 Southwest but we want to spread that  
8 capability through all the regions.

9 And continuing use our Call Center  
10 for outreach to our Vets and expanding our  
11 Anchor Program beyond what it is now.

12 So, any questions? Thank you.

13 MR. POWERS: Generals, Robert  
14 Powers on behalf of the Physical Evaluation  
15 Board. Ms. Crockett-Jones, Captain Sanders,  
16 Board members, I want to thank you for  
17 actually asking the PEB to come up here and  
18 brief. And I hope the Board doesn't mind, I  
19 have to say this Task Force really has made a  
20 difference regarding taking care of our  
21 Marines and Sailors. So, I want to thank the  
22 Board members for what they have done. I

1 really believe that this Task Force has really  
2 been a driving force, is on the road to making  
3 the IDES a better program. You have  
4 highlighted areas. And what we have done both  
5 at the Physical Evaluation Board, with BUMED  
6 working on behalf of the Secretary of the Navy  
7 is really tried to stay aligned with many of  
8 the issues that the Recovering Warrior Task  
9 Force is bringing to light. Actually, I am  
10 somewhat disappointed to hear that this is the  
11 last year because I think there are still some  
12 more issues that really, and it is great to  
13 see senior leadership on the Board making a  
14 difference but the Task Force really has  
15 isolated these issues and kept us focused. So  
16 again, thank you for asking us to be up here.

17 So to answer the specific queries,  
18 in essence, we are re-updating the SECNAV  
19 instruction, the very much needed instruction.  
20 I wish we could say we were already done with  
21 it. This is actually a herculean task. It  
22 actually takes a lot of manpower. Personally,

1 I am involved in it. We have had the  
2 Secretary of the Navy personally trying to get  
3 this developed and the goal is to try to have  
4 it by the end of the year.

5 Part of the reason was that,  
6 obviously, we were waiting for the DTMs. They  
7 are now out. Waiting for that, so we want to  
8 make sure that we are aligned with OSD.

9 The other query is specifically do  
10 we see the patient census trajectory. What we  
11 have done at the PEB is we looked at our past  
12 caseload and saw there was a direct  
13 correlation with draw down of the services and  
14 DES caseload. What we did with this graph is  
15 it represents the green and red bars. Red  
16 means there was a reduction in PEB caseload  
17 that year. Green means there was actually an  
18 increase in caseload. The below numbers  
19 represent, obviously, the year, and the  
20 numbers represent the reduction in end  
21 strength.

22 In the notes of the slide it talks

1 about now obviously in the 1990s we were at  
2 about a 750,000 end strength for Navy and  
3 Marine Corps. Now we are right around,  
4 hovering around 500,000. We have done some  
5 projections and, again, we are getting ready  
6 to go through the largest draw down we have  
7 gone through in 50 years. We are not quite  
8 seeing the impact yet but I believe we will.  
9 Rejections are the same but the next couple of  
10 years we will start seeing the spike.

11 Right now our actual chart are  
12 showing us that our caseload is on target.  
13 The short answer is that we are going to need  
14 the manpower that we have stood up ad hoc to  
15 continue to process these Marines and Sailors.

16 Areas of highlight. Probably the  
17 biggest thing is that, obviously, the aspect  
18 of War College, the aspect of organizational  
19 behavior, I really do believe that this IDES  
20 that we have in place is one of the best  
21 processes we can put in place, considering the  
22 theory that organizations make decisions



1       rationally but they are all altered by  
2       organizational culture and bureaucratic  
3       politics. But so what we have now, we have  
4       taken a system between the Department of  
5       Veteran Affairs, Department of DoD, and all  
6       the services and we are getting Marines and  
7       Sailors and Veterans a benefit delivered in  
8       200 plus days. It was taking 500 days.  
9       Obviously, there is improvements. But the  
10      important aspect is if we accept that the IDES  
11      is a very good process or a sufficient  
12      process, then we can start making some of the  
13      other more costly investments that we still  
14      have not done.

15                   First and foremost is we really  
16      have not set up our increased demand in a  
17      permanent structure for the IDES. As far as  
18      the Department of Navy Physical Evaluation  
19      Board, we are still relying on active duty  
20      special work to help the caseload. We are  
21      still using overstaff from the Marine Corps,  
22      from the Navy, making sure they are trying to

1 give us their manning.

2 So that is, until we really get  
3 this set, we will still be struggling with  
4 this temporary workload.

5 The other aspect is --

6 DR. STONE: Sir, today, how many  
7 billets are there dedicated to the disability  
8 system and the PEB system.

9 MR. POWERS: Right now, sir -- we  
10 had approximately 69 billets that we had last  
11 year. I am down to 59 personnel right now.  
12 We actually are trying to get it set at what  
13 is true personnel. We have got the manning  
14 documents in but I don't think, as a whole, we  
15 have set that yet. And I can't give you the  
16 specific number. I apologize. I can go back  
17 with that, though.

18 DR. STONE: Total number of  
19 individuals currently involved that are being  
20 served --

21 MR. POWERS: Right now --

22 DR. STONE: How many people are

1 going through right now? We know the Army is  
2 right up around 27,000 and has about 1,400  
3 personnel dedicated to it.

4 MR. POWERS: I cannot speak for  
5 the whole Department of Navy numbers. I can  
6 speak for the PEB as far as for the manning to  
7 in order process.

8 What we have, we have about 4,500  
9 Marines and Sailors going through the IDES  
10 right now. We process about 7,500 annually.  
11 And of course that includes the temporary  
12 disability retirement caseload. And so what  
13 we are seeing is that in the end -- and in the  
14 past the Board members have been here. I have  
15 been at the PEB since 2005. I have done some  
16 point papers that I started in 2008 saying  
17 what personnel we are going to need. You know  
18 it is sort of geeky to say well those numbers  
19 that we said in 2008, we still need the 60  
20 people in order to process. It is sort of a  
21 rhythmic formula. You know how many people  
22 are going through. You basically know how

1 long it takes to do a case. So, if you want  
2 it done in X amount of days, this is how many  
3 people you have.

4 We had that validated,  
5 incidentally, last year or two years ago. We  
6 brought in an industrial engineer team on  
7 behalf of BUMED, actually M81 was very  
8 helpful, and validated our processes in  
9 personnel.

10 DR. STONE: But the 59 number you  
11 gave of your current personnel, if I heard you  
12 right, that is strictly the PEB portion of  
13 this process.

14 MR. POWERS: Yes, sir.

15 DR. STONE: Got it.

16 MR. POWERS: And speaking on BUMED  
17 is certainly, they also have done a lot of  
18 hiring. I don't know if they want to comment  
19 on whether they feel that they are fully  
20 staffed.

21 I think that in the end, this is a  
22 very simple model. It is sort of like when

1 you walk in a Starbucks and you only have one  
2 server serving you and there is ten people in  
3 line. It is going to take a certain amount of  
4 time. If you want the caseload to move  
5 forward, you add servers. And I think that is  
6 what BUMED has certainly done over the years.  
7 They have added med staff and that is in fact,  
8 we saw that two years ago with our caseload.  
9 All of a sudden we had this massive surge.  
10 When they had the personnel to process, the  
11 people at the door, the service members at the  
12 door, things moved faster and we started  
13 getting to a sustained time line. Whether  
14 that all is still permanent structure for DON,  
15 I think we still have to look at closely.

16 CAPT SANDERS: Rob, I know you  
17 don't own the counsel but since the  
18 civilianization of the counsel, what are the  
19 numbers like? And can you tell me anything  
20 about what the counsel patient load looks  
21 like? If you try to process 7,500 a year,  
22 each one of those individuals has the

1 opportunity to talk to counsel, what does that  
2 load look like?

3 MR. POWERS: As far as the -- we  
4 work very closely with OJAG, sir, appreciate  
5 your time there, sir. The issue right now is  
6 they actually have just done, OJAG has just  
7 hired, I believe -- in fact, I talked to Ms.  
8 Morrisroe the program lead for that -- I  
9 believe they said they are hiring, they are  
10 trying to hire, bring on seven full staff to  
11 address. Because what they are trying to  
12 address for the caseload is, again, the  
13 Board's recommendation that we get 100 percent  
14 Recovering Warrior Task Force -- or recovery  
15 warrior contact. So, they have the informal  
16 board attorneys out there and then, of course,  
17 we also need the attorneys at the formal board  
18 to address for the hearings.

19 They are looking at the numbers.  
20 I know they have just done some recent  
21 civilian hires as well. I'm not sure I fully  
22 answered your question, though.

1                   CAPT SANDERS:  So, we haven't  
2                   fully figured out whether or not we need more  
3                   counsel on the formal side and the informal  
4                   side.

5                   MR. POWERS:  The answer is they  
6                   have just assessed that.  And they are  
7                   currently, as we speak, in the process of  
8                   hiring to meet that need.

9                   And in fact, I talked to Ms.  
10                  Morrisroe.  In fact, she used these slides to  
11                  go to OJAG.  What they are saying is they may  
12                  actually need eight attorneys in order to meet  
13                  the needs of the formal board and also for the  
14                  informal board members out there in individual  
15                  MTFs.

16                  CAPT SANDERS:  Thank you.

17                  MR. POWERS:  Yes, sir?

18                  DR. STONE:  I want to make sure in  
19                  your opening introduction to this subject I  
20                  heard you clearly.  You have taken the  
21                  position on behalf of the Navy that the IDES  
22                  system is a very good system that just needs

1 more personnel and funding?

2 MR. POWERS: I would clarify it  
3 would not be on behalf of the Navy. I can say  
4 personally on behalf of the Physical  
5 Evaluation Board, my personal opinion is I  
6 believe that Integrated Disability System is  
7 a very good system that is meeting the needs.  
8 And it is a process that if we accept that it  
9 is working, that you will start continuing to  
10 invest in it, instead of holding some of the  
11 major costly investments such as a case  
12 management system.

13 DR. STONE: So, as an  
14 administrative load, the funding to the IDES  
15 system that includes both MEB and PEB to the  
16 Navy is how much per year?

17 MR. POWERS: I don't have that  
18 answer. We can come back. I know we are  
19 working on the answer. I can come back to the  
20 Board, sir.

21 DR. STONE: My bet is for Army and  
22 Navy, which are the two behemoths in this, it



1 exceeds \$300 million a year in administrative  
2 load.

3 And so, your argument then is that  
4 is insufficient funding in order to  
5 effectively move this system and its 55 sub-  
6 processes in an effective manner.

7 MR. POWERS: Sir, that is not my  
8 argument. What I am saying is that we have,  
9 as far as when it comes to manning and setting  
10 up, and I am not saying -- by all means I hope  
11 I did not imply in any way or infer that this  
12 is not -- that we are not spending proper  
13 funding. What I am saying is that we need to  
14 go ahead and look at what -- senior leadership  
15 has said that they want their wounded warrior  
16 taken care of. And so what they have done is  
17 we have taken active duty special work, we  
18 brought on reservists, we have done temporary  
19 hires, we have brought in overstaffs that are  
20 all ad hoc manning to make this work. And it  
21 is working. The point is, years from now when  
22 this Task Force is no longer here and we

1 continue with our reduction, when they start  
2 looking at the line numbers and say well I  
3 know you say you need 69 people at the PEB but  
4 your manning documents only say you rate 32,  
5 there will be a struggle to bend the  
6 priorities. That is all that I highlight.

7 CAPT SANDERS: Have they also told  
8 you that, based on the Active Duty for Special  
9 Work reduction in funding, that you are going  
10 to lose people based on that alone in the near  
11 future?

12 MR. POWERS: I have lost it. Yes,  
13 sir. Yes, sir.

14 So for instance, last year I had,  
15 and forgive me the number is not exact, so I  
16 think had like nine ADSW. I have three ADSW  
17 right now. I had, last year, at the Physical  
18 Evaluation Board, we had 69 personnel  
19 processing our cases. We are now right now at  
20 59. So within the last year, I have lost ten  
21 personnel.

22 Now that is sort some of the

1 numbers it affected, some of it was a surge,  
2 so I don't necessarily need the 69 but if we  
3 keep losing our ADSW and there is no  
4 replacement, there is a concern that we will  
5 not be able to process as timely and fairly as  
6 we have been in the past.

7 CAPT SANDERS: And so have you  
8 gone forward in FY15 budget request for  
9 increasing permanent billets?

10 MR. POWERS: Yes, sir, we have.  
11 And I only highlight as a concern is whether  
12 we actually get that is a whole other answer.

13 CAPT SANDERS: Okay.

14 CO-CHAIR MUSTION: Can I ask a  
15 follow-up question? With 59 people, are you  
16 able to meet the standards established in IDES  
17 for processing?

18 MR. POWERS: Presently we are,  
19 sir.

20 CO-CHAIR MUSTION: You mentioned  
21 32 or 33 as a potential future number. If  
22 things stay on track, I guess that is what the

1 actual authorizations reflect. At that level,  
2 with the caseload that you have, will you be  
3 able to achieve and sustain the standards?

4 MR. POWERS: Right now, the  
5 standards, in order to meet is right now is  
6 59. The reason I use 32 is that is actually  
7 what our manning was prior to the IDES. And  
8 the people that we have now, the personnel  
9 that we have now are doing an incredible  
10 effort. They are actually an addition to what  
11 our TO is.

12 And I guess the last part would be  
13 is that if we accepted the IDES is a  
14 sufficient program that needs improvements,  
15 then you probably, what I believe one of the  
16 Recovering Warrior Task Force issue would be  
17 we could stream off a lot of days if we  
18 actually had an IDES case management system,  
19 a universal case management system.

20 Right now, one, we use a lot of  
21 resources and a lot of individual case  
22 management tools that take away a lot of time.

1 So for the PEB, we have the Joint Disability  
2 Evaluation Tracking System. That is our case  
3 management system that produces our reports  
4 and findings. We have the VTA, the Veterans  
5 Tracking Application that we actually are  
6 absolutely need so that senior leadership and  
7 so that we can, as an enterprise track and  
8 make sure cases are processing through. We  
9 have internal trackers.

10 We don't actually have a scan and  
11 electronic transfer process for these cases  
12 right now. We are still receiving them by  
13 mail. If you were all of a sudden to say well  
14 this is the age of PDF and scanners, why  
15 aren't you doing that? Because you don't have  
16 a system to go ahead and track and do version  
17 control, it is actually still faster for the  
18 service member to get it by paper.

19 So, the issue would be --

20 DR. STONE: Sir, the Army has been  
21 operating for a number of years a system that  
22 was developed in the Army National Guard that

1 does exactly all of these. Are you aware of  
2 that?

3 MR. POWERS: The ePEB and eMEB,  
4 yes, sir.

5 DR. STONE: Why hasn't the Navy  
6 accepted that?

7 MR. POWERS: We have looked at it.  
8 I think the processes are so different that we  
9 weren't able to accept it. And then the other  
10 issue is these cases have to be permanently  
11 stored.

12 DR. STONE: Why are the processes  
13 so different if IDES is a DoD program?

14 MR. POWERS: My understanding is  
15 on the ePEB and eMEB they are also still using  
16 the VTA.

17 CO-CHAIR MUSTION: The Army is  
18 still using parts of VTA, yes. I mean VTA  
19 still remains the repository, if you want to  
20 call it that, for the official tracking of  
21 information inside and outside the Department.  
22 But the Army has been using electronic file

1 transfer for a couple of years that we have  
2 been using to pass information both from MTFs  
3 to the PEB, and then from the PEB to the DRAS  
4 and back and forth.

5 MR. POWERS: And I think if you  
6 were to look at the time involved in using VTA  
7 and also using a separate system, whether it  
8 is JDES or ePEB, you will find there is a lot  
9 of time savings that we could save by  
10 combining those systems. That is probably the  
11 biggest point I have highlighted.

12 DR. STONE: So, have you put a  
13 budget request into your POM for this and you  
14 were turned down or you have been accepted?

15 MR. POWERS: No, sir. What we  
16 were looking at is there is two programs that  
17 we are trying to champion as well as the one  
18 is the ECFT, Electronic Case File Transfer  
19 System. So, we are definitely involved with  
20 that, working with BUMED and PEB, trying to  
21 see if that will work. So that is our  
22 transfer goal.

1           The other thing that is out there  
2           that I would hope we champion as a whole, and  
3           I think again it highlights if we accept the  
4           IDES overall as a process is OSD is currently  
5           looking at singular system for all of the  
6           services to use. JDES it is called and I  
7           would think that would streamline and resolve  
8           the time line and the case management for all  
9           the cases for all the services.

10           CAPT SANDERS: Are all the  
11           counterpart PEBs working with the Joint Staff  
12           to try to integrate their selves into this new  
13           potential system or is the Joint Staff off on  
14           their own?

15           MR. POWERS: No, sir. Regarding  
16           the JDES, we have had across the board across  
17           services meeting on it. I think the last  
18           meeting was about six months. I think the  
19           question is how much money OSD wants to spend  
20           on JDES. But we have been involved in trying  
21           to develop it. And we have collected the  
22           requirements by all the PEBs, all the



1 services, all the BUMED equivalents to try to  
2 develop this JDES program.

3 Actually, I was asked to provide  
4 backup slides. Were they loaded? Okay, I  
5 apologize. I thought they were loaded in  
6 there.

7 The highlights were the issue was  
8 is there second half guidance? I think the  
9 second half guidance is well, yes, there is  
10 very much. Obviously, the Assistant Secretary  
11 of the Navy have been very involved in senior  
12 leadership, very involved on our process. I  
13 think it will be distilled with the rewrite of  
14 the second half instruction.

15 The other query was there was a  
16 query on our IPEB processing. Currently right  
17 now, we are processing our IPEB cases. That  
18 is the informal adjudication in 13 days.

19 Now, at one time we were averaging  
20 six to seven days. Right now, there is a  
21 report up there, a report that shows that we  
22 are right around one month we are 14;

1       unfortunately, we hit 16 one month; and then  
2       the last six months it has been hovering  
3       around 14, 16, 14.

4                 The reason is one, we lost  
5       personnel this summer. We have had a  
6       changeover. We are training that.

7                 We are also experimenting with how  
8       better to receive and process cases from the  
9       MTFs. One of the things, there is really  
10      three major areas where we see delay at the  
11      PEB for case production. One is, actually,  
12      where the response pending where we have given  
13      the members their findings and we are waiting  
14      for them to decide what they want to do, meet  
15      with counsel, decide whether they want to go  
16      to formal hearing. That takes a lot of time.  
17      It is a balancing.

18                The other one obviously is at the  
19      formal hearing. And the third one is where we  
20      are actually getting a case from MTF and it  
21      may not be ripe for adjudication. It may be  
22      missing a document. We may need to suspend

1 it. We were trying to see if we could hold  
2 those cases and it has cost us a couple of  
3 days.

4 So, we have been working with  
5 BUMED here in the last month or so just go  
6 back to the standard processes. The way it  
7 works is if you do not send us a complete  
8 case, it is better to go back to the MTF on  
9 their desk, develop it and then send it back.  
10 So, I think that actually will -- that is more  
11 a housekeeping measure. So, the short answer  
12 is I don't see a systemic problem with their  
13 IPEB processing and I think you will see that  
14 it will stay under. Believe me, we want it  
15 under the 15 days.

16 DR. STONE: What is your rejection  
17 rate for your NARSUMs?

18 MR. POWERS: For the NARSUM, sir?  
19 We don't necessarily have a rejection rate for  
20 the NARSUM, though we track. Generally we are  
21 rejecting around three to five percent of the  
22 cases. And there is various reasons why we

1 are rejecting.

2 DR. STONE: The Navy has used the  
3 abbreviated NARSUM format, looking mainly at  
4 the disabling condition and then integrating  
5 a fair number of the VA tracking tools. You  
6 are satisfied that you are getting everything  
7 you need to make full adjudication of all of  
8 the disability?

9 MR. POWERS: Yes, sir. And I  
10 believe, and BUMED addressed it, Commander  
11 Charissis addressed it. The question is, do  
12 you have a complete case to make a decision?  
13 I would say the abbreviated MEBR NARSUM.  
14 Unfortunately that is a horrible term. The  
15 answer is we have a Medical Evaluation Board  
16 Report. And it is not the ten-page reduction  
17 that the Army has developed. It is more about  
18 four or five pages. And it is not about  
19 length. It is about substance. What do we  
20 need to know? And what we have asked them,  
21 and what we have sent out is when we say  
22 abbreviated, there are major elements that we

1 need to address. Primarily, what are the  
2 conditions for which you are referring the  
3 service member in there?

4 The beauty of what we have now is  
5 under the legacy, we would just get the MEBR.  
6 And then a lot of times they are either due to  
7 the MEBR not wanting to report it or just  
8 moving the system, too. There will be other  
9 conditions that it would be nice to hear from  
10 the MEBR that they have. Well, that is what  
11 we have now, the CMP exam.

12 So, we are not only getting our  
13 Medical Evaluation Board Report but we also  
14 get the CMP exam that the Board looks at the  
15 case in its entirety. So, that is very  
16 helpful.

17 The other issue was on our formal  
18 hearings. The reality is, right now, the good  
19 news is that -- and I really do appreciate  
20 OJAG's support with that. That has been a  
21 major factor. This is really a balancing act  
22 for the formal board time lines. In essence,

1 and we have had the other the Air Force PEB  
2 look at this, this process. In the end, we  
3 processed 7,500 cases a year. Eight-five  
4 percent of those by informal adjudication. We  
5 prioritized the informal adjudication process  
6 and input the formal board process as the  
7 second time priority. So, the goal is  
8 manpower goes to get at informal adjudications  
9 and in setting these formals. These formals  
10 take ten times the work of an informal  
11 adjudication. And what we have done is it is  
12 a balancing of getting the proper staff to  
13 develop the case. Also, having the OJAG. And  
14 so what we have done is we are processing, we  
15 are doing 30 hearings a week. This has  
16 reduced the caseload. It is sort of like your  
17 mortgage, as much as you would like to make  
18 extra payments eventually it gets paid off, as  
19 long as you are making payments.

20 We are paying off, we are doing  
21 more than we need a week to get this reduction  
22 down. And so what we have seen is we had a

1 backlog of -- I apologize for not having this  
2 memorized, a 105-day timeliness with 169 case  
3 inventory. Currently, we are at a 66-day  
4 average with 144 case inventory. We believe  
5 the extra attorneys is going to help continue  
6 to reduce the backlogs on the formal hearings.  
7 And I had a report showing that.

8           The last question the Board had is  
9 for FY13, I had a report for all the years,  
10 what are changed findings? The reality is  
11 last year for FY13 we heard 181 formal  
12 hearings. Of that, we had actually walked in  
13 and had a hearing. Of that, 95 or 52 percent  
14 were changed from the formal hearing.

15           I took the liberty of and what  
16 does changed means? So, bottom line is in the  
17 end, overall statistically, 40 percent had an  
18 increase, 40 percent had a decrease, and 20  
19 percent remained the same. And of that, only  
20 24, less than 13 percent appealed to the  
21 Counsel Review Board regarding the PEB's  
22 formal board findings.

1                   If the Board and the Task Force  
2                   doesn't mind, I just would add one other  
3                   thing. Mr. Mike Parker and I really have,  
4                   there is a lot of -- and the fact that we are  
5                   very much on the same team, he brought up two  
6                   issues I just would like to comment as it  
7                   would be his point about the TDRL, that is a  
8                   very interesting program. I think there is  
9                   value either way. Probably the easiest thing  
10                  to do that still is not, and I would certainly  
11                  defer to the legal expertise, right now the  
12                  TDRL program is for five years. The simplest  
13                  thing we could do is, and I know I have talked  
14                  to the board, is strike it and put it at  
15                  three. And so then you could continue to look  
16                  at whether the validity and the need for the  
17                  TDRL but the immediate thing would be to  
18                  change the three-year program. We have looked  
19                  at it statistically. Most of our decisions  
20                  are decided for those TDRL are at 18 months  
21                  and certainly by three years. The five year  
22                  is really an extra time that really doesn't



1 make a difference statistically that we have  
2 seen.

3 DR. STONE: What is your return to  
4 active duty service at the end of 36 months?

5 MR. POWERS: I have not looked at  
6 it recently, sir, but last that I remember is  
7 I think we were hovering right around three  
8 percent.

9 DR. STONE: So for 97 percent of  
10 people, they then went on to retirement?

11 MR. POWERS: They went on to  
12 another finding. And so I forgot the stats  
13 because it wasn't a question. What the real  
14 question on the TDRL program is I think what  
15 you will see what the struggle will be is one,  
16 how is it taken care of the Marine and Sailor  
17 or the service member at the time. There are  
18 cases, for instance, the person has Hodgkin's  
19 Disease cancer. They are going to be placed  
20 on there 100 percent or on the TDRL to get  
21 stabilization. Vice-versa, there is  
22 conditions that are inherently stable --

1 DR. STONE: Well, if they are not  
2 medically stabilized, why have they gone  
3 through the system?

4 MR. POWERS: They have gone  
5 through the system that they know they cannot  
6 continue to do active service but they  
7 certainly have a condition that actually  
8 warrants either temporary or permanent  
9 retirement.

10 It is really an issue -- there are  
11 cases that if you didn't have the TDRL, you  
12 could get them at 10 percent, separate them,  
13 and then 18 months' later, for instance, MS,  
14 Multiple Sclerosis, they would be at 10 or 20  
15 percent. And then that condition progresses  
16 pretty seriously. I would certainly defer to  
17 medical opinion. That could be a higher  
18 rating within a very short time. That is an  
19 equity issue that I think the senior  
20 leadership would have to address.

21 I am not commenting on the merits  
22 of TDRL. All I would say is that while we are

1 looking at it if it is an issue, is the  
2 simplest thing if we struck five and put  
3 three, that would be an immediate fix and then  
4 we could continue to evaluate the TDRL program  
5 as a whole.

6 DR. STONE: And you can provide us  
7 with the data that justifies your change from  
8 five to three?

9 MR. POWERS: Yes, sir.

10 The final is that --

11 CAPT SANDERS: Before you run past  
12 that, would the last two years be an opt-in?  
13 So after three they would come up for review  
14 again and then look at whether they would  
15 extend for those last two years or would three  
16 be the end state, come off TDRL and either be  
17 re-adjudicated on active duty or pushing to  
18 retirement?

19 MR. POWERS: I would offer that  
20 the senior leadership look at just literally  
21 one single change, change five to three.  
22 Because the reason that is, at the end of

1 three years, you would be removed from TDRL  
2 and statutorily, your pay stops.

3 The reason that is a critical  
4 factor is that TDRL program is, as the General  
5 just mentioned or implied, it is a very  
6 difficult program to manage. One of the  
7 hardest things about the program --

8 MS. DAILEY: Ladies and gentlemen,  
9 we need to wrap here.

10 MR. POWERS: Sorry.

11 MS. DAILEY: You are over time.

12 We can run down this rabbit hole if you want  
13 but just let me let you know that we are over  
14 time.

15 DR. STONE: I would like to see us  
16 close out the answer to the question. I think  
17 it is an appropriate question.

18 MR. POWERS: The answer sir,  
19 Captain, would be is that the difficult part  
20 about the TDRL program is issuing members, the  
21 TDRL members' orders, getting their address,  
22 getting them back to a hospital. A lot of

1 times they go off into the civilian world and  
2 it is difficult to get a hold of them. It is  
3 not difficult to get a hold of them when at  
4 the end of five years their pay stops, they  
5 are not able to get into TRICARE, and we get  
6 their updated address.

7 So, putting it at three years  
8 would move the population a little bit faster  
9 and better. And I think the issue we would  
10 have a closer understanding of what their  
11 stability is there.

12 A real quick note, the other thing  
13 is about the EPTS. We struggle. That is a  
14 very difficult decision for Board members to  
15 make that you have somebody who did seven  
16 years in the Marine Corps or Navy. They have  
17 retinitis pigmentosa and you have to put EPTS.  
18 And Congress has changed the law to try to  
19 make it clear and unmistakable. We are  
20 constantly being scrutinized.

21 A real quick, and I have already  
22 offered it to the task force a couple of years

1     ago, eliminate the EPTS. Eliminate that it is  
2     no longer a factor. When our numbers are  
3     arbitrary and that somebody who has eight  
4     years can have -- will not have the EPTS  
5     factor used against them, then why is it that  
6     somebody at six, five, four? The only thing  
7     we are worried about would be the moral hazard  
8     of fraudulent enlistment. I think that could  
9     be covered by looking at a better screening.

10                 That would, I think, be a policy  
11     to look at that I think Congress may be  
12     intrigued with. And I think it is something  
13     that I think would eliminate a lot of the  
14     scrutiny regarding our EPTS. In the end,  
15     three percent of our cases are EPTS findings.

16                 Thank you, Task Force, appreciate  
17     any follow-up questions.

18                 MS. DAILEY: Okay, a quick break,  
19     ladies and gentlemen. We are bring up the Air  
20     Force. Five minutes, please.

21                 (Whereupon, the foregoing meeting  
22     went off the record at 11:11 a.m.)

1                   and went back on the record at  
2                   11:20 a.m.)

3                   CO-CHAIR CROCKETT-JONES: We'll  
4 receive information from the Air Force  
5 regarding Warrior and Survivor Care Program.  
6 Mr. Horace Larry, Deputy Director of Air Force  
7 Service, Air Force Colonel Todd Poindexter,  
8 the Chief of Clinical Operations of the Air  
9 Force Medical Support Agency. You are going  
10 to introduce any of your other folks for us.  
11 I am going to let you do that.

12                   These are responses to 2013  
13 recommendations, specifically 5, 13, 15, 16,  
14 18, 19, 20, 21. We have this information  
15 under Tab K in our binders. And now you all  
16 can take the floor. Thank you.

17                   MR. LARRY: Well, thank you,  
18 ma'am. And for the whole Task Force Team, it  
19 is good to be here with you again.

20                   As she said, I am H.L. Larry, the  
21 Deputy for Air Force Services and one of the  
22 elements that is on the portfolio is wounded,

1 ill and injured programs. So, I will kick it  
2 off and then we will turn it over to Todd  
3 Poindexter. And after that we have Mr. Tim  
4 Townes, who will share some additional  
5 thoughts, some additional questions you had,  
6 and about the social media.

7 And then I will step up and do a  
8 wrap-up.

9 So on behalf of our Secretary  
10 James and Chief Welch and the whole Air Force  
11 leadership, it is also great to be here. And  
12 I can tell you without a doubt we look across  
13 the wounded warrior continuum of care in what  
14 we do and the Air Force personnel arena, that  
15 part is led by a Lieutenant General Sam Cox  
16 and then on the medical side by Lieutenant  
17 General Tom Travis. And of course, on the  
18 manpower reserve affairs side, what we make  
19 absolutely sure that we have a total force  
20 perspective on everything that we do,  
21 consider, and move forward with in taking care  
22 of our wounded, ill, and injured, we



1 absolutely ensure that it is total force. And  
2 that is very, very important because, as we do  
3 that, it not only focuses on what we currently  
4 have, what we currently provide, and what we  
5 currently do. That is a short-term element.  
6 But maybe more importantly, the long-term  
7 aspects of what must continually remain aware  
8 of because the thing work for us as we stand  
9 and sit in this room today may not necessarily  
10 work tomorrow. So, along with that element of  
11 pressure to bear, being ever present and  
12 knowing that we have our members that we must  
13 pay attention to and get things done.

14 One last point before I started,  
15 when we look at these, no doubt we focus on  
16 the organizational construct and hope that it  
17 would be in that it is how we help to ensure  
18 that we are providing the type of care, the  
19 quality of care, the level of care that we  
20 need. So maybe more importantly as we do that  
21 at the top, it is important to remind you that  
22 the real focus is here at the lower level, in

1 terms of every individual member, whether they  
2 are wounded on the range, injured in a car  
3 accident back home, or become ill, that we are  
4 doing the absolute best we can to take care of  
5 them and we are listening to them.

6 It is really good to be here and  
7 General, Mustion, sir, it is good seeing you  
8 again.

9 As we look across there is no  
10 doubt that we have lots and lots of acronyms.  
11 So we laid them out here in front. And  
12 someone I missed the one on IDES, the  
13 Integrated Disability Evaluation System. So,  
14 thank you for that.

15 And we promise we will remember  
16 this back when you let me go through it. Next  
17 up.

18 Of course, the construct here, the  
19 format revolved around the recommendations  
20 that we found that you had asked us to  
21 address. So, that is primarily what we will  
22 do. I will go through the first few of them

1 and Dr. Poindexter will proceed from there.

2                   Renewal of Active Duty Orders for  
3 Recurring Care of Recovery Warriors. When we  
4 do that, there is no doubt about it, we looked  
5 at the specific words up here, ensure  
6 continuous active duty orders and then  
7 encompass a complete period of care. We want  
8 to zero in on that because that is what we are  
9 focusing on, that element of continuous, a big  
10 word, making sure that we are bringing them  
11 in. We are going to get them in and take them  
12 to a certain point and then we don't -- notice  
13 continuous. We know that. And then from that  
14 become the complete period of how long they  
15 are going to be there. And from that, be  
16 consistent with the medical plan, knowing what  
17 is in there because that is what we have that  
18 working that individual, working with the doc,  
19 is what we look at in terms of those phases of  
20 moving that member from where he or she is  
21 today all the way out to their sustainment  
22 phase to make sure we are taking care of them.

1                   But Air Force supports this.  
2           There is no doubt about it. They are active  
3           duty orders. How do we make sure that we  
4           continue to do that in terms of the whole  
5           continuum of care. But after we do that, we  
6           want to be a bit cautious about saying that we  
7           are automatically going to do it 30 days' in  
8           advance. Because sometimes when you look at  
9           the medical provider and medical profile that  
10          they have, it may be a little bit inside that  
11          30-days.

12                   To give an example if H.L. Larry  
13          is there and I know I am comfortable in that  
14          30 days but my doc says it is going to be a  
15          few more days before we can assess and get  
16          this profile cleared up, so it wouldn't make  
17          much sense to go ahead and do it 30 days' out  
18          when you know at the 27-day point you have the  
19          profile released and you can know exactly what  
20          we are doing.

21                   So, while we are ever-present and  
22          we understand the point, we have it, no push

1 back, but we just want to look at it, and how  
2 do we look at it for each individual member in  
3 terms of that profile and how do we make it  
4 work for them. So, no push back. We go  
5 forward. We will make it happen.

6 CO-CHAIR CROCKETT-JONES: I think  
7 that as far as the language of this goes, when  
8 the Task Force was formulating this, some  
9 services were taking more than 30 days to have  
10 orders go from beginning a renewal process to  
11 getting to the service member.

12 MR. LARRY: Yes, ma'am.

13 CO-CHAIR CROCKETT-JONES: And that  
14 was the genesis of saying that 30 days was  
15 because you know most were getting those  
16 orders in under that 30 days but some, you  
17 know if they left it to start, the basic  
18 reality is, as long as somebody renews it with  
19 giving enough time for that paperwork  
20 administratively to be finished and that  
21 person to not drop off, then really the spirit  
22 of this, of our recommendation is being met.

1                   What we don't like to see is  
2 families fall out of DEERS and medical care  
3 stop because someone becomes ineligible for  
4 three days while they wait for their orders.  
5 It is not always critical. A few days isn't  
6 always critical but the anxiety revolving  
7 around this in some medical care, it is  
8 critical. Someone who, especially like PTSD  
9 or something where you are struggling to keep  
10 someone compliant and they might actually, you  
11 might actually get them to do it. But they  
12 can't continue because they don't have -- they  
13 are no longer eligible for the compensation  
14 that covers it. That is what the spirit of  
15 that recommendation was. And I think the Air  
16 Force is meeting it.

17                   MR. LARRY: Thank you, ma'am.

18                   DR. STONE: How many are RC  
19 individuals you currently have in the program?

20                   MR. LARRY: How many --

21                   DR. STONE: How many Reserve  
22 Component individuals are currently on orders

1 that are in the program?

2 MR. LARRY: I don't have that  
3 number.

4 DR. STONE: Sir, here is the  
5 genesis of the question. You are a pretty  
6 small program just because of the fact that  
7 the brunt of this war has fallen on the ground  
8 forces.

9 MR. LARRY: Yes, sir. That is  
10 correct.

11 DR. STONE: In fact most of your  
12 injuries have occurred in people in the  
13 program, my bet is with people in ground  
14 service, rather than in the air.

15 So, it is a pretty small program  
16 but the angst is, especially in the Reserve  
17 Component, and the reason this is very  
18 important and I am troubled with your answer  
19 is that for the most part, reserve component  
20 are receiving their medical care in a  
21 disbursed manner out in their communities and,  
22 therefore, when orders are about to expire,

1 they can't even make their next healthcare  
2 appointment. And so it seems fairly  
3 unreasonable in a very small population that  
4 you can't take a hard look at it. And it  
5 orders in a timely manner, which 30 days is  
6 certainly timely that allows a family's  
7 anxiety to go down significantly, that they  
8 know that they are going to be taken care of,  
9 that they have a source of income and that  
10 their benefits will continue.

11 Now, one of the requirements is  
12 when you come off of those orders, that you  
13 continue to get your healthcare benefit by DoD  
14 regulation for 180 days post-mobilization in  
15 the reserve components. So that does mitigate  
16 it somewhat. But it would be interesting to  
17 know how many Reserve Component Airmen do you  
18 have involved in this and, number two, how  
19 many of those are receiving their care in a  
20 disbursed manner.

21 MR. LARRY: Okay, sir. Just one  
22 clarification, though. I understand the



1 points you make but when go through this, we  
2 look at each individual case and to make sure  
3 that we have pinpointed it down to Air Force  
4 Personnel Center in San Antonio, Texas, under  
5 the leadership of Major General Peggy Poore,  
6 where we established a case management  
7 division there where they have each case, and  
8 we will get you the numbers, but they zero in  
9 and they make absolutely sure someone is  
10 watching and paying attention to it and we  
11 don't let things expire that shouldn't.

12 DR. STONE: So when you non-  
13 concurred, what data did you use to do your  
14 non-concur?

15 COL POINDEXTER: General Stone,  
16 maybe I can add a little bit of a  
17 clarification point and you will understand  
18 the issue of the non-concur.

19 Well, really it is more of a  
20 concur with comment is the way I would maybe  
21 spin it.

22 DR. STONE: You could get out of

1 this really quick by saying let us take this  
2 slide back and do a concur with comment.

3 COL POINDEXTER: Exactly. And the  
4 concur with comment would be that we have a  
5 MEDCON cell. And that MEDCON cell is  
6 responsible for any Guard and Reserve  
7 individual who are going through MEDCON. When  
8 they get up to the window of the time where  
9 there are orders, there is an active case  
10 management that is occurring. There is a case  
11 manager that is assigned at our Air Force  
12 Personnel Center. And what they will do is if  
13 they see the profile is about to expire, they  
14 will make sure that if the profile expires and  
15 the orders are going to drop, it is because  
16 the provider has said that is what they want.

17 If the profile is expected to be,  
18 there is an appointment and there would be an  
19 expectation of some more feedback and the  
20 profile could be extended, they will make  
21 contact, make sure that before the orders  
22 drop, that they actually now can extend the

1 orders.

2 So in a sense, we went from a  
3 process where it was somewhat decentralized to  
4 now we are doing central case management. And  
5 because we have smaller numbers, our entire  
6 total Guard and Reserve population in our  
7 Wounded Warrior Program was around 600. The  
8 ones who are under case management are, I  
9 think, around less than 200.

10 So, with those smaller numbers, we  
11 do have the luxury to do that centralized case  
12 management. And what we have seen since we  
13 have done that in the last year, year and a  
14 half, I mean huge benefits and changes in the  
15 fact of not having orders drop, not having  
16 people go through this escalating worry that  
17 they could drop. And also, in some sense, for  
18 them, and even for the system, people are  
19 moving through the system more smoothly and  
20 that decreases anxiety and it also is better  
21 care.

22 LT COL WONG: I just also want to

1 make for the record for the Board members and  
2 also Air Force regarding when we look at the  
3 complete period of care, as the presidential  
4 recall of orders are going away now, surge  
5 operations or reserve counterpart members are  
6 being brought on on just ADOS orders, that  
7 180-day veteran benefit is not available for  
8 that benefit.

9 MR. LARRY: ITO orders and Non-  
10 Medical Attendant orders for families. OUSD  
11 P&R, there was an element there where you  
12 asked us to look across the board at the Joint  
13 Travel Regulations or Joint Regulation to make  
14 sure we are being consistent across all these  
15 services. And not only that, when you look at  
16 the payment processes.

17 So, we walked through these. No  
18 push back. The Air Force concurs. We concur  
19 with you for the work you are doing because  
20 OSD, they still have the lead in working  
21 through it and looking at the language itself.

22 But for us in terms of those three

1 elements, the travel orders the service has  
2 provided and the payment process, we concur  
3 with the statement, we continued to work  
4 through that.

5           And for the Air Force, that has  
6 went fairly well with we had members who we  
7 need to get there to be at the next site, we  
8 work through it and usually up to three  
9 members. And if it was stateside, we needed  
10 to get someone in about 24 hours, have them  
11 set and ready to go overseas by 44 or 48  
12 hours. It works really well.

13           And then we make sure that if we  
14 have someone we need to get there and they are  
15 still working through it, then we get them  
16 there and we reconcile the Defense Travel  
17 System to take care of those families, that  
18 member and their family who has to be there.  
19 So, we make sure of that. So, we concur.

20           TSGT EUDY: And the Task Force is  
21 backing behind this recommendation. But we  
22 know that all services comply with the JTR.

1 It was just the implementation and the  
2 bureaucracy to get those orders processed as  
3 cut or those payouts. They were varying  
4 within the services to service members again,  
5 the same injury. Who is going to get to the  
6 bedside first, mom and dad from one service  
7 branch or mom and dad from the other? Just  
8 from the paperwork standpoint, that was the  
9 intent behind this original recommendation.

10 MR. LARRY: Okay, thank you. And  
11 then from there, become this -- I know the  
12 activities for daily living there is  
13 compensation involved in there. No doubt, a  
14 very good program. And the way that you had  
15 asked us, we were going through it and looking  
16 at it, how do we make sure it doesn't matter  
17 what type of care provider you were working  
18 with, whether it is medical, non-medical or  
19 recurring care coordinator? How do we handle  
20 him then in a team that they can look across  
21 the construct and make sure that from their  
22 awareness of what is out there to build new

1 from that with the member's understanding we  
2 are aware of it. In time, we understand it a  
3 bit and here are the cases and teams that we  
4 are working with to help us to be able to  
5 execute and get the support that we need.

6 So we have to concur with that.

7 And when we go through it, we  
8 looked at it for the Air Force when we first  
9 started, we had about 32 people enrolled and  
10 now we have well over 100. And we are pushing  
11 information out either by word of mouth or  
12 getting out there in the flyers, getting them  
13 papers, social, legal, let people know what is  
14 out there. And we are helping you. What else  
15 we can do to help? And make sure that is  
16 important, not only get there but get there in  
17 a timely manner where people can take  
18 advantage of it.

19 Any questions?

20 Non-Medical Service Info to  
21 Reserve Component Organizations. When we  
22 worked through this, we started looking at how

1 do we best ensure in working with our Reserve  
2 Component teammates that we have, many we have  
3 in the room with us today, that we continue to  
4 provide the best care that is out there.

5 I had a chance about three months  
6 ago when we had our Recovery Care Coordinator  
7 Conference in San Antonio, Texas to be there.  
8 And I talked to one of the members at the  
9 headquarters reserve down at Dobbins Air Force  
10 and it was amazing speaking with him because  
11 he was able to walk through the things that  
12 not only the Air Force but importantly we  
13 drilled down to that last common at base  
14 level, hear the things that we are doing being  
15 embedded to make the program better. And I  
16 not only got the chance to speak with him but  
17 many members of the Reserve Component what we  
18 are doing and how we continue to make this  
19 work.

20 And fortunately there, too, we had  
21 the Case Management Division from the Air  
22 Force Military Personnel Center was there.



1 And when you listened to them and the way they  
2 were walking through the construct to be able  
3 to do, to be able to validate and then have us  
4 circle back. Because with only the element of  
5 -- one thing they have a process but how do  
6 you make sure that is well vetted, is hitting  
7 the target it ought to be, and it gets people  
8 through the gates where they ought to be in  
9 terms of the information awareness and  
10 support. So, it was great personal feedback  
11 from the individuals at the installation level  
12 and the headquarters level who have the hands-  
13 on with the program. Here is how we do it and  
14 here is how we make it happen. So, it worked  
15 out pretty well.

16 And also, they have to make sure  
17 there is work throughout for the Reserve  
18 Component leadership to that installation. We  
19 had Billy Mitchell Field up in Wisconsin and  
20 at Hancock Field in Syracuse, New York we have  
21 people that they were there, too. There were  
22 elements to make sure we are providing support

1 to our Guard and, again, from our Personnel  
2 Center.

3                   The Case Management Division I  
4 think is really, as Dr. Poindexter was  
5 explaining, able to make a big difference in  
6 awareness and understanding, giving people  
7 what they need. Because from personal I can  
8 tell you that a family member was severely  
9 injured, not dying, but severely injured. And  
10 there are so many things that happen to you so  
11 quickly and you are struggling not only to get  
12 the information but to understand it and see  
13 what it means to you and how do you execute it  
14 in terms of taking care of that member, in  
15 terms of providing what is needed to go  
16 forward. So, it is really something that we  
17 pay particular attention to. And again, not  
18 only for the short-term but whatever lessons  
19 learned we can draw from that as we continue  
20 to advance the Air Force Wounded, Ill, and  
21 Injured Program.

22                   And one last one here on the

1 Guidance for Standardized Care. Absolutely no  
2 push back there. We clearly understand it.  
3 We clearly understand the magnitude of it, the  
4 ramification of it, and the need for it in  
5 terms of having a standardized, well-vetted  
6 process that codified in the regulations or in  
7 the instructions here is how we do business.  
8 This is why we do business this way and here  
9 is how we go about it.

10 And then, too, from the regions  
11 that we set up with our Recovery Care  
12 Coordinators is to make sure that our Command  
13 Sergeant Major, our First Sergeant, and our  
14 Senior Master Sergeant and supervising  
15 commanders, they understand what is available.  
16 They know how the processes work. They may  
17 not know every step or who is it, a Medical  
18 Care Coordinator, a Non-medical Care RCC?  
19 They may not know all the details got it but  
20 they will know that there is somebody in this  
21 chain that is there to help me.

22 And every time in need help, there

1 will be somebody there. If my commanders  
2 called or whatever they are termed to be there  
3 to help my team, my wingman, my battle buddies  
4 to understand what is available and what we do  
5 on a continuous basis day in and day out to  
6 learn from where we are today and continue to  
7 make steps forward in building for what we  
8 need to be tomorrow to make sure we have a  
9 great system in place.

10 With that, I will bring up -- if  
11 there are no questions for me right now, I  
12 will bring up our esteemed Dr. Poindexter.

13 COL POINDEXTER: Thank you very  
14 much. Colonel Todd Poindexter, I am, as  
15 already stated. And I have been involved in  
16 policy with Wounded Warrior and actually have  
17 spoken before. And it is good to see some of  
18 the individuals who are here from the past.

19 I just want to go over the  
20 recommendations that are medically related.  
21 The first one was Standardization of MEB  
22 Process. The Air Force concurs with

1 standardization. Of course, we always will  
2 throw in the caveat that sometimes the  
3 services do have service-specific issues and  
4 so we need to keep that in mind as we are  
5 going through. This process would have few  
6 but there may be some.

7           One of the things that we have  
8 actually done in order to ensure that all of  
9 the diagnoses are documented and the quality  
10 of care is occurring is that we have the MEB  
11 president is the point person for that quality  
12 review and they can then provide feedback  
13 directly to the provider.

14           We also have a feedback loop where  
15 the IPEB, who is reviewing all cases across  
16 coming from all bases and they will then roll  
17 that feedback up to headquarters and we can  
18 then create any particular training plans or  
19 things that we need to adjust in order to make  
20 sure that people are actually doing the  
21 process correctly, accurately, and making sure  
22 that all of the quality documentation is

1       there.

2                   And so again, we support  
3       standardization and have no concerns with this  
4       recommendation. Any questions?

5                   The next thing is tour length.  
6       And this one will be a concur with comment and  
7       you will understand that as I go.

8                   So, we absolutely concur with the  
9       intent, what I interpret as the spirit and  
10      intent. Anytime you can have someone in a  
11      position longer rather than shorter, they gain  
12      more expertise. They have a better Rolodex of  
13      reaching out and they knew how better to  
14      support families. And so it is our absolute  
15      goal to try to meet this intent. The only  
16      reason that we are partially concurring is  
17      because right now we do not have permanent  
18      positions. These are matrixed from the host  
19      medical MTF. And so sometimes, due to  
20      extenuating circumstances, we do have to  
21      rotate them back and put someone else in.

22                   Recently, the person who, the two

1 that are there, one of which has been there  
2 for two years and so was extended to the 24-  
3 month period. We are also investigating the  
4 possibility of making these permanent  
5 positions so that they would be two or more  
6 years' longer and then we wouldn't have to  
7 worry about this at all. The only challenge  
8 that we have with that is in the current  
9 climate, the current climate for the Air  
10 Force, similar to the other services, is  
11 facing in-strength reductions, rather than  
12 growth. And so any increases in one area  
13 creates decreases in another. However, this  
14 is considered a priority program. Wounded  
15 warrior care is definitely an Air Force  
16 priority and so we are looking at this.  
17 However, we can't guarantee, at this stage,  
18 that we will be able to make them permanent  
19 but that is our goal and that is what we are  
20 exploring.

21 And I know there is going to be a  
22 question.

1                   TSGT EUDY: I would like to  
2 reflect, sir, on two other programs. If you  
3 look at the Unit Deployment Manager Program,  
4 which now establishes two-year positions that  
5 were listed as special duties within their own  
6 units and also the First Term Airman Center  
7 Program. Most bases now establish an NCO that  
8 teaches an eight-day course to brand new  
9 Airmen for a period of two years.

10                   If the Air Force is placing that  
11 effort on those initiatives, this is an  
12 initiative that is long-term dealing with our  
13 families and their lives. And to be able to  
14 meet that need, all of our services reflect  
15 that it takes, once somebody gets on ground,  
16 three to six months before they are completely  
17 spun up and ready to tackle all of their  
18 duties and responsibilities.

19                   But being able to meet that, if  
20 the focus has been placed on other areas in  
21 the Air Force, I believe that it continues and  
22 needs to be stressed to meet this need,



1 especially as you talk about the draw-down of  
2 our Guard and Reserve dealing with the ill and  
3 injured population. You know rises in cancer  
4 rates, we talk about that often amongst  
5 different Communities in the Air Force. And  
6 those persons that need long-term care, as we  
7 just saw with the amount of personnel with the  
8 Wounded Warrior Game Trials, the majority of  
9 personnel that were there were requiring long-  
10 term medical care and needed that expertise.  
11 But it also gives you, sir, and the Chief of  
12 Staff a bellybutton to see how the program is  
13 progressing and getting that immediate  
14 feedback from your family members and those  
15 service members on your program.

16 COL POINDEXTER: And I would  
17 absolutely concur. And again, and I think for  
18 us the priority is more Walter Reed than it is  
19 Landstuhl. And the reason for that is that  
20 mission is not going away at Walter Reed. The  
21 next war may be coming -- well of course now  
22 with the news, maybe Landstuhl will still be.

1 But still, we may be in a different location.  
2 So, we have to be careful sometimes  
3 programming positions forever that I do not  
4 foresee any change in the flow of need at  
5 Walter Reed. And so that is why it is a  
6 priority to try to do that.

7 But I just wanted you to  
8 understand some of the pressures that we face.  
9 And we will make our absolute best attempt to  
10 do that and I definitely support your  
11 comments.

12 Any other questions?

13 The next thing is non-clinical  
14 behavioral staff. And this talks about those  
15 areas where it is remote or difficult to staff  
16 with civilians to use active duty. This is a  
17 problem, of course, that the Air Force, I  
18 would say, we may face maybe more than some of  
19 the other services. We have some small  
20 outposts that are in areas that may not be  
21 considered all that. I think each service has  
22 a few of those. And so we have had to look at

1 that. And that is something that we do take  
2 seriously and we are already looking at. And  
3 when we lay down our mental health staffing,  
4 we make sure that one of the first questions  
5 we ask, is this is an environment where we  
6 think that a contractor or civilian could  
7 actually be hired. And if the answer is no,  
8 we will preferentially make that an active  
9 duty position and move that contractor  
10 civilian position into maybe one of our  
11 locations that is a more larger urban area,  
12 where we think that we could actually partner  
13 and actually hire and fill that position.

14 In the FY16 POM, we are actually  
15 re-looking at the entire mental health lay  
16 down and redistributing. So, we are doing  
17 another re-look. And one of the things that  
18 they are looking at is the ability to fill  
19 positions. And so we will have another chance  
20 in this POM cycle to make adjustments, if we  
21 need to, if there are any areas that are  
22 reporting struggles. And our mental health

1 consultants have been feverishly working on  
2 this and this should be presented to the  
3 corporate structure over the next several  
4 months.

5           The next recommendation was in  
6 relation to the outreach to family members.  
7 And we definitely concur that having families  
8 part of the process is absolutely the best way  
9 to go. Of course, it does require some level  
10 of concurrence of the service member. We are  
11 going to add this to our PEBLO checklist so  
12 they make sure that they are prompting this,  
13 that this is something that we are proactively  
14 seeking, rather than passively expecting. We  
15 also have our RCCs whom can participate as  
16 well in that outreach to make sure that the  
17 member knows that it is important to have the  
18 family member. Our case manager, medical case  
19 managers also will ensure that the member is  
20 aware of the importance of the family member  
21 and that any time that the family members are  
22 welcome in any step along the process. And we

1 don't have any concerns with trying to include  
2 them to the fullest extent possible.

3 Any other questions related to the  
4 recommendations that we just talked about?

5 CO-CHAIR CROCKETT-JONES: Can I  
6 just -- I'm just going to give you the same.

7 COL POINDEXTER: The same? Okay,  
8 here we go.

9 CO-CHAIR CROCKETT-JONES: When it  
10 comes to language, passive language and  
11 passive policies are going to result in a  
12 passive perspective from everyone, all the way  
13 down to the bottom.

14 This is one of the toughest things  
15 for everyone.

16 Everywhere we go, getting family  
17 members in is tough. The Air Force actually  
18 is not the worst on this. You guys have more  
19 family participation than some. But I will  
20 say that there is no reason to adopt passive  
21 language and passive policies. There is a  
22 huge, big area between passively inviting and

1 mandating. And no one is expecting anyone to  
2 mandate, although I think an argument could be  
3 made for if you get a DEERS card, you have got  
4 to meet some responsibilities.

5           At the same time, there have to be  
6 some things in-between where active  
7 encouragement of participation is the  
8 perspective of the service, rather than a  
9 passive we invite and we can't make them come,  
10 so that is it. All we do is invite. There is  
11 so much other work that can be done in there.  
12 And I would just like to see, considering how  
13 much better outcomes are in the particular  
14 IDES, the more information that a service  
15 member has, the better their satisfaction with  
16 their outcomes and folks who have a tough time  
17 remembering and are stressed, remember more  
18 and understand it better if they have that  
19 second set of years. There is always  
20 exceptions. Some family members would be  
21 horrible to have in there. Some circumstances  
22 would be made worse. Those are exceptions and

1 policies shouldn't be to default to a hands-  
2 off, passive view. It should be to be  
3 proactive in encouraging family members in to  
4 get the information that pertains to them and  
5 to help that service member retain the  
6 information that they need.

7                   There, I have given my little pep  
8 talk.

9                   COL POINDEXTER: And I would  
10 concur. I mean with, again, the spirit and  
11 intent. And our goal is to actively encourage  
12 the member. I think where we probably, you  
13 see the services and especially the medical  
14 community gets a little bit nervous is, again,  
15 we can only get to a certain point, typically  
16 in a medical encounter, and if the member says  
17 no, we cannot tell anything to the family  
18 member. So, you will sense some of that  
19 hesitance spill over into what is an  
20 administrative type of process. And since it  
21 is the medics who are driving the initial  
22 invitation is probably why you are sensing

1 some of that hesitance.

2 But it is something that we are  
3 aware of and we wanted to be as active as we  
4 can. And if the member will allow it, then we  
5 will reach out proactively and say fine, here,  
6 we will send a letter or do other things that  
7 we can do to try to reach out to the family  
8 and let them know and invite them, if we can  
9 just get that initial permission.

10 And again, if DoD takes in and  
11 mandates a more active role, we will fall in  
12 line, absolutely.

13 Any other questions?

14 And now, I will turn it over to  
15 Mr. Tim Townes. He is with Al Air Force  
16 Personnel and he is going to go over the last  
17 slides that we have.

18 MR. TOWNES: Good morning. I'm  
19 Tim Townes. I am the Program Manager for Air  
20 Force Warrior and Survivor Care. Part of my  
21 portfolio is the Wounded Warrior Program. I  
22 am responsible for policy program development



1 and oversight for the program.

2           You had some additional questions  
3 that you wanted us to address, beyond the  
4 recommendations. So, I would like to deal  
5 with those now. The first one is, you asked  
6 for our patient census trajectory from 2011 to  
7 2014. On our slide, we have got the  
8 information listed and what you will see is a  
9 growth. Specifically, from FY12 to FY13,  
10 there is a huge jump. The reason that  
11 occurred is we went from our Air Force Wounded  
12 Warrior Program dealing only with combat and  
13 wounded at Randolph and we combined that with  
14 our recovery care coordinator program to make  
15 a synergistic program that works for all  
16 wounded, ill, and injured. So you see now the  
17 combination of FY13 of the wounded ill and  
18 injured altogether. So, that explains the  
19 jump in the numbers there. Our projected  
20 number, based on our current growth, we should  
21 be around 3500 to 3600 enrolled in our program  
22 by the end of FY14.

1                   Actually, we will probably exceed  
2                   that because right now we are over 3300,  
3                   almost to 2400 now. So, the growth has been,  
4                   was actually double last month than what we  
5                   normally expect.

6                   So, that is actually a good news  
7                   story because we are getting the information  
8                   out. We are getting more people involved in  
9                   our program and a lot of that comes from the  
10                  Guard and Reserve. And one of the slides that  
11                  Mr. Larry talked about from our reserve  
12                  component part, from our RCC there, as well as  
13                  from our guard RCCs that we placed, we are  
14                  getting the word out a lot better to the guard  
15                  and to the reserve. It is actually running,  
16                  there is still gaps that we have to fill.  
17                  There is still information that we have to get  
18                  out, and still people we would have to contact  
19                  but we are getting there. So, we are making  
20                  big strides that way.

21                  DR. STONE: And over the 1519 you  
22                  believe 3500 is your steady state number?

1                   MR. TOWNES: No, sir. It will  
2 continue to grow at about a rate of -- right  
3 now we are seeing a growth of about 50 a month  
4 into our program enrollment. More of that is  
5 from getting the word out. And a lot of  
6 people are ending up in our MEB process with  
7 being diagnosed or identified with PTSD that,  
8 perhaps, we didn't know about and we are  
9 identifying them at that point. So, it is a  
10 little later in the game.

11                   DR. STONE: What number did you  
12 budget to?

13                   MR. TOWNES: I'm sorry, sir.

14                   DR. STONE: What number did you  
15 budget to? What steady state for the Air  
16 Force post-hostilities?

17                   MR. TOWNES: Right now, we  
18 budgeted to about 4,500 and we are going to  
19 continue to look at that every year. And that  
20 includes the number of -- that is based on the  
21 number of personnel we need to run the  
22 program. We do expect it to grow a little

1 bit. And again, we keep individuals assigned  
2 or enrolled in our program beyond their  
3 transition.

4 So, we have got 1,800 right now  
5 that are in sustainment phase. In other  
6 words, they have no additional needs that we  
7 require but we continue to maintain contact  
8 with them, so that we can help them if there  
9 are any needs that come up. And some of that  
10 is six-month contact. Some of that is a year  
11 contact. And then we don't drop them out of  
12 the program or suspend their case, unless they  
13 specifically ask us not to contact them. And  
14 then we will still probably reach out to them  
15 about once a year just to make sure everything  
16 is okay.

17 DR. STONE: So, of your 4,500  
18 steady state, you are estimating 1800 will be  
19 in that sustainment phase and that is post-  
20 leaving the Air Force or are a percentage of  
21 those back on active duty?

22 MR. TOWNES: The ones that are on

1 active duty, we continue to maintain in the  
2 active role, so that we can assist them, if  
3 necessary. But the sustainment phase, it is  
4 really hard to predict whether it is going to  
5 be 1800 or whether it is going to be 2200. It  
6 depends on how quickly they move out of the  
7 service and how much additional assistance  
8 they require. Because some of them have goals  
9 of education and employment that we continue  
10 to help them with and work with the VA to make  
11 it happen.

12 DR. STONE: So, you can take this  
13 for the record. The other services have done  
14 that. What are the gaps that you have  
15 identified that cause you to feel the need for  
16 the sustainment contact post-uniform service?

17 And you are welcome to take this  
18 for the record. The Navy and the Army did so.  
19 But what we are trying to understand is all  
20 three services have similar programs that  
21 reach post-service. There are organizations  
22 authorized by congress to fulfill those needs.

1       What gaps do you see that should be taken care  
2       of?

3                       MR. TOWNES:  Yes, sir.  And we  
4       will identify those gaps and get them to you.  
5       I will tell you, though, from the Air Force  
6       perspective, the one thing that we want to do  
7       is make sure that those families don't feel  
8       like the Air Force has ever left them and that  
9       they never left the Air Force.  They are still  
10      part of the Air Force family.

11                      One of the things we encourage  
12      with wings in our installations is that they  
13      continue to invite those family members and,  
14      specifically, like the spouses and the  
15      families of the fallen, we want to make sure  
16      that those families have continued opportunity  
17      to be part of the Air Force family, to be  
18      involved in activities if they wish.  So, we  
19      continue that outreach to them as well.

20                      The second question that you asked  
21      was our long-range vision for the  
22      organization.  We have a few things on the

1 slide here. One of the things, specifically,  
2 I will point out that has already been  
3 mentioned, our adaptive sports is becoming a  
4 huge thing for our Airmen but it is not the  
5 competition that is really growing this  
6 program. What it is is the rehabilitative  
7 aspects of this where they get together with  
8 others that have the same problems and their  
9 caregivers get together with them as well, get  
10 together with other caregivers, which is huge.  
11 That peer support is extreme.

12 So, where do we go long-range?  
13 What we are looking at is we look at each  
14 Airman. This whole program is built around  
15 one Airman. It doesn't matter if we have got  
16 2,500, 4,200, whatever the number is. Every  
17 time we deal with an Airman, it is an  
18 individual case and it is always different.

19 So, we want to make sure that we  
20 build this program based on what is best for  
21 that Airman. If there are programs out there,  
22 if there are requirements out there, or if

1 there are ideas out there and they don't  
2 support the Airman but they support the  
3 service, we lean to the Airman. It is  
4 important that we make sure that the Airmen  
5 are taken care of and we don't put  
6 administrative or other requirements into this  
7 program that are going to hinder our  
8 capability to support that Airman and lead  
9 them to whatever the next step is in life.

10 So, that is really where we are  
11 going long-term. It is always about the  
12 Airman and their families, obviously.

13 And one of the things we have done  
14 recently and what we are growing, this is  
15 another future initiative that we are working  
16 on is caregiver support. Our folks at AFPC  
17 now have developed or they are working on  
18 developing a caregiver mentorship program that  
19 is modeled around our Recovering Airman  
20 Mentorship Program that we have in place  
21 already. They are also working on or they  
22 also have in place now an invitation-only



1 Facebook page for caregivers so that our Air  
2 Force caregivers can get together and start  
3 talking to one another and connect with one  
4 another. And then we are looking down the  
5 road at peer support groups at cluster  
6 locations where we have a lot of caregivers.  
7 And we have already got two caregivers that  
8 have stepped up and said that they want to  
9 take the lead on this in their area. So, we  
10 are making some progress there.

11 Any questions on this one? Okay.

12 The last one. What would we like  
13 to highlight? There are a few things that we  
14 put on the screen here that we wanted to make  
15 sure we highlighted. One is the  
16 sustainability of our program. Our program  
17 was built within the structure of the Air  
18 Force that already existed. We didn't look to  
19 build a new organization or new buildings or  
20 whatever because we didn't -- to be honest, we  
21 didn't know how many Airmen we were going to  
22 be supporting. And we wanted to make sure

1 that it was set up so that we concentrated on  
2 them. That is one of the reasons we have gone  
3 to a regional construct for our Recovery Care  
4 Coordinators. And we have had that in place  
5 for several years.

6 As of March of this year, we  
7 joined the non-medical care managers into  
8 those regions. So now, every Airman in that  
9 region, they talked to one Recovery Care  
10 Coordinator and one non-medical care manager  
11 for the entirety of their care, so they have  
12 and they know the people that they are going  
13 to talk to. And it is very important for us  
14 to do face to face for our recovery care  
15 coordinators and those Airmen.

16 And our non-medical care managers  
17 back at Randolph support that effort by  
18 providing that subject matter expertise on  
19 transportation, housing, finance, and other  
20 areas. And they can do the footwork within  
21 the organization to get answers for the RCC  
22 and for that Airman. So, we designed a

1 program that is going to it doesn't matter if  
2 it is combat wounded, ill, injured, we have  
3 got people out there and we have got a program  
4 that is continually sustainable.

5 A couple of last things I want to  
6 update you on is one of the things we  
7 introduced last year to you was that we put,  
8 in the hands of our RCCs, an iPad with a CAC  
9 reader so that they could do their  
10 Comprehensive Recovery Plan directly with the  
11 Airman, as opposed to having to take notes,  
12 take it back to their office, and type it into  
13 the system there.

14 This system has worked. There are  
15 some limitations currently, just because of  
16 where it is housed. But by the end of this  
17 month or by next month, OSD has said that they  
18 will have the DISA site up and it will unlock  
19 all of those capabilities within this system.  
20 Our RCCs will be able to work and write the  
21 CRP with the Airmen and their family in their  
22 home or wherever they would like to meet that

1 is comfortable for them. They will be able to  
2 get it taken care of, let the Airmen and their  
3 family comment on it, let them review it and  
4 sign it right there, instead of having to do  
5 two or three different visits. So, it takes  
6 some of the stress out of it.

7           And it makes it work because this  
8 also feeds into the contact with our Airmen.  
9 Direct contact is important and our iPads all  
10 have FaceTime capability. So, we do texting.  
11 We do FaceTime with our Airmen. We connect  
12 with them on the level that they are  
13 comfortable because especially the young  
14 Airmen are more comfortable or, in most  
15 instances, more accessible through electronic  
16 media than trying to catch them just through  
17 a phone call.

18           And most of us know, I mean I have  
19 got a son that if I call, he won't answer the  
20 phone but if I text him, he will immediately  
21 reply. So, that is just the way that he is  
22 more comfortable that way. And then I tell

1 him to call and he does, eventually.

2 CAPT SANDERS: Before you move on

3 --

4 MR. TOWNES: Yes, sir?

5 CAPT SANDERS: -- on the IDES case  
6 management, 100 percent electronic MTF to  
7 IPEB, when the Navy was here a minute ago,  
8 they talked about the fact that one of the  
9 issues in processing times was incomplete case  
10 files forwarded over in the process, having to  
11 send them back. How do you resolve that with  
12 100 percent electronic system?

13 MR. TOWNES: I'll have to get you  
14 that answer, sir. I am not -- let's see.  
15 Okay, we have got folks that -- yes, we do  
16 have someone here that can answer. Great.

17 LT COL MEERSMAN: In reference to  
18 the electronic case file transfer capability  
19 we have, it is right now technology that we  
20 use with A1. And there is a feedback loop  
21 where 100 percent of the facts that arrive at  
22 the IPEB are reviewed for compliance and X, Y,

1 and Z. And that feedback loop, and Colonel  
2 Poindexter referred to it earlier is provided  
3 back through AFMOA, the Air Force Medical  
4 Operations Agency folks and back to the MTF.  
5 So, we have a feedback loop and it is built  
6 into the training he referenced earlier as  
7 well.

8 But 100 percent of those cases are  
9 reviewed for completeness, compliance, the  
10 accuracy, and that feedback. It has really  
11 only been running for about three to six  
12 months. And we will ultimately grow into what  
13 is forthcoming, which is the Quality Assurance  
14 Program that is the Congressional mandate.

15 Did that answer the question, sir?

16 CAPT SANDERS: So, a case file,  
17 upon transfer from the MTF is known to be 100  
18 percent but it shows up as not 100 percent  
19 does not need to be sent back? You can  
20 electronically upload the remaining missing  
21 parts?

22 LT COL MEERSMAN: Yes, sir, we

1 can.

2 CAPT SANDERS: Okay.

3 LT COL MEERSMAN: Whatever  
4 discrepancy there is.

5 CAPT SANDERS: Thank you.

6 LT COL MEERSMAN: Yes, sir.

7 MR. TOWNES: One of the things we  
8 briefed on last year was our efforts towards  
9 social media. Last year we had a Facebook  
10 page that the RCCs had. We had a web page,  
11 the official Air Force Wounded Warrior web  
12 page, and we had a newsletter that we sent  
13 out.

14 Since then, we have hired a  
15 wounded warrior to come in and be the lead for  
16 our social networking. And just in a few  
17 months, he has gotten us connected to, well we  
18 have got three different Facebook pages, one  
19 specifically for adaptive supports. We have  
20 still got the website. We have still got the  
21 newsletter. We have got a Flickr account.  
22 We have got an Instagram account. We have got

1 a Twitter account. And I am sure I am missing  
2 one of them up there but we have got quite a  
3 number of ways to reach out to our Airmen, to  
4 reach out to the families, and, to be honest,  
5 to reach out to the public and let them know  
6 what we are doing and let the Air Force  
7 corporate structure know what we are doing as  
8 well because there are a lot of moving parts  
9 to this program. There are a lot of things  
10 that happen that we get a lot of articles  
11 printed -- published on our Adaptive Sports  
12 Program, on our SCAADL Program, on our PAC  
13 Program, on just the wounded warrior support.  
14 And hopefully, before too long, we are going  
15 to have some good feedback on the caregiver  
16 program as well. So, we are really working.

17 Part of how we know that we are  
18 working is we are actually involved in another  
19 RAND survey that they are in the process of  
20 working that now. It is going to be base-  
21 lined off the first one that we did in 2011 to  
22 let us know, again, how we are doing and what



1 things we can continue to pay attention to.

2 And it is always good to have  
3 someone look in from the outside and let us  
4 know what we may be missing, as we go along in  
5 this process.

6 But again, it really is all about  
7 that one Airman. And I know all of you have  
8 either been there or have seen it, when you  
9 step in a room, in a hospital room, you step  
10 in a house with one of these wounded warriors,  
11 it is not about your program. It is not about  
12 how we deliver services. It is about what we  
13 can do for them.

14 And if we can maintain that one-  
15 on-one connection that we have got with the  
16 RCCs, non-medical care managers, the medical  
17 case managers, the physicians, and we can  
18 continue to make it about that one individual,  
19 then we will success in what we are trying to  
20 do.

21 Okay, any additional questions for  
22 me? All right, let me turn it over to Mr.

1 Larry one more time.

2 MR. LARRY: Okay, thank you, Tim.

3 MR. TOWNES: Yes, sir.

4 MR. LARRY: Just to look at the  
5 outcome as to closure, see what other  
6 questions you may have. While we are here  
7 today and we understand your questions in this  
8 discussion in your presence right now, we  
9 could tell you it extends well beyond that.

10 As an example, I can remember in  
11 2011 we stepped on stage where you had some  
12 very, very tough questions that made us a bit  
13 uncomfortable because, simply, while we have  
14 worked through this and thought we had it  
15 about right in terms of the way you went about  
16 it, it was quite obvious we had gaps in terms  
17 of the way we were getting the awareness out  
18 and helping people to understand, helping our  
19 members to understand.

20 So, for today, we will tell you we  
21 appreciate your comments regarding the MEDCON  
22 orders, the comments regarding sustainment,

1 the comments regarding medical records, the  
2 comments regarding the liaison and what we do  
3 for that. And then, of course, the comments  
4 regarding the families. We absolutely  
5 appreciate it and we understand it because  
6 from 2011 we learned a lot from them. We keep  
7 circling back to see what else we need to do  
8 to make things even better.

9 So, from that construct, we can,  
10 no doubt, and I mean this, we made sure we  
11 made it made a difference. It made a  
12 difference in the way we focus. And I can  
13 tell you that Mr. Gonzales, back there, for  
14 the Secretary Air Force, he and I would ask  
15 them, okay, what are you going to do next?  
16 Here are the things you have done but what is  
17 next?

18 And we are always saying, no, not  
19 just the personnel side. What about the  
20 medical side? And what their answer to help  
21 us to keep a present focus on the care  
22 attendants, whether they are non-medical,

1 medical, Recovery Care Coordinators, those  
2 named in designation have a lot of meaning for  
3 us. But for the number on that receiving end,  
4 somebody is there for me. Somebody cares.  
5 And I know if I need help, I would get it. I  
6 would get it right away and it would be at the  
7 right level. And if it is not at the right  
8 level, here is who I notify within the  
9 continuum of care and we would fix it.

10 So, that is kind of our focus. So  
11 again, your leadership has made a big  
12 difference as we work through this, we will  
13 continue to stay with it. We are maintaining  
14 a good partnership, not only from the Joint  
15 Service perspective, we have OSD and have Mr.  
16 Townes and Dr. Poindexter walk through this,  
17 it is the point of understanding that no  
18 matter how hard you try sometimes, there could  
19 be some blind spots.

20 And, therefore, we have  
21 independent reviews and people like RAND who  
22 will help us to take a look and say what if.

1       What direct feedback did you get? Because we  
2       are there, there may be some things that  
3       family of the member may not say to us. They  
4       are not shy. We know that. But there are  
5       some things that maybe they have a better way  
6       of asking the questions to get to the bottom  
7       of what we need to do with that.

8                       But ultimately, it is a point of  
9       we remain vigilant, we remain on our toes, and  
10      we will stay ready hopefully to come upon our  
11      reaping the benefit through the continuum of  
12      care and how do we do this on behalf of our  
13      Secretary in Chief and the whole Air Force  
14      contingent that is with us today and  
15      throughout our Air Force and all the services,  
16      and what you have brought to the fight,  
17      helping us to understand better about what we  
18      do, why we do it and how we can do it better.

19                      So, we really appreciate you. Any  
20      final questions while I got the people who  
21      have good answers?

22                      CO-CHAIR CROCKETT-JONES: Thank

1       you very much.  Thanks very much for all you  
2       have presented us today.

3                       MR. LARRY:  Thank you, ma'am.  And  
4       thank you Air Force team.  We appreciate it.

5                       CO-CHAIR CROCKETT-JONES:  And I  
6       think -- is it lunchtime?

7                       MS. EBERLEY:  Yes, ma'am,  
8       lunchtime.

9                       And we are back here at 1:15,  
10      ladies and gentlemen, for the last  
11      presentation of the day, which will be the  
12      Marine Corps presentation.

13                      Thank you, my Air Force compadres.

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

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

2 (1:16 p.m.)

3 CO-CHAIR CROCKETT-JONES: Okay,  
4 welcome back. This afternoon, we will receive  
5 information from the Marine Corps Wounded  
6 Warrior Regiment. We welcome back Marine  
7 Corps Colonel Willard Buhl, Commanding Officer  
8 of the Wounded Warrior Regiment; Mr. Paul  
9 Williamson, Command Advisor for the Wounded  
10 Warrior Regiment. They will brief the Task  
11 Force on their response and status for the  
12 2013 report and recommendations that apply to  
13 the Marine Corps specifically, 5, 13, 15, 16,  
14 18, 19, 20. All the information is under Tab  
15 L of our binders. I'm going to turn it over  
16 to you, now.

17 COL BUHL: Thank you, ma'am.

18 Okay, am I -- I am. I'm on.

19 Ladies and gentlemen, the Wound  
20 Warrior Regiment has the distinct pleasure to  
21 present to you, following the lunch hour, and  
22 as the last of your presenters. So, I hope

1           that I can at least keep you awake for the  
2           final stretch of presentation. I will do my  
3           level best.

4                         Good afternoon, everyone. Thank  
5           you so much for having us aboard. I am going  
6           to read my first statements to you. I did  
7           write it myself. And let me say that I -- we  
8           sincerely appreciate this opportunity to  
9           answer your questions about the Marine Corps  
10          Wounded Warrior Regiment. As I stand before  
11          you a third time, I continue to be inspired by  
12          your efforts improving wounded, ill, and  
13          injured medical and non-medical care  
14          integration for the betterment certainly of  
15          our Marines and Sailors and their families but  
16          for all of our service men and women in  
17          uniform.

18                        And as I was saying to Mr.  
19          Crockett-Jones just a few minutes ago, the  
20          work that you do certainly aids us in many  
21          regards. Specifically, you light fires. You  
22          light fires that we can't light to get people



1 to go faster on things that need to be done.

2 I have been watching it for two years.

3 I look forward to providing you  
4 with a strategic overview of the Wounded  
5 Warrior Regiment. And as you know, the  
6 Regiment has actively supported wounded, ill,  
7 and injured Marines and their families for  
8 seven years now.

9 We are standardized at all of our  
10 locations and have gained the experience  
11 necessary, I think, to anticipate challenges  
12 ahead and identify best practices. Of course,  
13 you have helped us a lot with that.

14 Of important note, last month was  
15 the first month since I have been in command  
16 of the Regiment that we have not had a  
17 personnel casualty report from combat action.  
18 So, how about a round of applause for that?

19 (Applause.)

20 COL BUHL: More to come, we pray.

21 While we are all very thankful for  
22 that, I am reminded every day that we still

1           have a difficult road ahead. The number of  
2           Marines that we have on the roles at the  
3           regiments has remained constant over the past  
4           couple of years. And I will talk to that in  
5           a few moments. And we do have a large number  
6           of complex behavioral health cases. And they  
7           are in, in many regards, more challenging than  
8           the severe physical wound cases that we have.

9                         We also have a lot of vehicular  
10           accidents and the normal sorts of things you  
11           would expect with people contracting  
12           illnesses. And as I said, the number that we  
13           have joined to the Regiment, that we have  
14           supported with our RCCs, we think it is going  
15           to remain constant in the near medium term.  
16           Very little fluctuation.

17                        Our command's footprint has  
18           changed very little, thanks in great measure  
19           to our commandant's steadfast commitment to  
20           the wounded warrior care mission. Our  
21           commandant and his lady. We continue to  
22           provide global support across our Navy and

1 Marine Corps team. We are staffing regimental  
2 staff at 14 separate locations from Landstuhl,  
3 Germany, all the way out to Okinawa, Japan.  
4 And with the ongoing Asia Pacific regional  
5 pivot, we anticipate continued, if not  
6 slightly increasing, wounded warrior care  
7 requirements from Asia and are postured in  
8 Japan and Hawaii to continue to support, to  
9 provide direct support to our Pacific  
10 commanders and their Marines.

11 I was pleased to note that your  
12 questions continue to reflect a high-level of  
13 interest in the result of our surveys. As a  
14 survey proponent I know that without solid  
15 feedback from those we serve we cannot make  
16 sound improvements. I would like to point out  
17 that our trend data shows the Wounded Warrior  
18 Regiment's satisfaction levels remain high.

19 We are, however, continuously  
20 identifying improvements and I plan to  
21 highlight some of those for you today. Areas  
22 of particular focus include outreach to

1        reservists, increased communication with  
2        active duty and reserve family members and  
3        heightened regimental support for Marines  
4        transitioning to VA care services.

5                    In the past, several members of  
6        the Task Force have asked questions regarding  
7        our marketing and outreach efforts. I am  
8        pleased to provide you with some exciting  
9        improvements in our communications program.  
10       Our Facebook membership continues to grow  
11       exponentially. In October, the last time I  
12       spoke with you, we had approximately 34,000  
13       fans on our Facebook site. As of this  
14       morning, we are very close to 64,000 fans of  
15       our Facebook page. Excitement for this page  
16       stems from targeted campaigns, including this  
17       month's focus on family member and caregiver  
18       resources.

19                    During our recent Marine Corps  
20        trial in Camp Pendleton involving over 300  
21        wounded, ill, and injured athletes from ten  
22        countries, we live-streamed videos of the

1           competitions and the result was viewer  
2           participation from around the globe, including  
3           families and friends of nine participating  
4           nations outside the United States.

5                         Additionally, our Wounded Warrior  
6           Regimental Mobile Application just received an  
7           update to Version 2.0. And I respectfully  
8           encourage you to download our upgraded app.  
9           Check it out at the App Store or the Google  
10          Play Store and take a look at its exciting new  
11          features. And it is noticeably different from  
12          the previous one, even more user friendly than  
13          the last. It reaches out and grabs you with  
14          pictures right away as you open it up and  
15          start to view. Included in it of note, of  
16          importance, are the IDES handbook and the  
17          electronic version of our KIAT, the keeping it  
18          altogether handbook for our families that  
19          takes them step-by-step through the phases of  
20          acute care recovery and rehabilitation and  
21          transition.

22                         We also have had already nearly

1           6,000 downloads on this and it is increasing  
2           every day. So, it is happening and it is  
3           something that we can quantifiably measure.

4                         Finally, let me take a moment to  
5           sincerely thank you for your dedicated and  
6           compassionate work over the past five years.  
7           I certainly, we recognize, that for many of  
8           you, this is a collateral duty and that the  
9           time that you have spent traveling to our  
10          various sites, never mind the rest of our  
11          military and meeting with our staff and their  
12          Marines and their families is often your  
13          personal time and commitment.

14                        We have proudly offered our  
15          support, both with the two Lieutenant Colonels  
16          you see here at the table, Sean Kean, and Ted  
17          Wong and Justin Constantine, who I am missing  
18          today and in efforts that we have made to  
19          ensure that our presentations and responses to  
20          you are timely and in accordance with your  
21          intentions, your desires. We are working, all  
22          of us, towards the same goal of taking care of

1 the best of the 9/11 generation. And I know  
2 that our wounded, ill, and injured Marines and  
3 Sailors and their families are better for the  
4 work that you have done, that this task force  
5 has done and our work together.

6 Those are scripted, for the most  
7 part. I know that you were anxious to get  
8 into the slides. Our staff up here has  
9 already been introduced. But helping me  
10 today, Paul Williamson is a plank holder with  
11 the Regiment. He has been here from the  
12 beginning. He is the brains behind the  
13 operation, seven years' of experience, never  
14 mind his PEBLO presidency and a long career in  
15 our Navy.

16 And April, briefing our surveys  
17 was our Recovery Care Coordinator Deputy  
18 Program Manager, before she assumed the lead  
19 of our Future Initiatives Team. And Alicia,  
20 her trusty sidekick, is in the FIT. And it is  
21 a powerful thing. I almost don't want to  
22 advertise it too much because they are just

1           amazing with the capabilities that they have.  
2           I am afraid someone will steal them from the  
3           Regiment.

4                         So, we have deferred our position  
5           in a number of the slides to the Department of  
6           Defense, rightfully so, appropriately so. But  
7           where able, I shall tell you what we are doing  
8           and what our strategies are for. And I am, of  
9           course, here to answer any concerns that you  
10          have.

11                        And so without further ado, if I  
12          could ask for the first slide to be pulled up.  
13          And as I said, we have deferred to the  
14          Department of Defense in a number of areas.  
15          And in this particular recommendation, we  
16          absolutely have done that. We expect DoD will  
17          release policy sometime in the fourth quarter  
18          of fiscal year '14. And what we understand is  
19          that we will be provided with the authority to  
20          retain Reserve Component members on line of  
21          duty until found fit or until they receive  
22          their final disposition in the IDES. We are



1 told that that new issuance, that DoD order is  
2 coming out shortly. It is in coordination.  
3 And at this point, the Marine Corps is  
4 standing by to ensure that our equities are  
5 addressed in the policy.

6 Are there any questions on that?

7 DR. STONE: Does the Marine Corps  
8 really need guidance?

9 COL BUHL: We are functioning just  
10 fine but we --

11 DR. STONE: So what would this  
12 guidance give you that you don't have today?

13 COL BUHL: Paul, do we have any  
14 additional concerns with that, beyond what we  
15 are doing now? Because I haven't -- in my  
16 mind, not a great deal, except that new  
17 guidance is forthcoming and we are just -- we  
18 don't expect any significant changes in the  
19 way we are doing business at this point beyond  
20 admin.

21 DR. STONE: So, this is really  
22 about timeliness in the generation of orders

1 for your Reserve Component --

2 COL BUHL: Yes, I think it is  
3 catch-up.

4 DR. STONE: -- in order to provide  
5 predictability. I am just not quite sure what  
6 DoD is going to give you that you don't have  
7 already.

8 COL BUHL: I think it is catch-up.  
9 Right, Paul?

10 MR. WILLIAMSON: Right. Right. I  
11 agree with you. I don't believe there is  
12 anything coming in this policy that will  
13 directly impact the way that the Department of  
14 the Navy is addressing issues of line of duty  
15 but I think it may apply to the other  
16 services.

17 COL BUHL: Catch-up would be the  
18 best phrase. We are working well.

19 Any other concerns? Next slide.

20 Again, we are deferring to DoD for  
21 decision. As you, I think, everyone at the  
22 table knows, we do not have a separate

1 Physical Evaluation Board, nor do we, the  
2 Marine Corps, have medical providers. And we  
3 don't have direct influence in the PEB. Our  
4 Care Coordinators do remind every Marine to  
5 take special note of the conditions that they  
6 are claiming. We assist them every step of  
7 the way to ensure that they are comfortable in  
8 the IDES process and with the documentation  
9 that is going into the IDES for submission.  
10 And when Marines or Sailors have concerns,  
11 both before, during, or even after findings,  
12 we have IDES attorneys that are on hand and  
13 ready and do assist wherever required.

14 If anything, the IDES is a very  
15 good news story, in terms of timeliness, of  
16 the integration that has occurred between the  
17 VA and DoD. And if anything, it is just  
18 steadily improving and we are pleased.

19 Paul, do you want to add anything  
20 to that?

21 MR. WILLIAMSON: Just the fact  
22 that the Department of Defense is in the

1 process right now of establishing a Quality  
2 Assurance Program. We have been reviewing  
3 what that new policy will involve.

4 In the in-state, there is going to  
5 be at least five different levels of review.  
6 There is going to be an in-process case  
7 review. There is going to be a post-process  
8 case review. There is going to be a  
9 consistency reviews process. Customer  
10 surveys, which are currently used as a measure  
11 of effectiveness will remain a component of  
12 that. And then the fifth piece will be VTA  
13 data review. Again, that is currently being  
14 utilized to monitor the effectiveness of the  
15 process.

16 Those are going to be the in-state  
17 elements of this Quality Assurance Program,  
18 which is intended to be completed and in place  
19 by the end of FY15. By the end of this year,  
20 the fourth quarter of 2014, this DoD manual,  
21 Volume 3, will come out and lay out the  
22 specifics of how this Quality Assurance

1 Program will be instituted. The goals and  
2 objectives will be in there. The roles and  
3 responsibilities with detailed disability case  
4 review and reporting process will be revealed,  
5 as well as the quality improvement activity  
6 reporting. And all of this will be reviewed  
7 quarterly by the Disability Advisory Council.

8 So, I think this is going to be a  
9 good step forward to ensure consistency of the  
10 disability evaluation process at all stages,  
11 the MEB phase, PEB phase, and then the  
12 transition phase going forward.

13 COL BUHL: Thank you, Paul. The  
14 next slide.

15 On this, the Marine Corps did not  
16 concur with the recommendation. And just  
17 quite frankly, along the lines of a previous  
18 question, we are unaware of any significant  
19 issues in terms of supporting Marine Corps  
20 family members, travel claims, or claim  
21 processes. And we don't think there is any  
22 change required for us.

1                   We also do not want to prevent or  
2                   in any way hamper our line leadership's  
3                   ability to take care of our family members.  
4                   We don't think there is a policy change needed  
5                   in this.

6                   DR. STONE: So, this is not asking  
7                   for a policy change. This is asking for  
8                   uniform application of the existing JFTR. Is  
9                   your non-concur then asking for maximum  
10                  discretion of the command to not follow JFTR?

11                  COL BUHL: No, not at all. We are  
12                  all legally bound to follow the JFTR,  
13                  absolutely.

14                  DR. STONE: So, I am just not sure  
15                  why there is a non-concur, then.

16                  COL BUHL: Well, I think -- Paul,  
17                  do you want to step in on that one?

18                  MR. WILLIAMSON: The non-concur  
19                  stems from it is the unintended consequence  
20                  that might result from a more prescriptive  
21                  manner by which this would be instituted. It  
22                  may solve this problem. It may have a

1 reaction elsewhere within the ability of  
2 commanders to issue invitational travel  
3 orders, those types of things.

4 Now, this issue is from our Pay  
5 and Entitlement, not from the Marine Corps  
6 Wounded Warrior Regiment but from the overall  
7 Marine Corps pay system looking at this,  
8 again, at the unintended consequence.

9 CO-CHAIR CROCKETT-JONES: I'm  
10 going to jump in because I think that this is  
11 a misunderstanding of the recommendation.

12 The genesis of this recommendation  
13 was that two service members, different  
14 services, find themselves in beds next to each  
15 other, same injury, same time lines. One  
16 manages to get their family members bedside  
17 pretty quickly. And the other service,  
18 because of the process that they use to follow  
19 JFTR regulations, takes seven days' longer and  
20 has more, they have added some stops in the  
21 paperwork. Those family members don't get  
22 bedside at the same time. And this is felt

1           painfully by the service members and their  
2           families.

3                         And we want a duty to say services  
4           are equally obligated to meet the spirit of  
5           those permits and that those pay issues that  
6           get someone to the bed side. And we wanted  
7           them to eliminate some of these discrepancies  
8           by saying the end result is the way we measure  
9           this. Did you get the people there in a  
10          consistent and standardized manner? That was  
11          the entire genesis of this recommendation was  
12          to see those. As we go to more purple MTFs,  
13          we are going to have more and more people  
14          side-by-side in beds from different services.  
15          And where they are using different processes  
16          and one is a much better practice than the  
17          other, we want the answer to be we can do it  
18          that way and have the better effect. It is  
19          the genesis of this recommendation.

20                        So, when we see the Marine Corps  
21          saying they don't concur, we are worried that  
22          this is the Marine Corps saying we don't want



1 to be obligated to get people to the bedside  
2 in every case. So, that is why we wonder why  
3 you non-concur.

4 All we are saying is we want  
5 people to get to the bedside in some standard  
6 fashion and with some equalized time lines.

7 COL BUHL: I know Paul wants to  
8 speak. I will tell you, look you in the eyes  
9 and tell you I would be standing in front of  
10 General Amos' desk and maybe Mrs. Amos would  
11 be nearby if I didn't have family members  
12 bedside post-haste. And we do. I am  
13 accountable for that. But, Paul, please.

14 CO-CHAIR CROCKETT-JONES: That is  
15 why we are surprised at the non-concur.

16 MR. WILLIAMSON: Part of this,  
17 too, Ms. Crockett-Jones, was not the case  
18 where one of the services, once a service  
19 member was taken out of a military treatment  
20 facility and transferred to a non-military  
21 facility, the issue of non-medical attendants  
22 was in question as well. Maybe I am taking

1           this a little bit further than --

2                           TSGT EUDY:  And that issue was  
3           addressed, actually, yesterday by the Army and  
4           the panel of one representatives amongst the  
5           services talking about getting together to  
6           make sure that everyone is doing it on the  
7           same exact time line so that the same entitled  
8           benefit that one member sees in another  
9           service are going to get it in that exact same  
10          manner, versus just a different sub-  
11          interpretation of the same language that  
12          everyone is reading.

13                          MR. WILLIAMSON:  Right.  And to  
14          the point, as the Colonel stated, there is  
15          also no reason that the Marine Corps would  
16          object to any service member or their family  
17          realizing the same opportunity to have their  
18          loved ones bedside.

19                          The non-concur from the Marine  
20          Corps was more along the lines of making this  
21          more prescriptive may have unintended  
22          consequences elsewhere within the JFTR.  Not

1 to be seen but we are not non-concurring with  
2 the recommendation that all service members  
3 should have the opportunity to have their  
4 family bedside.

5 CO-CHAIR CROCKETT-JONES: Yes, I  
6 just -- this is one of those things where we  
7 haven't asked for a policy change. We haven't  
8 asked for a DTM or DoDI or anything. We have  
9 just asked that the DoD oversee consistency  
10 between services in providing this benefit.

11 So, I would just say maybe it  
12 needs another pass through to say is this  
13 really you are concurring but with a caveat of  
14 we don't want to change our policy. I just  
15 don't understand. That is why we don't  
16 understand the non-concur.

17 COL BUHL: I think it is fair that  
18 because there is some discussion here, that we  
19 will revisit this again. But I will stand  
20 before this Task Force and tell you that we,  
21 I pray in all cases, that any family member  
22 would tell you that the Marine Corps keeps

1 faith and goes above and beyond the call of  
2 duty to get family members there.

3 And where we run into requirements  
4 by the JFTR that we are unable perhaps to get  
5 an extended family member aboard or a fiancée  
6 that might not be legally covered, then we go  
7 to some wonderfully supportive non-profits to  
8 assist us. And I have never been refused, not  
9 in my tenure as a commander, with any requests  
10 of that nature, sometimes under extraordinary  
11 circumstances overseas, relatives, et cetera.

12 So, we feel very good and proud of  
13 what we are doing for our families in that  
14 regard. So, we will take a look at the  
15 language one more time, ma'am.

16 Moving to the next slide, SCAADL.  
17 We certainly understand that there is a  
18 defined intent for SCAADL and appreciate that  
19 SCAADL serves to offset wages lost by  
20 caregivers, oftentimes, leaving the workforce  
21 to support their catastrophically injured  
22 service member who might, otherwise without

1           their support, potentially be  
2           institutionalized, certainly in some of our  
3           more traumatic extreme cases. And in reality,  
4           we strongly believe that the benefits, this  
5           benefit supports keeping families together by  
6           providing that economic support to the  
7           caregiver under any circumstance, particularly  
8           at a very traumatic and vulnerable time for  
9           that family.

10                         We absolutely want to ensure that  
11           all eligible families know about the benefit,  
12           have the assistance in applying for it, and  
13           receive a determination of their eligibility  
14           as quickly as possible, particularly in that  
15           critical early time where all that disruption  
16           has occurred with the family and family  
17           members are under a great deal of stress.

18                         With regard to the entirety of  
19           this recommendation, we partially concur. And  
20           for the purposes of my response, I am going to  
21           address the improved awareness to the eligible  
22           SCAADL population. We have specifically

1           addressed this identified challenge with  
2           multiple outreach efforts. We have  
3           aggressively marketed the benefit to those  
4           eligible via our social media platforms. But  
5           I think far more importantly, through our one-  
6           on-one information push through our recovery  
7           care coordinator program, those RCCs. They  
8           are the campaign planner and they are  
9           consistent. They have been aboard in most  
10          cases for a long time, longer than the  
11          uniformed leadership and they are the  
12          educators.

13                        We are also educating our  
14          leadership to this. I brief every Marine  
15          Corps Commanders course. The Regimental  
16          Sergeant Major briefs every senior enlisted  
17          seminar. So, we are pushing this out in the  
18          uniform chain.

19                        We have, what I believe, is a very  
20          clear application and appeal process for  
21          Marines. In fact, speaking aside, I have had  
22          only one SCAADL reassessment that I have that

1 has been turned down that I have signed off on  
2 in my two-year tenure. So, we err to the side  
3 of taking care of our service members.

4 We work through the RCC's  
5 principally with the Marines, their families,  
6 and the medical case managers to ensure that  
7 the applications are completed correctly and  
8 submitted to the Wounded Warrior Regiment Pay  
9 and Entitlement Section for determination.

10 I will also add because the  
11 numbers, thank God, have come down so much in  
12 terms of overall numbers now with the  
13 reduction in the severe combat injuries out on  
14 the battlefield, we are able to get to the  
15 providers with that just in time training  
16 quickly because the numbers are manageable.  
17 I spoke with my Regimental Surgeon about that  
18 last night.

19 We also ensure that caregivers  
20 receive the required caregiver training  
21 through the Easter Seals while they are on  
22 active duty, so that we can ensure that there

1 is a smooth transition of benefits from DoD to  
2 VA. Our RCCs support the Marine and the  
3 caregiver in completing that VA caregiver  
4 stipend application and we follow it. We  
5 track it through final determination.

6 Additionally, we proactively  
7 provide the VA caregiver program manager with  
8 a monthly list of every Marine in receipt of  
9 SCAADL, so that they can plan ahead for  
10 incoming needs and actively reach out to the  
11 Marine and the caregiver to assist with the  
12 application process. So, we are hitting our  
13 VA leadership. And Sean Keane knows that all  
14 too well because he was our VA Headquarters  
15 Representative for a number of years.

16 Additionally, as I said, we are  
17 continuing to provide emergent means of  
18 communication for people and this is on the  
19 top of the list for an area that we will  
20 continue to push information out through  
21 various communication means.

22 LTCOL KEANE: Sir, I have a quick



1 point.

2 COL BUHL: Yes, Sean.

3 LTCOL KEANE: What you said seems  
4 contradictory to one line in here and what I  
5 learned being at the Regiment. As far as  
6 getting the word out, when this came out in  
7 2010, the Marine Corps was the leading DoD  
8 agency in getting it. The Army was months and  
9 months behind us. We had Soldiers calling my  
10 office and calling the VA, how do we do this  
11 SCAADL. They didn't have an implementation  
12 plan.

13 What I am referring to is if the  
14 RCC determines a need for SCAADL, the RCC will  
15 brief the Marine and the family on the  
16 benefit. That isn't what I was aware of,  
17 unless that is a change or that is a mistake  
18 by being in there. That seems to be that the  
19 RCC is the first hurdle. If the RCC  
20 determines, then --

21 COL BUHL: That is a miswording.  
22 Obviously, the RCC -- the uniformed leadership

1 has the final say in everything. I sign off  
2 on the SCAADL applications on behalf of Deputy  
3 Commandant for Manpower and Reserve Affairs  
4 and our Commandant. But the RCC is often that  
5 -- not often. The RCC is that campaign the  
6 Comprehensive Recovery Plan architect.

7 LTCOL KEANE: Sir, just the way it  
8 is worded.

9 COL BUHL: Yes.

10 LTCOL KEANE: It looks it is a  
11 hurdle. If the RCC determines, then you will  
12 brief the Marine.

13 COL BUHL: No, it is uniformed  
14 leadership. And in terms of eligibility, that  
15 is a medical providers determination and we  
16 cannot -- no one influences that. That is a  
17 doctor's determination. But in terms of  
18 eligibility, once a doctor has identified that  
19 an individual appropriately rates it, the  
20 assistance, then we sign off on it.

21 You want to add to that, Paul,  
22 anything?

1                   MR. WILLIAMSON: Just again, when  
2                   the RCC is engaged with that Marine and  
3                   family, part of that checklist is the various  
4                   benefits that they may be eligible for. And  
5                   if there is the slightest indication that  
6                   there may be an entitlement to SCAADL, the RCC  
7                   will help that Marine and family initiative  
8                   that application for that. And as the Colonel  
9                   mentioned, it proceeds then on to the medical  
10                  provider who will complete the critical  
11                  evaluation, then to the Unit Commander for the  
12                  certification of line of duty entitlement, and  
13                  then on to the Regiment for processing.

14                  COL BUHL: And if I, airing the  
15                  Regiment's laundry, so to speak, if there is  
16                  an area I have had challenges with in that  
17                  regard, one earlier when the numbers were much  
18                  larger, the doctors across our Navy, I don't  
19                  think we have had a uniform education on what  
20                  SCAADL was. And we had to follow-up to inform  
21                  our providers about what it is and how it  
22                  works, et cetera. I think we are there now

1 but perhaps earlier we had some challenges  
2 with that. Not perhaps -- we did.

3 And too, that chain that Paul just  
4 described, so a service member is identified  
5 as a probable recipient, potential recipient,  
6 we push immediately the evaluation to the  
7 provider, then it goes back through the chain.  
8 Making it move through that chain quickly has  
9 required command-level focus, particularly at  
10 our outlying detachments where the  
11 administration might not quite be as -- isn't  
12 as robust and not quite fully responsive. So,  
13 we have addressed that during my tenure as  
14 well. I am very comfortable now that we move  
15 these applications quickly through the chain.  
16 The numbers are small. We know who they are.

17 CO-CHAIR CROCKETT-JONES: So, the  
18 non-concur would be on -- do you have a  
19 position on the exemption from taxes and the  
20 AHLTA access? Can I hear you talk about those  
21 just a little?

22 MR. WILLIAMSON: Well the AHLTA

1 access issue is just a difficult technological  
2 issue. And it is not that -- again, we don't  
3 have -- the Marine Corps doesn't control  
4 AHLTA.

5 COL BUHL: We don't.

6 MR. WILLIAMSON: We don't have any  
7 providers. But if it can be done, by all  
8 means.

9 The tax exempt piece, that was one  
10 of the questions we had initially posed is how  
11 is it that the VA caregiver stipend is going  
12 to be a tax-free benefit but the SCAADL  
13 benefit is not. And it was at that point that  
14 I don't want to say we were rebuked but we  
15 just said that anymore entitlements that were  
16 subject to tax-free benefit are well beyond  
17 the Marine Corps' capability to influence.

18 CO-CHAIR CROCKETT-JONES: Yes, but  
19 we can try.

20 MR. WILLIAMSON: Yes, ma'am.

21 CO-CHAIR CROCKETT-JONES: I just  
22 want to know if you had a reason that you felt

1           it should stay within a taxable lane and the  
2           answer is no. It is not that there is a  
3           reason to keep it there. Okay, that was my  
4           question.

5                           COL BUHL: Next slide. With  
6           regard to resourcing behavioral health, the  
7           Wounded Warrior Regiment concurs the best  
8           possible care is provided to our Marines and  
9           families. But in terms of staffing and  
10          manning, behavioral staffing billets, we are  
11          going to defer to the DoD. The Wounded  
12          Warrior Regiment is part of Marines and  
13          Families Division in Manpower and Reserve  
14          Affairs. We have the Behavioral Health  
15          subsection of that division in Marines and  
16          Families. But again, we are deferring to the  
17          DoD really for the billet specifics in terms  
18          of numbers.

19                          As a regimental commander with a  
20          staff consisting of active duty, mobilized  
21          reservists, GES civilians, NAF civilian,  
22          government workers, and contractors, I

1 understand very well, I believe, the ongoing  
2 challenges of manning to the appropriate  
3 level, commensurate with needs. That is one  
4 of my great daily challenges.

5 So, we are standing by for DoD  
6 guidance. We defer on that with Behavioral  
7 Health.

8 If I felt that I had an area that  
9 was insufficiently met or staffed, I  
10 absolutely would address that through my chain  
11 of command.

12 CAPT SANDERS: So, while I have  
13 got you on that point, Colonel, one of the  
14 other services talked about the reduction in  
15 some permanent staff in different levels  
16 because of reductions in active duty for work.  
17 And I am curious to know, is a great number of  
18 your staff augmented by Reservists brought on  
19 active duty? And have you been able to POM  
20 for those to be permanent? And are you using  
21 those people and is it impacting your ability  
22 to do your job?

1                   And you don't have to answer me  
2                   now.

3                   COL BUHL: No, that is a great  
4                   question. I will field it now. And I will  
5                   suggest that it rolls into the overall way  
6                   ahead, the way forward of the Regiment.

7                   And the answer is over 80 percent  
8                   of the Wounded Warrior Regiment's uniformed  
9                   staffing is mobilized Reservists. And in many  
10                  cases at our detachments, in particular, it is  
11                  near 100 percent and we are working through  
12                  the POM process as the OCO, the contingency  
13                  operational funding diminishes exponentially.  
14                  It is being halved every year.

15                  Our Commandant, my general officer  
16                  chain of command is very well-informed. The  
17                  Navy Department knows this. We are watching  
18                  this closely. We believe that we have  
19                  sufficient resources through the remainder of  
20                  this fiscal year and the next. And so we are  
21                  looking at the year beyond as a first real  
22                  critical year. And we are exploring ways to



1           move to the baseline budget to continue what  
2           we are doing. And I am confident that we will  
3           find a solution for that. Our leadership will  
4           find a solution for that.

5                            CAPT SANDERS: Thank you.

6                            COL BUHL: Yes, sir. Next slide.

7                            The USMC concurs with the  
8           recommendation and we have the resources in  
9           place, I believe, to ensure that our reserve  
10          component, wounded, ill, and injured Marines  
11          and Sailors joined to the Regiment receive  
12          case management identical to their active duty  
13          counterparts.

14                           We continually strive to ensure  
15          that our Reserve Component Marines who are  
16          wounded, ill, and injured Marines who are away  
17          from our bases and stations are made aware of  
18          the Regiment and its care coordination  
19          capabilities. And accordingly, we have  
20          several key initiatives established and/or  
21          underway to specifically support this  
22          population.

1                   Lieutenant Colonel Ted Wong at the  
2                   table here with you was assigned as the  
3                   Regiment's Liaison Officer to Marine Forces  
4                   Reserve in New Orleans last spring,  
5                   particularly, to address this area of reserve  
6                   support. He is the connection between our  
7                   staff here in Quantico and the MARFORRES staff  
8                   in manners related to care and support of  
9                   active and reserve wounded, ill, and injured  
10                  Marines and families assigned to MARFOORES  
11                  units. Ted's roll-up every month is  
12                  substantial. He is busy. He has a lot of  
13                  work to do. He is engaging in a lot of cases  
14                  and he is educating a lot of people.

15                  We have established relationships  
16                  that allow for briefings at training events  
17                  hosted by Marine Forces Reserve, including  
18                  their annual I&I conferences, their IRR  
19                  musters, their PME education for the Marine  
20                  For Live Program, and others. We are very  
21                  embedded and invisible across Marine Forces  
22                  Reserve. And as I just answered in a question

1           just now, 80 percent of my command are  
2           mobilized Reservists. So, there is a lot of  
3           interaction. I am able to hire and populate  
4           my leadership through the Reserve network that  
5           we have. It is very important. We are  
6           embedded. We have got good relationships and  
7           I don't see them changing.

8                     Our RCC program has been trained  
9           on reserve-specific subject matter to assist  
10          our Reserve Component Marines and their  
11          families. We have integrated into the RCC  
12          training.

13                    The Wounded Warrior Regiment has  
14          begun sending a personalized letter to every  
15          Marine on MedHold or in a line of duty status,  
16          informing of the resources available through  
17          the Regiment. So, we are sending out a direct  
18          letter to everybody in that regard.

19                    Our communications program has  
20          developed a reserve-specific tool kit, which  
21          provided access to policies, forms, fact  
22          sheets, common definitions, and a checklist

1           that we have created geared toward our  
2           reservists and their families.

3                       The RMED Section, Reserve Medical  
4           Entitlement Section continues to oversee all  
5           cases of wounded, ill, and injured reservists  
6           who require medical care or referral into the  
7           disability evaluation system for service-  
8           incurred ailments. And we all met last time  
9           at the Sergeant Merlin German Call Center. Of  
10          course, I've got an active, what we think is  
11          the best outreach program, in terms of follow-  
12          ups with direct phone calls to every wounded,  
13          ill, and injured service member. It is  
14          powerful. It is active. You saw it for  
15          yourselves, when you visited us last.

16                      So, that is how I have attacked  
17          that challenge.

18                      Okay, next slide. Thank you.

19                      In Recommendation 20, family  
20          member involvement, we are going to defer,  
21          again, to the DoD for the official response.  
22          But it is our practice to, of course, highly

1 encourage family member participation in the  
2 recovery and transition process every step of  
3 the way.

4 We have a robust protocol for  
5 contacting family members that starts with, as  
6 we spoke at lunch, aggressively encouraging  
7 Marines to provide consent to communication  
8 for family members with that family contact  
9 authorization form. I believe it has been  
10 cited as a best practice by the Task Force.

11 CO-CHAIR CROCKETT-JONES: Yes, we  
12 do say that methodology is an active voice  
13 versus a passive voice. And I have been  
14 harping on this for the past two days.

15 One of the things that I want to  
16 throw out to you, the reason why the IDES  
17 process became a touch point for us is because  
18 it is not a medical process. It is an  
19 administrative process which has a time line.  
20 And I use this example because I think it is  
21 one that easily goes unseen. A family member  
22 has an EFMP status, a child. And perhaps the

1 spouse is well aware of all the subsidies and  
2 programs that being in that EFMP program  
3 entails. But maybe the service member,  
4 because they have deployed a lot is less aware  
5 of how urgent that program support is and how  
6 necessary it is. And when that person hits  
7 that DD214, the EFMP stops.

8 And the primary caregiver who has  
9 been monitoring that child in an EFMP status  
10 has to find alternate support, subsidy,  
11 programs, whatever, in the area where they are  
12 going to come to reside. Those things  
13 generally take time. Frequently, local  
14 service provision requires all kinds of  
15 documentation and approval processes. And  
16 these can be difficult to get into. They  
17 sometimes have waiting lists. There are all  
18 these concerns for this person.

19 If there isn't an awareness of the  
20 time line and we know it is going to be, we  
21 have an idea, everybody has an idea of how  
22 long IDES is going to take, if we don't bring

1           that person in, that primary caregiver in, at  
2           some point, to say you know you have got about  
3           200 days and you have got to take care of  
4           this, they are really left out in the cold.  
5           And that is totally separate from any medical,  
6           other concerns that you rightly want to  
7           protect the privacy of that service member.

8                         And so, there are plenty of stuff,  
9           as you have demonstrated, there are plenty of  
10          methods that are short of mandating that can  
11          encourage someone to get the people who needed  
12          the information they need.

13                        And we do use your methods and the  
14          active voice you have taken, we use that  
15          frequently as an example to others on how they  
16          can use a perspective change without actually  
17          changing much in the way -- there is no  
18          mandate but the active voice creates better  
19          outcomes.

20                        And so, this is a touch point in  
21          the process that is important. Some families  
22          it is extremely important to, this kind of

1           planning, long-term planning, transition. So,  
2           this is why the recommendation featured this  
3           point was because really there is a lot that  
4           changes and the time line becomes a  
5           significant contributor.

6                       COL BUHL: I wish, Ms. Jones, I  
7           wish you would have been -- recently we had a  
8           caregiver luncheon during the trials out in  
9           Camp Pendleton because we had so many family  
10          members from across the Regiment gathered and  
11          a lot of resources there. This specifically  
12          came up, the EFMP. And our Family Readiness  
13          Offices are very read into that and so are our  
14          RCCs, who are really charged with informing.

15                      And I couldn't agree with you  
16          more. And I have an EFMP son. My wife knows  
17          more about the program than I do or she did.  
18          And we have the EFMP Section in the Marines  
19          and Families Division also in the division I  
20          work and of course Marine Corps.

21                      We also address this, I am on a  
22          little role to say that I was pleased to see



1           this addressed carefully and thoroughly, at  
2           our EAS Boot Camp that I attended down in Camp  
3           Lejeune about a month ago with Battalion East.  
4           We had almost a hundred families in a very  
5           large hall and this was an area that was  
6           covered. And a lot of the families were, it  
7           was husband -- it was Marine and spouse in the  
8           room together. So, we are on it.

9                           And I will say over and over  
10          again, we can never be good enough at this.  
11          But it is an area that we address. We address  
12          it proactively.

13                          And I will add just another thing.  
14          I think often it is family members that give  
15          us the greatest challenges, in terms of making  
16          sure we get them everything that they need.  
17          The Marines, most of the time, come right in  
18          line, but most of the time, and comply. It is  
19          the members we want to make sure we are not  
20          missing something with or that are more  
21          complicated.

22                          We, in nearly all cases, the

1 Marines actually do welcome their family  
2 member involvement in their recovery and  
3 transition planning. And in our recent Care  
4 Coordination Survey, 97 percent of the Marines  
5 that responded stated that involvement of  
6 their family members in the CRP enhanced their  
7 recovery and transition. So, we absolutely  
8 believe that family members have to have  
9 visibility on that Comprehensive Recovery  
10 Plan.

11 We actively promote the use of our  
12 social media tool, including Facebook and our  
13 App as an immediate tool to access all these  
14 important benefits and entitlements  
15 information. And that App, I can't speak  
16 enough about it. It is so easy to use. It  
17 lays every entitlement out very clearly for  
18 them. It walks them through it. It is easy  
19 to understand, easy to use, and it is not the  
20 KIAT handbook in a giant binder. It is right  
21 on their telephone.

22 This month, we focused, as I

1 mentioned in my opening remarks, on a  
2 caregiver information push. And our Facebook  
3 site, as I said, has had some exponential  
4 increases in the recent months, that big  
5 number I told you about, 20,000 in the last  
6 few months. So, I am confident that this is  
7 a viable platform to get important information  
8 out and to stay in contact with our families.

9 And I have already spoken of it  
10 but I will one more time say that regular  
11 contact with our Marines is maintained  
12 systematically through the Sergeant Merlin  
13 German Call Center; 119,000 calls last year;  
14 six to one outreach to input last year. We  
15 are actually increasing that. It is over six  
16 to one. It is a big powerful outreach.  
17 Nobody does it like we do it.

18 We are participating in the DoD  
19 Warrior Care Policy Initiatives to create  
20 joint policy and processes to support  
21 caregivers. We are going to continue to  
22 identify innovative ways to encourage family

1 member involvement. And as I said, we could  
2 never be good enough at that.

3 Next slide, our patient  
4 population, patient census trajectory. If,  
5 and I will tell you I think it will, but if  
6 the population continues to track consistently  
7 with the history that we have seen over the  
8 course of certainly the past two to three  
9 years but over the course of the Regiment's  
10 history, we do not anticipate any significant  
11 fluctuations in patient numbers for the next  
12 two years.

13 Our recent Care Coordination  
14 Survey, 67 percent of the population reported  
15 that they are receiving care for a head  
16 injury; 62 percent of our patient population,  
17 our recovering Marine population have post-  
18 traumatic stress. While this is based on  
19 self-reporting, personally, based on my  
20 experience, and all the input that I get, I  
21 believe this is an accurate portrayal of the  
22 demographics of our current population.

1                   Anecdotally, my battalion  
2           commanders are telling me that their patient  
3           population is changing. And as you would  
4           expect, the kinetic injury numbers have gone  
5           down significantly but the behavioral health  
6           challenges are on a rise. And I can speculate  
7           a bit on that, give you my professional  
8           opinion but as the op tempo has lessened,  
9           people are now, as the units are not going  
10          back to combat, and as people are transferred,  
11          Marines are transferred to follow-on  
12          assignments that are not necessarily any less  
13          stressful, recruiting duty, drill instructor  
14          duties, et cetera, they are raising their  
15          hands and coming forward with PTS issues.

16                   Also, the education, in terms of  
17          identifying TBI cases, has continued apace.  
18          And we are discovering people with TBI that  
19          might not have been identified earlier for  
20          whatever reason. And so we are seeing a  
21          spike, a steady increase in those Behavioral  
22          Health cases.

1                   And with the complexity associated  
2                   with supporting those, that on its own is a  
3                   challenge. But with a large force, we are  
4                   drawing down a bit but we are still not quite  
5                   200,000 uniformed Marines that are training in  
6                   austere environments, very challenging combat  
7                   training. We are going to have injuries out  
8                   in training. And of course, there is the  
9                   steady flow of automobile and motorcycle  
10                  accidents and people get sick.

11                  We had a number of cancer patients  
12                  competing in our trials, two of whom the  
13                  doctors' prognosis is that they would be  
14                  terminal. You know, Marines want to beat the  
15                  odds under every circumstance.

16                  So, people are going to continue  
17                  to get sick. They are going to continue to  
18                  get injured in training off-duty. And about  
19                  half of our population right now are ill or  
20                  injured outside the combat zone. So, we see  
21                  a steady state for the next two years.

22                  You can see the numbers on the

1 graph there. The recovering Marines and  
2 Sailors on the active roles slightly  
3 decreasing over the past years but the number  
4 of Marines that are receiving recovery  
5 coordination care, being supported at their  
6 commands, which is our Commandant's intent,  
7 just slightly increasing, resulting in a  
8 steady state of support.

9 Okay, next slide. Long-range  
10 vision. I think the answer is written up  
11 there in the box for you. We see a steady  
12 requirement, an enduring requirement to care  
13 for those Marines and Sailors who have been  
14 ill or injured in training or on and off-duty.  
15 We believe that we will continue to see lesser  
16 numbers coming from combat, as we transition  
17 there in Afghanistan.

18 We also this flow of Behavioral  
19 Health issues steady for the next couple of  
20 years. I don't know how far beyond that we  
21 are going to have cases like this but we have  
22 been at war for a dozen years and it is often

1 a tour or two, and sometimes three, after the  
2 combat action that these signs manifest  
3 themselves. It is often in events that occur,  
4 potentially misconduct, et cetera. But  
5 sometimes it is two or three tours later.

6 So, there is an enduring need  
7 here. We have never done it before like the  
8 Regiment does it. And people ask us, our  
9 Commandant has said I cannot imagine not  
10 having this capability going forward, where we  
11 have one command that is dedicated, organized,  
12 trained, and equipped, so to speak, to care  
13 for the wounded, ill, and injured in the  
14 Marine Corps.

15 So, what we see is our  
16 detachments, the peripheral detachments being  
17 reduced to liaisons with Recovery Care  
18 Coordinators to continue to ensure that we  
19 have sentinels out at the periphery of some of  
20 our installations but also, those sentinels  
21 are out in a positive outreach to the local  
22 commanders and their bases and stations.



1                   Those RCCs are there to provide  
2                   that support for the Regiment at the outlying  
3                   sites. And then if we identify people in need  
4                   of being joined to the Regiment, for whatever  
5                   reason, we then move them to Centers of  
6                   Excellence. We have five identified: Walter  
7                   Reed, Camp Lejeune, San Antonio, Balboa, and  
8                   Camp Pendleton. And the two battalion  
9                   headquarters that you are well familiar with  
10                  on each coast of Camp Pendleton and Camp  
11                  Lejeune are the centers. And there, we will  
12                  continue to staff robustly what we need to  
13                  take care of our Marines and Sailors and their  
14                  families.

15                         And we don't think this is just a  
16                         downsize approach. This make sense that we  
17                         can get people where they can get all the  
18                         resources in one place, the best of  
19                         everything, where we have the hospitals, the  
20                         barracks, the headquarters, all of that, the  
21                         Hope and Care Centers all in one location.

22                                 CAPT SANDERS: Just a comment.

1       The other services all projected 48 months'  
2       out a rise in their client population, as  
3       opposed to a steady state. So, I just had  
4       that as a note of difference in thought.

5                   COL BUHL: Dare I speak for the  
6       other services, I won't. But I will say that,  
7       again, it is our Commandant's intent that our  
8       Marines and Sailors, wherever possible will  
9       heal in their parent commands, with their  
10      brothers and sisters who they are serving with  
11      on a day-to-day basis.

12                   So, if there is a high acuity  
13      hospitalization, for example, extended  
14      appointments more than a unit is capable of  
15      supporting, things of this nature, then we are  
16      going to join that Marine or Sailor to the  
17      Regiment and give him or her the care they  
18      need with us.

19                   But otherwise, we are going to  
20      continue to support them through RCCs and  
21      remotely at their units and provide all the  
22      backup and expertise of an in-depth regimental

1           headquarters. And those battalion  
2           headquarters, I mentioned. So, if I am  
3           answering your question --

4                        CAPT SANDERS: It was more of a  
5           comment than a question but thanks for the  
6           answer anyway.

7                        COL BUHL: Right, okay. Yes, we  
8           are going to take care of them but our numbers  
9           should remain, I think, constant for the next  
10          two years.

11                      MR. REHBEIN: If I may, for a  
12          moment, sir. You touched on a couple of  
13          points here that piqued my interest a little  
14          bit. One, about the probability that two or  
15          three tours later some of these behavioral  
16          health problems come to the surface. And then  
17          you also mentioned something about having some  
18          sentinels out there.

19                      We all know that, quite often,  
20          behavioral health problems manifest themselves  
21          as behavior problems. How do you envision  
22          those sentinels interacting with unit command,

1           to determine whether a particular behavior  
2           problem in a Marine is really a behavioral  
3           health problem? How do you make that  
4           connection?

5                       COL BUHL: Like for example,  
6           anxiety disorder versus post-traumatic stress,  
7           et cetera, et cetera. Of course, I nor any  
8           uniformed member, aside from the Regimental  
9           Surgeon and the Battalion Surgeons are  
10          doctors. So, we rely on our medical  
11          professionals to make those type of  
12          assessments.

13                      But where we have behavioral  
14          issues manifesting themselves that come to the  
15          attention of a commander, we are hitting it  
16          again in multiple ways. One, at the commander  
17          to commander level, we are informing every  
18          group of commanders at the lieutenant colonel  
19          and colonel level that are going out to the  
20          Fleet Marine Force. Every class, we speak to  
21          them and provide a full brief and going to  
22          questions of this nature with the commanders.

1 We are doing that for our senior enlisted  
2 seminars as well.

3 The liaisons that are out at, for  
4 example, Twentynine Palms, staff NCOs  
5 experienced, will provide briefs routinely for  
6 the base and will go to commands on request  
7 and we tell our commanders, as they go out to  
8 the fleet, ask for the briefs for your people.  
9 We will provide them at any time. And we do.  
10 We are very busy.

11 We are also in the staff  
12 academies. And I attended a briefing out in  
13 Okinawa when I was there last for all the  
14 staff NCOs that were in the academy there in  
15 III MEF at the time.

16 So, a lot of outreach. And in  
17 terms of these manifestations that we see  
18 emerging and occurring in the years forward,  
19 there is a great deal of discussion across the  
20 Marine Corps about this because probably first  
21 and foremost legally, we are seeing legal  
22 challenges. But you know the health of the

1 force and certainly suicide prevention and  
2 other domestic abuse, sexual assault  
3 prevention, et cetera. Everything is inter-  
4 related in terms of behavioral health.

5 And so I don't think this could be  
6 any further at the forefront of our  
7 commanders, our leadership.

8 Did I answer your question?

9 MR. RECHARDT: You did because  
10 commanders out there are going to be faced  
11 with the situation is this particular drinking  
12 problem better handled through the normal  
13 disciplinary channels or better handled  
14 through behavioral health channels.

15 And as long as they are given the  
16 training and have the judgment that they could  
17 make that decision intelligently, yes. And I  
18 think what you described to me is the basis of  
19 forming that kind of judgment.

20 COL BUHL: Yes, sir. And I would  
21 also add, regarding your remarks, it is both.  
22 Both work in conjunction and we ensure that we

1 are taking into account a Marine service  
2 record. And when you start -- for example,  
3 just notionally, two DUIs in a 30-day period  
4 and you look and this individual has had two  
5 meritorious promotions on the battle field to  
6 corporal and sergeant and suddenly he is in  
7 trouble, potentially, being administratively  
8 separated and you start looking back at his  
9 combat record and you see that he has made  
10 five deployments to Iraq and Afghanistan.  
11 Okay, and then we start digging a bit.

12 MR. REHBEIN: Out in the civilian  
13 sector, we are very often finding that those  
14 kinds of combat veteran behavior problems are  
15 better handled through special courts, where  
16 there is some extra sensitivity given there,  
17 --

18 COL BUHL: Absolutely, sir,  
19 veterans court.

20 MR. REHBEIN: -- that there is  
21 potential behavior --

22 COL BUHL: And our DISCs are

1 District Injured Support Coordinators, who I  
2 know the Task Force is familiar with, we have  
3 31 of them across the United States are very  
4 involved in caring, assisting in our veteran  
5 population in cases of that nature are  
6 occurring. And that is exactly the path we  
7 use.

8 Yes, sir?

9 CSM DE JONG: Sir, if I may?

10 COL BUHL: Yes.

11 CSM DE JONG: I know we are about  
12 to close this out. I am probably going to hit  
13 a nerve here. So, I was waiting until the end  
14 in case I get a microphone thrown at me.

15 I know it is the Marine Corps'  
16 stance --

17 COL BUHL: I will just have Ted  
18 elbow you.

19 CSM DE JONG: Okay.

20 COL BUHL: No.

21 CSM DE JONG: I know it is the  
22 Marine Corps' stance and it is the



1           Commandant's stance to leave a lot of injured  
2           Marines within their formations, their line  
3           units.

4                       COL BUHL: I understood what you  
5           meant.

6                       CSM DE JONG: Okay. What we  
7           continuously have heard over the last three or  
8           four years is that it doesn't work. But when  
9           we talk to a group of Marines and we ask the  
10          pointed question of while you were receiving  
11          care in your line unit, was it working, and  
12          the resounding answer is no. The resounding  
13          answer is why couldn't I just get to the  
14          Regiment earlier so I could focus on my  
15          recovery, focus on healing and continue to be  
16          a Marine?

17                      So, when we hear that it doesn't  
18          work, where can the Regiment help leverage  
19          where is the right place for a Marine to heal?

20                      COL BUHL: I will tell you that  
21          the greatest challenge I have had as the  
22          Wounded Warrior Regimental Commander is with

1 peer commanders explaining why a Marine either  
2 should be joined to the Regiment or should not  
3 be joined to the Regiment. That is the art of  
4 command. It is a great challenge and we  
5 carefully review everything, particularly the  
6 medical piece, the doctors' recommendations.  
7 And we believe that because of the high  
8 percentage of people, we leave an outlet for  
9 every -- there is a lofty goal of extended  
10 permanent limited duty where our comment on is  
11 said if you are injured in combat, we are  
12 going to find a place for you if you want to  
13 stay and continue to serve. And we are doing  
14 that but the numbers are very small. But the  
15 opportunity exists.

16 But the percentages say that if  
17 you come to the Wounded Warrior Regiment, you  
18 are probably going into the IDES and you are  
19 probably going to find yourself with a medical  
20 retirement.

21 And so, we want them to continue  
22 to serve. And sometimes we take people TAD,

1 TDY for 90 days. Sometimes we extend that and  
2 try to get them back to their units. But we  
3 have found that the union cohesion says that  
4 if they leave their parent commands, their  
5 line units, their formations, that they will  
6 probably not remain in the service. And that  
7 probably is at the epicenter. And so is it  
8 perfect? No, it isn't. It is the art of  
9 command. And I am engaged with commanders to  
10 convince them one way or the other. Those are  
11 the toughest conversations that I have.

12 CAPT SANDERS: Would that, as a  
13 philosophy, are you taking on from internal to  
14 the Regiment a way to try to reverse that  
15 process and trend so that automatic movement  
16 to the Regiment means you are not going to be  
17 a former Marine in short order?

18 COL BUHL: Well again, the art is  
19 that you will return -- the intent is that you  
20 will return to full duty. That is our goal  
21 for every Marine. In some cases, it is just  
22 not going to be possible for whatever reason,

1 usually medically. A lot of times, Marines  
2 decide in their families, they make conscious  
3 decisions based on their illnesses or injuries  
4 that they will have to move on. Sometimes, it  
5 is out of their hands.

6 CAPT SANDERS: And I fully  
7 understand that and have seen it in the past.  
8 But I guess get somewhat troubled by the  
9 concept that if the thought process for  
10 leadership is that when we get to the Warrior  
11 Regiment, more than likely you are not going  
12 to get back to a line --

13 COL BUHL: We don't believe  
14 everyone who joins and say guess what, 94  
15 percent you may be in the 94th percentile  
16 here. No, of course not. And in fact,  
17 everything is positive and focused on healing,  
18 recovery, return to full duty.

19 Our motto, the Regiment's motto is  
20 Etiam in Pugna, "Still in the Fight." And  
21 everything that we do along the five lines of  
22 operation, mind, body, spirit, family, medical

1 is focused on returning that individual Marine  
2 back to full duty or to the best full life  
3 that he or she can look forward to ahead. And  
4 I am not going to stand up as a propaganda  
5 here in front of you. I am just going to say,  
6 a lot of these -- I just went rock climbing  
7 last week with a group, a couple of more  
8 amputees and most of them had never been rock  
9 climbing before. I had only been once or  
10 twice in my life. A lot of these young men  
11 and women are doing things in their lives that  
12 they never would have imagined that they would  
13 do before, specifically because they found  
14 themselves in the Wounded Warrior Regiment,  
15 while creating a lot of avenues for  
16 achievement and fulfillment in their life  
17 ahead. The goal is to get them back to full  
18 duty. The reality is most of the marines that  
19 are joined to the Regiment that reach that  
20 level of high acuity are probably going to be  
21 medically retired.

22 MS. DAILEY: Ladies and gentlemen,

1 we really need to kind of wrap here.

2 COL BUHL: Yes, ma'am.

3 MS. DAILEY: If you have got  
4 questions, let's put them on the table  
5 quickly. We would like to get to the survey.  
6 If she moves quickly through it, we can bring  
7 Colonel Buhl back. I saw a red button.

8 Okay, we might have time. It  
9 depends on how fast April moves.

10 COL BUHL: Okay. April is much  
11 more efficient than I am. And I don't think  
12 she is any less passionate than I am but she  
13 is very efficient.

14 So, April, do you want to -- I  
15 will remain on deck with no rush or hurry if  
16 anyone out in the grand audience or at the  
17 table here wishes to speak to me about  
18 anything related to anything I have said.

19 MS. PETERSON: Okay, good  
20 afternoon.

21 So, I am standing in for Erica  
22 Osain, who is our Assessment Survey Analyst,

1           who I know that you have heard from before.  
2           But Colonel Buhl and I will try to live up to  
3           her expectations of us.

4                        So, the first slide, our Annual  
5           Care Coordination Survey was conducted in  
6           December of 2013. And over the past few  
7           months, we have been analyzing our data. You  
8           guys should have the survey instruments in  
9           your package. We did make a couple of changes  
10          this year which really proved to be positive  
11          for our survey efforts. One, we ended up  
12          taking up a random sampling of our population  
13          by doing a census which we have done the last  
14          couple of years. And second, we put proctors  
15          on-site at our battalions and detachments to  
16          give the surveys to the population. And what  
17          happened was we got a 100 percent response  
18          rate. So, for us, I think this year was our  
19          best year for data, in terms of being able to  
20          use it for trends and being able to site  
21          recommendations for improvement.

22                        Any questions?

1                   Second slide. So, as always, we  
2                   have been doing the Care Coordination Survey  
3                   for three years now and we always look at the  
4                   same elements. So, Section Leaders, RCCs,  
5                   DISCs, Call Center, and our Contact Center  
6                   Staff. So, we have got three years' worth of  
7                   trend data which you can see there from 2011,  
8                   2012, and 2013.

9                   You can see in almost all areas  
10                  that our satisfaction levels have increased or  
11                  stayed pretty steady.

12                  Next slide.

13                  COL BUHL: The areas that we have  
14                  most encouraging results, staff, and I would  
15                  say for myself, across the force, there is no  
16                  more blessed duty in our Marine Corps than  
17                  serving in the Wounded Warrior Regiment. No  
18                  more blessed duty and everybody feels that  
19                  way. And I think a good number of the Marines  
20                  that are in the Regiment, particularly the  
21                  mobilized Reservists, they have had options  
22                  over this last period of war to serve across



1 the Reserve Force and they actively seek to  
2 serve in the Wounded Warrior Regiment. It is  
3 almost a missionary, a sense of duty.

4 Transition, we have a lot of  
5 positive feedback on transition --

6 DR. STONE: How do you correlate  
7 that with the fact that 80 percent of your  
8 staff is Reserve Component, if, in fact, this  
9 is considered by the Marine Corps to be sacred  
10 duty, why isn't it balanced better between the  
11 components?

12 COL BUHL: Because we are a total  
13 force, like all the services. It doesn't  
14 matter whether you are a Reservist or you are  
15 an active duty Marine. And I have served both  
16 as an enlisted Reservist, an Inspector  
17 Instructor --

18 DR. STONE: So, Colonel, as you  
19 move through the reduction in your wartime  
20 funding and are forced then to use your active  
21 component Marine in this work, are you  
22 comfortable that the Marine Corps will view

1 duty and assignment of a young marine to this  
2 in the same manner as they would a line  
3 assignment for future promotion and  
4 evaluation?

5 COL BUHL: Absolutely, sir. I  
6 have sat on two promotion boards: the Wounded  
7 Warrior Regimental billets were briefed well;  
8 the Lieutenant Colonels Board two boards ago,  
9 very solid. I wondered if it was because I  
10 was sitting in the room as a brand spanking  
11 new Regimental Commander in the room with  
12 other peer colonels. Very strongly viewed.

13 One of my battalion commanders out  
14 on the West Coast is a Colonel Select at the  
15 junior enlisted level. The NCOs, we have had  
16 consistent meritorious promotions at Quantico  
17 and other places. We just had our recent  
18 awards with the Marine Corps Association  
19 Foundation for Civilian and Uniform Caregivers  
20 leadership awards that are recognized. There  
21 were 13 general officers in the audience  
22 there. So no, I think the duty is prestigious

1           in that sense and meaningful. And there is no  
2           more active proponent and advocate than the  
3           Commandant of the Marine Corps for it and he  
4           presides over my change of command, himself,  
5           personally, and he doesn't do that for three-  
6           star generals.

7                         So, I do believe that it is, sir.

8                         With regard to transition, I think  
9           that our transition cells at our battalions,  
10          and at some of the detachments as well are  
11          significantly above what the Marine Corps'  
12          fine standards are. We say transition on  
13          steroids. In saying that, we are continuing  
14          to refine the efforts that we have ongoing.  
15          We are trying to ensure, and your help here is  
16          important that we continue to harness the sea  
17          of good will. As the shooting wanes, we don't  
18          want to forget about our wounded, ill, and  
19          injured, and our ill and injured in the Marine  
20          Corps.

21                         We are continuing to leverage  
22          resources and we are providing employment

1 paths and careers and education opportunities  
2 for people. So, I feel good about that.

3 The focus on recovery, I think I  
4 said enough about this just now but it is not  
5 just physical healing. It is spiritual. It  
6 is mind, body, spirit, family. It is all  
7 interrelated. It is not just getting better,  
8 your wounds are healing up. And a lot of  
9 times it is the inner wounds that are the most  
10 challenging.

11 We have built a structure of  
12 support and we have an enduring requirement.  
13 And we think that this structure now, as it  
14 has been refined over seven years can be -- it  
15 can be modulated, God forbid that we should  
16 have another major crisis.

17 So, I believe answering the  
18 question about promotions, we have  
19 institutional buy-in and that the Regiment is  
20 going to endure and continue to be supportive.

21 Next slide, the challenging areas.  
22 Staff coordination. I think communication is

1 the toughest thing that we do. It just is.  
2 And it is tough internally and it is tough  
3 between staff and recovering Marines and it is  
4 tough between their families as well. And so  
5 it is an area that I have emphasized,  
6 especially recently in the wake of these  
7 surveys and we use these results to drive home  
8 the point that we have to get better at that.

9 We have just, finally, it took me  
10 18 months to get Section Leader training  
11 standardized and onboard but our uniformed  
12 "squad leaders" are now formally trained. We  
13 have an established process and we are seeing  
14 immediate results from it. It took too long  
15 but it is working. It is going now. And we  
16 are getting great feedback on that.

17 I already talked about the 31  
18 DISCs in terms of handoff to the VA, warm  
19 handoff and continued support. And that is  
20 the number one thing we see on the Call Center  
21 in terms of areas of being addressed, when  
22 people call in to the Call Center.

1                   And so like I just said, at the  
2                   end of the day, communication is our toughest  
3                   challenge. It is identified there.

4                   MS. PETERSON: The next slide  
5                   speaks to our Reserve response rate. You can  
6                   see that at the time of the survey there were  
7                   42 reservists joined to the regiment. 22 of  
8                   those reservists completed the survey for our  
9                   52 percent response rate. But still with such  
10                  a low number, we reported the percentage and  
11                  the aggregate and 95 percent were satisfied  
12                  with the services provided by the Wounded  
13                  Warrior Regiment.

14                  COL BUHL: Are we eight minutes  
15                  over our time? Okay.

16                  MS. DAILEY: Did April finish  
17                  already?

18                  MS. PETERSON: Yes.

19                  COL BUHL: We hustled for you,  
20                  ma'am.

21                  MS. DAILEY: Well you are over-  
22                  achieving. You are 20 minutes' ahead of time,

1           actually.

2                               So you all don't have any more  
3           questions about the survey program for April  
4           or Colonel Buhl?

5                               I am sure if you give Colonel Buhl  
6           one more question, I bet we could make up  
7           these 20 minutes.

8                               (Laughter.)

9                               COL BUHL: Well, I can talk as  
10          little or as long as you wish. I am very  
11          passionate about what we do. We have never  
12          had anything like this. And for the senior  
13          ladies and gentlemen in the audience who  
14          remember, who have lived through the last  
15          generation, we never had anything like this  
16          for our people. Nothing. They came home and  
17          the nation turned their backs to them. Never  
18          again.

19                              And so that is what our senior  
20          leadership believes right down to the men and  
21          women who are living through this last ten  
22          years of war.

1 DR. STONE: Colonel, if I may ask  
2 one question.

3 COL BUHL: Yes, sir.

4 DR. STONE: You were in the unique  
5 position in the Marine Corps as being a  
6 consumer of services, rather than provider,  
7 much different than the other three services  
8 that we have heard from in the last three days  
9 or the last two days.

10 What is it that you don't have  
11 that you feel you need in order to serve this  
12 population better?

13 COL BUHL: Well, I think that my  
14 greatest challenge, aside from those one-on-  
15 one conversations with peer commanders in  
16 terms of joining, my other greatest challenge  
17 is the same challenge that is shared by all of  
18 us in the force. And there is a constant  
19 battle to get people onboard, stabilized, and  
20 serving. We are constantly challenged with  
21 manpower. And by extension, as the support  
22 structure across the military, across our



1 bases and stations is adjusted, so to speak,  
2 based on budgetary constraints and stuff, we  
3 feel second and third order effects from that.

4 Is it affecting our ability to  
5 take care of our people? Not yet. Not yet.  
6 I believe that we have been fenced, if you  
7 will. We are getting what we need to do what  
8 we need to do. But I worry about it. I am  
9 concerned about it in the future years that we  
10 will feel those second and third order effects  
11 across, whether it is mental health counseling  
12 for family members that we might have talked  
13 about here, other things, services that affect  
14 us indirectly, if you will.

15 So, my big challenge continues to  
16 be getting people but we are getting what we  
17 need. We are getting what we need right now.

18 MR. REHBEIN: Let me ask you to  
19 speculate for just a minute on something that  
20 intrigues me. Ninety-four percent of the  
21 folks that joined the Regiment go into IDES  
22 and leave the Corps.

1 COL BUHL: Approximately.

2 MR. REHBEIN: How much of that is  
3 because of the acuity of the health problems?  
4 Is there something about being in the Regiment  
5 that tells Marines it is time to leave the  
6 Corps?

7 COL BUHL: I think it is always  
8 personal, individual. Every case is unique.  
9 Every individual Marine in his or her  
10 situation, their families are unique, whether  
11 it is the injuries, their age, their time in  
12 life, their career progression, what have you.  
13 But the answer is that in nearly all cases, it  
14 is the medical determination which drives  
15 everything.

16 Marines have sometimes confounded  
17 their doctors and healed and functioned better  
18 than -- they beat the odds. They beat the  
19 statistics and I like to say there is a  
20 separate category in that medical book for  
21 Marines. It is another chart.

22 But it is usually the medical.

1 Medical drives this, sir.

2 MR. REHBEIN: We struggled with, I  
3 personally, have struggled with the concept of  
4 is it better to leave wounded, ill, and  
5 injured with their line unit as much as  
6 possible or is it better to move as many as  
7 possible into something like the Wounded  
8 Warrior Regiment or a Warrior transition unit  
9 in the army and wondered effect being in a  
10 strictly medical recovery unit has on the  
11 psyche of the individual Marine or soldier as  
12 to whether or not it tends to tell them that  
13 maybe their time in the uniform is coming to  
14 an end, just by being in that unit.

15 Questions you can't answer.

16 Questions no one can answer definitively.

17 COL BUHL: I understand what you  
18 are saying.

19 MR. REHBEIN: As we are setting up  
20 or not setting up these kinds of units and  
21 assigning people here or there, depending on  
22 what may be best for them, that is something

1 I think needs to be kept in --

2 COL BUHL: It is a careful,  
3 individual, very personal, specific. We don't  
4 have a process. We have a relationship with  
5 every Marine and Sailor and their families.  
6 And it is a family decision in many cases but  
7 it is driven predominately by the medical  
8 situation. We celebrate every success and  
9 return to full duty. We celebrate it, we  
10 recognize it. We meritoriously promote. We  
11 did not have meritorious promotions during my  
12 time in command with those who come online.  
13 And we tout these and show others what can be  
14 realized. You can come back. Our motto is  
15 "Still in the Fight" and at every level that  
16 is emphasized.

17 So, the mindset is you are a  
18 Marine. You are going to stay in the fight.  
19 You are going to keep pushing. You are going  
20 to come back to full duty. And in so many  
21 cases, it is a deep, powerful, hurtful  
22 emotional conclusion that they cannot remain

1           in active duty in their uniforms and continue  
2           to serve and sew these trials and games and  
3           other things that we do to tie our veterans  
4           back in to continuing to stay a part of the  
5           Regiment and a part of the Marine Corps are so  
6           important and get so much emphasis in and  
7           beyond our command.

8                         This Saturday, I was in Camp  
9           Pendleton. Rob Jones, a sergeant who lost  
10          both is legs in Afghanistan in 2010, a combat  
11          engineer, rode, finished a 5,100 bike ride  
12          that he started in Maine, rode down the  
13          Eastern Seaboard and then rode across the  
14          country, six months, 30 miles a day, through  
15          the winter, blown off his bicycle, specially  
16          modified prosthetics so he could ride upright.  
17          And I was at the finish line there and his  
18          family was there. His little brother who  
19          graduated from high school drove a box truck  
20          all the way up from Maine to San Francisco and  
21          his dad did the final stretch down to Camp  
22          Pendleton. I mean, he is keeping them, us, in

1 the public's eye. I mean I am just giving it  
2 as a quick example, a personal, how important  
3 it is.

4 So, that is what we want. That is  
5 what we strive for. And that is what we  
6 celebrate.

7 MS. DAILEY: Did you all get the  
8 last tasking? Sir, you had sort of tasked the  
9 other services to talk about their post-DD214  
10 requirements. Did you pass that to them while  
11 we were --

12 Okay, we will do that. We do have  
13 a mental requirement for you to answer. What  
14 you are identifying is the what is your  
15 requirement for post-DD214 services?

16 DR. STONE: Just to state it, it  
17 is a for the record. You can respond later.  
18 All the other services are going to come back  
19 with it. We have recognized the fact that in  
20 your post-discharge connection of a Marine  
21 back to the Regiment or to the Corps, you  
22 extend certain services beyond retirement.

1           Why do you feel the need for that? What are  
2           the gaps that you see? And what are other  
3           organizations not doing for your Marines that  
4           you feel need to be done?

5                       MS. DAILEY: And we don't need the  
6           answer right now.

7                       COL BUHL: And I will just say  
8           that I think I have given the answer in Rob  
9           Jones' story and what we say how important it  
10          is to keep our veterans connected to the  
11          current active duty population. We want to  
12          show them what life can be for them that the  
13          best is yet to come. It is important to keep  
14          that connection going and to assist our  
15          Marines to know that they have reach back that  
16          they are still part of a unit. They still  
17          belong. Yes, they are retired but they  
18          belong. They still have a regimental  
19          headquarters there for them. It is important  
20          to us. It is all about our motto, Semper  
21          Fidelis.

22                      MR. WILLIAMSON: Sir, if I may, I

1 think the thing that we have noticed in our  
2 contact with our Veteran Marines through our  
3 Call Center is the gap is many of them don't  
4 ask for help. And our ability to reach out to  
5 them and encourage them to do so through our  
6 DISCs, being able to, literally, take them to  
7 a Veterans Integrated Service Network and  
8 bring them to that facility, to start  
9 receiving the healthcare that they need is a  
10 very important piece.

11 It is the Commandant's intent that  
12 we keep faith for our Marines, the fact that  
13 we still care about them, that they know we  
14 care about them and we are interested in them  
15 receiving the services and support that they  
16 deserve, even if they don't want to ask for  
17 them.

18 COL BUHL: I will add a very short  
19 addition and say that from the years  
20 approximately 2003 to 2007, we didn't have and  
21 in the first year to two that we grew the  
22 Regiment and formed what we have today, we



1 missed people. We didn't give them all the  
2 thorough reviews of their injuries and their  
3 illnesses and we have been steadily making up  
4 for that over time. And many of these are  
5 identified by the Call Center, the Sergeant  
6 German Call Center.

7 MR. WILLIAMSON: One of the best  
8 things that I have heard as being part of the  
9 Regiment is the father of one of our Veteran  
10 Marines who is also a Veteran Marine, I can't  
11 tell you how proud I am to have been a part of  
12 an organization that now takes care of my son  
13 the way that they didn't take care of me at  
14 the end of my service. Very powerful.

15 MS. DAILEY: And we are going to  
16 pass that to you guys as a formal request and  
17 circulate it back to us.

18 And then I did want to ask just  
19 one thing, April, on your slide, your survey  
20 results. And then any last questions and we  
21 will wrap here.

22 Is it concerning to you all that

1 the Call Center, although very high ratings,  
2 is the lowest of your high ratings? Your Call  
3 Center is getting 87, 89, 88 percent. Great  
4 number but there is a lot of resources going  
5 into your Call Center. A lot of money going  
6 in there. Would you not expect something  
7 higher in those percentages?

8 MS. PETERSON: You know I think  
9 when we out-briefed the Call Center on those  
10 results, a couple of things came out of it  
11 when we spoke to the manager. One, when we  
12 released the survey, that goes out via an  
13 email, with a survey link.

14 So, the type of people that choose  
15 to take those surveys are slightly different  
16 than the ones with the joint population when  
17 we do a sampling.

18 So, I think that accounts maybe  
19 for a slight difference. Two, the call  
20 center, oftentimes, depending on the severity  
21 of need, makes one phone call a year vice our  
22 care manager's population who are there every

1 day holding the hands of our Marines.

2 So, it is just a slightly  
3 different type of population. For us when you  
4 consider that they are making one phone call  
5 a year and we have got satisfaction ratings,  
6 this high, meaning Marines, recognize the  
7 services that they are providing and they are  
8 satisfied. To us, sure, it gives us an area  
9 to work on. It wasn't as concerning as if we  
10 had seen that like in 2011, when we had 88  
11 percent for an RCC, that put us on a mission  
12 to make improvements in our RCC program.

13 MS. DAILEY: And what is the  
14 difference between a Contact Center and the  
15 Call Center?

16 MS. PETERSON: So the Call Center  
17 is the Sergeant Merlin German, Wounded Warrior  
18 Call Center. That supports a primarily  
19 veteran population. Our contact cells are  
20 located at both of the Hope and Care Centers  
21 at Camp Lejeune and Camp Pendleton. Those  
22 contact centers support a primarily active

1 duty population. So, they are supporting our  
2 external Marines.

3 And in the cases of the contact  
4 centers, oftentimes they are right there face-  
5 to-face with the Marines that they are  
6 supporting at Lejeune or Pendleton. So, there  
7 is a higher touch than say the Sergeant Merlin  
8 German.

9 CO-CHAIR CROCKETT-JONES: If that  
10 is the last question, then thank you all very  
11 much again.

12 COL BUHL: Thank you. Thank you  
13 very much.

14 CO-CHAIR CROCKETT-JONES: Thank  
15 you for being our final briefing, the most  
16 exciting.

17 And this is the end of our April  
18 business meeting. See you all in May.

19 MS. DAILEY: One last thing, we  
20 did have someone leave something, a very  
21 expensive and sentimental pen. If anyone has  
22 picked up a pen that says Happy Retirement

1 Colonel Phillip Thornton, please bring it over  
2 to this gentleman here. Did you find it? Oh,  
3 great! Great!

4 All right. Yes, see you all in  
5 May. You have a homework assignment for  
6 Tuesday, please. Review of the members'  
7 observations.

8 (Whereupon, at 2:55 p.m., the  
9 foregoing meeting was concluded.)

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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: Task Force on the Care, Management  
and Transition of Recovering Wounded

Before: US DoD

Date: 04-17-14

Place: Arlington, VA

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