

U.S. DEPARTMENT OF DEFENSE

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

+ + + + +

BUSINESS MEETING

+ + + + +

WEDNESDAY
APRIL 3, 2013

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

PRESENT

- SUZANNE CROCKETT-JONES, Non-DoD Co-Chair
- JUSTIN CONSTANTINE, J.D., Member
- RONALD DRACH, Member
- TSGT ALEX T. EUDY, USAF & SOCOM, Member
- CAPT CONSTANCE J. EVANS, USN, Member
- KAREN T. MALEBRANCHE, RN, MSN, CNS, Member
- MG RICHARD P. MUSTION, USA, Member
- STEVEN J. PHILLIPS, M.D., Member
- DAVID REHBEIN, M.S., Member

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ALSO PRESENT

DENISE F. DAILEY, PMP, Executive Director,
Designated Federal Officer
TINA ATHERALL, Executive Vice President,
Hope for the Warriors
MARIE C. BALOCKI, Acting Executive Director
for the Department of Defense Yellow
Ribbon Reintegration Program
RICHARD BANNICK, PhD, FACHE, Director,
Beneficiary and Benefit Analysis &
Evaluation
WILLIAM BRIM, PsyD, Deputy Director, Center
for Deployment Psychology
FRANK C. DIGIOVANNI, Director, Training
Readiness and Strategy, Office of the
Deputy Assistant Secretary of Defense
(Readiness)
SUSAN S. KELLY, PhD, Principal Director,
Transition to Veteran Program Office,
Office of the Under Secretary of
Defense
CAPT JAMI MASON, Navy Liaison Officer for
the Yellow Ribbon Reintegration Center
JOHN MOLINO, Chief of Staff, Wounded
Warrior Project
LISA MORGAN, Family Caregiver Program
Coordinator, Yellow Ribbon Fund
MICHAEL A. PARKER, Wounded Warrior Advocate
MARK E. ROBBINS, CAE, Executive Director,
Yellow Ribbon Fund
DONNA SEYMOUR, Acting Principal Director,
Office of Warrior Care Policy
TRICIA WINKLOSKY, Clinical Health and
Wellness Director, Hope for the
Warriors

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

2 8:06 a.m.

3 MS. DAILEY: Good morning. Welcome
4 to the second day of our business meeting,
5 Wednesday, 3 April.

6 I have all the members that I'm going
7 to have. We'd like to start. And, Ms.
8 Crockett-Jones, please.

9 CO-CHAIR CROCKETT-JONES: All right.
10 Welcome, again, to our second day. With us this
11 morning to provide an oral statement for the
12 public forum we have Mr. Michael Parker, a
13 wounded warrior advocate.

14 Please turn to Tab I for his
15 information.

16 Welcome back, Mr. Parker.

17 MR. PARKER: Well, good morning.

18 Enclosure 5 of DoDI 1332.38 lists
19 conditions that are not considered disabilities
20 and can lead to an administrative separation
21 without DoD disability compensation.

22 Examples of such conditions are sea

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1 sickness, adjustment and personality disorders
2 and sleepwalking.

3 Key provisions of this policy state
4 that the Secretary of Defense must designate
5 such conditions and that these conditions cannot
6 be caused by a compensable disability.

7 The Services abused this policy by
8 administratively separating members found fit
9 by a PEB by stating they had a condition, not a
10 disability, that made them unsuitable for
11 further military services.

12 They simply called a compensable
13 medical issue a condition not constituting a
14 physical disability without the condition being
15 designated as such by the Secretary of Defense.

16 As a result, these members were
17 removed from service due to a compensable
18 condition without DoD disability benefits.

19 I addressed this issue in my DES
20 Outreach #3. As a result, Congress passed
21 legislation in the 2011 NDAA that prohibited the
22 Services from administratively discharging

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1 members for a condition a PEB found fitting.

2 Subsequently, I began seeing cases
3 where members were denied reenlistment for a
4 condition a PEB found fitting.

5 Congress fixed this issued in the
6 F72012 NDAA. The congressional fixes are
7 captured in 10 USC 1214(a).

8 At the time, I and other advocates
9 became concerned that the Services could avoid
10 the new laws by simply not referring members for
11 DES processing.

12 In short, the Services could avoid
13 the law by avoiding PEB fit findings. This
14 concern was validated in two recent cases that
15 were brought to my attention.

16 The first case involved a sailor
17 with ten years of active service with Turner
18 Syndrome.

19 The other case involved a Marine
20 with 11 years of active service with a low back
21 condition.

22 These conditions were required to be

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1 submitted for DES evaluation. Instead, these
2 members were ordered to be administratively
3 separated without disability benefits. I have
4 attached their separation messages for your
5 review.

6 I brought these two cases to the
7 attention of Admiral Nathan last month. As a
8 result, these members are now undergoing proper
9 DES processing.

10 So, thank you, Admiral Nathan.
11 However, there are undoubtedly other such cases
12 out there across the Services.

13 I'm aware of a soldier who was
14 administratively separated in 2009 without DES
15 processing for a compensable mental health issue
16 deemed to be a condition, not a disability.

17 He was subsequently awarded a
18 hundred percent disability rating from the VA
19 for the same condition.

20 I call on the Task Force to make
21 recommendations to DoD and Congress to ensure
22 that such administrative separations are indeed

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1 limited to non-compensable conditions
2 designated by the Secretary of Defense as
3 outlined in Enclosure 5 of DoDI 1332.38.

4 I also ask the Task Force - I also
5 ask that the Task Force recommend that DoD
6 conduct a review to identify and rectify past
7 abuses of this policy.

8 This concludes my statement, unless
9 you have any questions or comments.

10 CO-CHAIR CROCKETT-JONES: As the law
11 stands now, these folks are required to go to the
12 DES, and they are not going.

13 Is that the way it is, or am I missing
14 - I'm trying to understand the situation.

15 MR. PARKER: Well, if you - I have
16 included in my statement Enclosure 5 of DoDI 1338
17 and it lists conditions that are not considered
18 disability.

19 And in those cases, those folks
20 can't be administratively separated without DES
21 processing, but it is limited to those
22 conditions designated by the Secretary of

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1 Defense.

2 So, anybody who has a condition not
3 on that list ought to be going through the DES
4 system, and they're not.

5 They're basically saying, hey,
6 that's just a condition, not a disability. And
7 these are conditions that are clearly outlined
8 in DoD and service regulations as requiring DES
9 processing.

10 MEMBER PHILLIPS: Mr. Parker, you
11 mentioned reenlistment as well.

12 MR. PARKER: Yes.

13 MEMBER PHILLIPS: Is there a
14 difference between the services? Do they treat
15 them differently, would you know?

16 MR. PARKER: Well, this condition has
17 predominantly been in the Navy. I mean, I would
18 say at least 90 percent of the times I've seen
19 this it's been in the Navy and Marine Corps,
20 Department of the Navy generically.

21 So, I haven't seen any cases outside
22 of the Navy where somebody was actually denied

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1 reenlistment for it, but I've certainly seen
2 Navy cases where somebody was found fit by a PEB
3 for a back condition and then he was told he
4 cannot reenlist because of that condition.

5 MEMBER PHILLIPS: Because I was
6 wondering you mentioned motion sickness. Well,
7 I can understand that. But if you transfer to
8 perhaps the Army, then you may not be exposed to
9 those conditions.

10 MR. PARKER: Yes, I would have to
11 agree that that's probably a Navy-centric
12 issues, but there's - folks are airsick or
13 whatnot. There might be other services that
14 have that issue.

15 CO-CHAIR CROCKETT-JONES: Thank you,
16 Mr. Parker.

17 MR. PARKER: Thank you.

18 CO-CHAIR CROCKETT-JONES: This
19 morning we welcome Dr. Susan Kelly, principal
20 director of the Transition to Veterans Program
21 Office, and Mr. Frank DiGiovanni, director of
22 Training Readiness and Strategy.

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1 Are those guys ready to go?

2 Thank you. Dr. Susan Kelly was a
3 member of the DoD VA Employment Task Force and
4 will discuss redesigns to the Transition
5 Assistance Program.

6 Mr. DiGiovanni will address
7 servicemember job training, employment skills
8 training, apprenticeships and internships.
9 Tab J for their information.

10 DR. KELLY: Well, good morning. I am
11 delighted to finally be here to address the Task
12 Force and tell you what the interagency has been
13 working on to redesign the Transition Assistance
14 Program.

15 I've missed a couple of meetings
16 just due to process. That has been overcome.
17 So, let me move right on to this first slide.

18 Bottom Line Up Front is that the
19 interagency redesigned the Transition
20 Assistance Program to establish career
21 readiness standards for military members who are
22 separating from active duty.

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1 So, just like military members have
2 to meet fitness standards, training standards,
3 they will also meet career readiness standards
4 before they separate.

5 You can see some of the key elements
6 of the program. Preparation for separation
7 begins at early in the career. We're calling it
8 accession. It's actually at the first
9 permanent duty station.

10 Military members will be compelled
11 to begin considering what will they do when they
12 separate from active duty. This is a big
13 culture change for the Department.

14 So, we are actually implicating the
15 message that if you are lucky, everyone
16 separates from active duty at some point whether
17 that's at four years after your first term, or
18 after 20 years, 25 years after a career in the
19 military, but everyone will separate and how do
20 you align the military training and the military
21 experience you receive with the civilian
22 occupations that you want to pursue after you

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1 separate.

2 So, it begins at accession. It
3 focuses on individual goals. Again, another
4 big culture change.

5 We're focusing right now on
6 education, either higher education or career
7 technical training or employment.

8 The member develops an individual
9 transition plan. And this individual
10 transition plan is a standardized plan.

11 Now, a standardized form, very
12 holistic. That leads the military member step
13 by step to consider different aspects of their
14 lives including social support systems, what are
15 the needs of their family members, children,
16 spouses, what are the conditions of the
17 geographic location to which they are moving to
18 if they are relocating.

19 And finally, there's a standardized
20 curriculum that is aligned to standardized
21 learning objectives. And those standardized
22 learning objectives build the skills that

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1 military members need to provide the
2 deliverables that allow them to meet the career
3 readiness standards. And you'll see how that
4 plays out in just a minute.

5 We are rolling this out in a phased
6 approach. The first phase going on through 2013
7 is to roll out the transition - the redesigned
8 curriculum which we're calling Transition GPS,
9 goals, plans, success.

10 The second piece of that is in 2014
11 when we embed it across the military life cycle
12 and you can see a scheme.

13 This is notional, actually, of how
14 both active duty and the reserve component would
15 create touch points where their career readiness
16 standards are considered and they start to put
17 plans in place.

18 So, the key differences of the old
19 Transition Assistance Program and the new,
20 redesigned program: Career readiness standards.
21 That's the foundation. There's an expanded
22 timeline so everyone has more time to prepare

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1 rather than in the last 90 days or last year of
2 your career to prepare for separation.

3 The Task Force was also very, very
4 cognizant of the need to build bridges between
5 DoD and Veterans Affairs, between DoD, the
6 Department of Labor in reference to employment,
7 and also academia or technical training schools.

8 So, the bridges were built
9 specifically, and again you'll see that in the
10 career readiness standards.

11 Commanders or a commander designee
12 verifies the military member has met those
13 career readiness standards.

14 We've actually developed a new
15 Department of Defense form called the Individual
16 Transition Plan Checklist in which each one of
17 the career readiness standards is listed.

18 And either the member meets the
19 career readiness standard, or they do not meet
20 that career readiness standard. Yes or no.
21 And they have to show concrete deliverables to
22 meet those career readiness standards.

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1 If the answer is no for some reason,
2 they have time to go back and get recycled into
3 some of the training that they might need, or
4 there is a warm handoff that's documented to our
5 interagency partners, Veterans Affairs,
6 Department of Labor, or any other helping agency
7 that we think that member might need as they
8 relocate to their home where they're going back
9 to or that they're establishing.

10 So, for the first time Command has
11 a role in overseeing that a military member is
12 actually ready for transition to the civilian
13 sector.

14 And we also focus all throughout
15 this process of building the bridges, looking at
16 the gap between the military training and
17 experiences that the military member is
18 receiving while they're in active duty and what
19 they want to do in their civilian career and
20 encouraging them to fill that gap during their
21 military career if they can, for instance, with
22 Transition Assistance Program, in college

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1 courses or even the post-9/11 GI Bill and using
2 that both for higher academia and also technical
3 training.

4 As well as now even looking at some
5 of the entrepreneurial efforts that are going on
6 with the Small Business Administration. So,
7 that's the Bottom Line Up Front.

8 We've moved from a discontinuous set
9 of activities for servicemembers, to a very
10 organized approach with modular curriculum -
11 modules that pertain to the service member's
12 individual goals.

13 You can see all of the interagency
14 partners that were involved with the Task Force,
15 DOL, Veterans Affairs. They've been our
16 traditional partners, but we also have had OPM
17 step up to develop curriculum for finding jobs
18 in the federal sector.

19 Small Business Administration has
20 made a significant commitment to
21 servicemembers. They've developed a two-day
22 entrepreneurial curriculum for servicemembers

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1 if they want to attend.

2 And once they have completed that
3 two-day curriculum, they can sign up for an
4 eight-week online course. And at the end of
5 that course, the military member will have a
6 completely developed business model for their 2B
7 small business, as well as they are matched up
8 with a mentor for life, if they want to, from the
9 small business community in the location to
10 which they're moving. A very large commitment
11 on the part of the Small Business
12 Administration.

13 You can see, again, the modular
14 curriculum. Higher education so that members
15 learn how to make informed decision about what
16 colleges to attend based on the courses of study
17 that that institution offers, if they are also
18 accepting the post-9/11 GI Bill, if they are a
19 Yellow Ribbon university, in other words,
20 matching funds from Veterans Affairs if the GI
21 bill does not pay all of the tuition.

22 So, there's lots of information in

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1 this particular curriculum using web tools so
2 that they not only learn how to do it one time,
3 they learn how to navigate these tools over and
4 over again, because we expect them to access this
5 information over and over again throughout their
6 careers.

7 Same for technical training. How
8 to make an informed decision about the best
9 technical training institutions to attend. And
10 finally, the entrepreneurship track from the
11 Small Business Administration.

12 The VA benefits briefings has been
13 completely updated. And a second one has been
14 added that teaches military members how to
15 navigate VA's eBenefits portal and shows them
16 how to sign up for benefits and register for
17 those benefits.

18 That is in addition to the original
19 VA benefits briefings that they conducted
20 before, as well as we built the mandatory bridge
21 between DoD and Veterans Affairs that all
22 servicemembers have to register in eBenefits.

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1 So, they have - Veterans Affairs has
2 the information on each one of our
3 servicemembers to reach out to them for the rest
4 of their lives.

5 The Capstone event is between the
6 commander or the commander's designee and the -
7 and the servicemember reviewing the individual
8 transition plan, is it a robust, sound
9 individual transition plan, and also verifying
10 those career readiness standards.

11 So, at the end you have a very
12 enriched set of tools for an end-of-term, but,
13 again, our long-term vision is to embed this
14 across the military life cycle.

15 It focuses on the DOL Employment
16 Workshop on critical job skills for today's
17 labor market.

18 Military Occupational Code
19 crosswalk. So, we actually step the members
20 through a comparison of what are the skills that
21 they're getting out of the military experience
22 and training to what is the alignment in the

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1 civilian occupational code, what are the skills
2 that they need in that civilian occupational
3 code or the certifications, the licensure, and
4 then that lines them up to then choose whether
5 they're going to go to the education track or the
6 career/technical training track.

7 So, they have to actually identify
8 the gap between what they're getting out of their
9 military careers and what's in the civilian
10 world.

11 If, for instance, without combat
12 arms folks there is no specific MOC that
13 corresponds to the civilian occupational codes,
14 it educates them about how to use this tool and
15 how to look at the civilian occupations that are
16 available in the civilian job market.

17 But in that course, we also nudge
18 them along one more step. Go to the geographic
19 location to which you are moving, look at the
20 labor market in that geographic location.

21 Does that labor market demand the
22 civilian occupation that you are entertaining to

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1 go into?

2 If not, what's your Plan B? Because
3 there's an indication that either you have to
4 choose a new career field, or you need to choose
5 another geographic location so that you have a
6 good quality of life.

7 So, we're nudging them along to
8 consider these things far earlier than in the
9 last couple of weeks of their active duty.

10 MEMBER DRACH: Doctor, excuse me.

11 DR. KELLY: Sure.

12 MEMBER DRACH: Okay. Now, this is
13 being built into the full military life cycle.

14 So, somebody that's coming on to
15 active duty today, when will he or she develop
16 their transition plan? How soon after entry?

17 DR. KELLY: Our long-term goal is to
18 embed this across the military life cycle for
19 2014.

20 MEMBER DRACH: Okay.

21 DR. KELLY: There's already a DTM
22 that has been published that requires career

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1 readiness standards and the development of
2 individual transition plans.

3 In 2013, we are putting those
4 processes in place.

5 MEMBER DRACH: Okay. All right.

6 Now, your second dot point there
7 talks about the unique education, technical
8 training and entrepreneurship tracks.

9 DR. KELLY: Yes.

10 MEMBER DRACH: So, that's part of the
11 modular curriculum, but that doesn't kick in
12 until when?

13 Are we actually getting ready to go
14 through the transition?

15 DR. KELLY: Actually, we are piloting
16 that. Small Business Administration has
17 completed their pilots and is rolling that out
18 now across the installations.

19 The education track, we've piloted
20 that. We're starting to roll that out across
21 the installations.

22 The career technical training rack,

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1 we just piloted. We're rewriting the
2 curriculum.

3 MEMBER DRACH: But when does that
4 track start in the individual's transition
5 cycle?

6 DR. KELLY: It can - whenever they -
7 if we - once we put into the military life cycle,
8 it can be at any point.

9 MEMBER DRACH: Oh, okay.

10 DR. KELLY: There's no mandatory
11 point that you have to start this.

12 Our answer to that is, though, is to
13 make it accessible at any time. And we're
14 putting all of these curriculums into a virtual
15 curriculum that can also be accessed 24/7 by
16 servicemembers at any time during their military
17 life cycle.

18 So, they'll both have brick and
19 mortar and a virtual curriculum that tracks
20 their participation in those curriculums.

21 MEMBER DRACH: So, who in the chain
22 of command has responsibility to making sure

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1 that the transition plan is developed, the
2 checklists are proper and it's followed up on?

3 DR. KELLY: The unit. The command.

4 MEMBER DRACH: Unit command.

5 DR. KELLY: Yes.

6 MEMBER DRACH: Are you seeing any
7 pushback? I mean, that's an additional heavy
8 responsibility for the unit command.

9 DR. KELLY: It is a heavier
10 responsibility. But as was said at the DMAG, we
11 have a surge of people coming who have served us
12 for the last ten years in this long war. They
13 deserve our full attention with this.

14 And with the DTM, the Decision-Type
15 Memorandum, coordinated across the Department,
16 across the services and everyone signed up for
17 that.

18 MEMBER DRACH: I may be getting ahead
19 of your presentation, but - and I know this is
20 pretty new: What kind of accountability
21 standards are going to be implemented to make
22 sure that it's -

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1 DR. KELLY: Let me get to that, okay?

2 MEMBER DRACH: Thank you.

3 DR. KELLY: But, please, if I don't
4 address it fully, bring that up again.

5 So, this is Transition GPS. You get
6 pre-separation counseling. That was the only
7 mandatory piece in the program prior to the TAP
8 redesign and prior to the VOW Act.

9 There's a core curriculum which is
10 the DOL Employment Workshop, again mandated with
11 some exemptions by the VOW Act.

12 Transition overview. We want
13 people to be aware of the dynamics that they're
14 about to go through in reference to transition
15 moving from one culture to another culture.

16 The MOC Crosswalk I described.
17 Resilient transitions. We actually bring to
18 the surface the issues of PTSD, military sexual
19 trauma, other issues that military members may
20 be facing, and there is a strong encouragement
21 to take care of those concerns now. Please go
22 to the behavioral health specialist, please go

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1 to the subject matter experts. And those
2 resources are given to the military members.

3 Once again, the message is we don't
4 want you leaving the service with these burdens.
5 Let us address those now.

6 MEMBER DRACH: I'm sorry, another -

7 DR. KELLY: Sure.

8 MEMBER DRACH: On the MOC Crosswalk,
9 what are you - are you using the MOC Crosswalk
10 that's in the National Resource Directory?

11 DR. KELLY: We're using the MOC
12 Crosswalk - they get - they use their VMATs and
13 they use their own military documents.

14 We use O*NET to show the crosswalk
15 between the civilian occupational codes to the
16 civilian codes. And then we use My Next Move on
17 the DOL website that takes them to the labor
18 markets across the United States and shows them
19 what is in demand in those labor markets.

20 It actually has - shows them green
21 careers. It also gives them projections for
22 certain - for certain career fields across ten

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1 years, if it will be growing, if it will be
2 decreasing. It's a very robust tool that the
3 Department of Labor has developed.

4 MEMBER DRACH: Well, the reason I ask
5 that question is I know that the NRD has a
6 crosswalk. And we also know from site visits
7 that nobody knows but the NRD.

8 So, if the NRD is going to be the
9 primary tool for the MOC Crosswalk, I think
10 there's a lot of work that needs to be done
11 particularly with the current cadre of
12 transitioning servicemembers, the wounded, ill
13 and injured that we're seeing at the site visits.

14 DR. KELLY: The National Resource
15 Directory is identified as a resource, but it
16 actually is not used as the tool in the
17 curriculum. It's O*NET and My Next Move.
18 There are other resources that are listed,
19 though, in the curriculum.

20 We used several websites across the
21 curriculum. We acknowledged that they're not
22 the only websites, but we have a limited time and

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1 a limited opportunity to teach them how to
2 navigate some of those tools in depth and to get
3 the information that they need, but the other
4 resources are always identified.

5 MEMBER DRACH: Thank you.

6 DR. KELLY: You also have financial
7 planning so that the career readiness standard
8 that's met by the financial planning is a
9 12-month post-separation budget.

10 The Consumer of Financial
11 Protection Bureau helped us develop that
12 curriculum.

13 You also have, again, a VA benefits
14 briefing and eBenefits enrollment, and then the
15 ITP review.

16 You have the tracks, your choice of
17 the tracks. And then you have the capstone
18 event where the ITP and the career readiness
19 standards are verified.

20 These are the curriculum outcomes -

21 MEMBER REHBEIN: Before we go on, let
22 me follow up on something that Ron was saying.

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1 There's a lot of work going on in the
2 credentialing area out there in the various
3 state legislatures.

4 DR. KELLY: Absolutely.

5 MEMBER REHBEIN: And so, that's going
6 to affect the service member's decision where to
7 go as much as - as much as the availability of
8 a job in their particular area, the ability to
9 credential -

10 DR. KELLY: To get -

11 MEMBER REHBEIN: - to work in that
12 field.

13 DR. KELLY: And to get -

14 MEMBER REHBEIN: So, will -

15 DR. KELLY: - a credit for their
16 military experience and credentialing.

17 MEMBER REHBEIN: So, will that become
18 part of your database that the - and, frankly,
19 keeping up on that patchwork is a very - it is
20 an annual task that is going to require
21 significant effort.

22 DR. KELLY: And you bring up a very

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1 good point. We are only getting started in
2 developing this redesign and to implement it.
3 And we certainly see it constantly evolving
4 because we want to see much of this area mature
5 and become even richer for our military members.

6 Credentialing is a perfect example.
7 There are lots of examples of that that we hope
8 that we will have to be renewing over and over
9 again, but that is exactly why we reverse
10 engineered this entire program.

11 We started with what do we want
12 military members to leave with? Then we
13 established the learning objectives. Then we
14 built a curriculum around those learning
15 objectives. And then we built the time that's
16 needed for each one of those learning objectives
17 in that curriculum. So, it's a reverse
18 engineering process.

19 So, this is what the military
20 members come out with. These are the pieces
21 that they need.

22 In the core curriculum, you see this

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1 continuum of military service. All the
2 military members are expected to consider the
3 offer to go into the reserve component or the
4 national guard.

5 For our active duty, see the MOC
6 Crosswalk. We ask them to document their
7 licensure and certifications. Registration
8 for any benefits, the budget and the ITP
9 Checklist.

10 In the Employment Workshop, we build
11 that bridge to the Department of Labor's
12 American Job Centers. There's a job
13 application, or there's a job application
14 package that they have to develop before they
15 leave. Again, your resume, get your personal
16 references, your professional references in
17 place before you leave. Two job applications,
18 or the actual job offer letter.

19 The education track and career
20 technical training in the education track, we
21 ask them to do an assessment.

22 The services can choose which

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1 assessment tool they want to use in that
2 particular place, but we also again connect them
3 to the universities.

4 So, their career readiness
5 standards requires them to have a confirmed
6 one-on-one counseling with the advisors at those
7 institutions.

8 And then finally, the
9 entrepreneurship track. So, it's verifiable
10 tangible outcomes.

11 This is our way ahead. Again, we
12 are busy at the installation level trying to
13 implement this. Get the curriculum in place,
14 get trainers, get facilitators trained.

15 This is a shared program with
16 Veterans Affairs. They're training their
17 instructors. Department of Labor have trained
18 and contracted their instructors. They are all
19 deployed to the 206 installations.

20 Our staff at the Transition
21 Assistance Program or at the Family Readiness
22 Centers are being trained. There's a lot going

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1 on.

2 We have an MOU across the
3 interagency. Again, this is a very large
4 effort. We are coordinating that MOU right now.

5 We are looking at performance
6 measures and embedding those processes, as well
7 as assessment processes, getting those in place.

8 And I'll address that, because you
9 asked for that. We've actually established an
10 online assessment so that each participant goes
11 through. As they complete each module, there's
12 an assessment of the - if they mastered the
13 learning objectives, if - we're monitoring their
14 confidence level, if this course gave them what
15 they expected, as well as we ask them to evaluate
16 the facilitators and the facilities at the
17 installation level.

18 That is all anonymous. There is no
19 PII attached to it. We will provide those
20 reports at the installation level so that the
21 installations can keep track of how well their
22 facilitators are doing, how well their local

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1 program is doing, but all the more important is
2 for us to stay - to make sure that the curriculum
3 stays relevant and is doing what we hope it to
4 do. And to have a constant feedback from the
5 servicemembers themselves.

6 We also had the Task Force establish
7 performance measures, career - a number of
8 military members meeting career readiness
9 standards, military members attending the
10 mandatory pieces.

11 There is a whole swath of
12 performance measures, 17 that the Task Force
13 established both short-term, mid-term and
14 long-term.

15 One of those long-term performance
16 measures being the completion rate of military
17 members in their courses of study at the
18 universities and at technical training
19 institutions.

20 You can understand that we're having
21 some time putting that data collection process
22 in place.

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1 Implementing across the military
2 life cycle, and you're right. That is going to
3 be a heavy lift.

4 And then continue to seek the
5 support of other external partners. Very much
6 engage with academia.

7 Again, one of the recommendations of
8 the Task Force was to identify best practices on
9 our college campuses that support and embrace
10 our military members coming to those campuses,
11 identify those and promulgate those across the
12 universities. So, the Department of Education
13 is very much engaged with that effort.

14 Lots of work going on in other areas
15 beyond just the first four recommendations in
16 the Transition GPS, which is what I've briefed
17 to you today.

18 MEMBER PHILLIPS: A question about
19 the education track.

20 DR. KELLY: Yes, sir.

21 MEMBER PHILLIPS: You may not have
22 the answer specifically related to the GI Bill

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1 and for-profit universities versus standard
2 educational institutions.

3 Would you have any percentages or
4 information on the number of servicemembers that
5 enter these programs versus completing the
6 programs?

7 DR. KELLY: That's what the
8 Department of Education and Veterans Affairs is
9 looking at now.

10 They're looking at the usage of the
11 post-9/11 GI Bill and the successful completion
12 of that.

13 I would have to defer to both of
14 those organizations for that data.

15 MEMBER PHILLIPS: It would be, you
16 know, I've read that - again, I don't know how
17 accurate these numbers are when you see them in
18 the papers or on the internet. And I know some
19 of the senators have been concerned about this,
20 Harkin and others, that there's a fairly robust
21 entrance rate into these programs, but a very,
22 very low, less than five percent completion rate

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1 and, you know, wondering why this is happening.

2 Are these numbers accurate? Is
3 there something that can be done to modify this?

4 DR. KELLY: I don't have the specific
5 numbers, but I can tell you that with the Task
6 Force there were several offsite week-long
7 working groups, multiple working groups and much
8 of what we have done and put in place is based
9 on those very concerns.

10 We wanted - we knew that there was
11 a low completion rate of the coursework. I
12 don't know what those statistics were, but
13 that's what VA and the Department of Education
14 brought to the table, one of their concerns in
15 redesigning the Transition Assistance Program,
16 which is exactly why we have the higher education
17 track and we have the technical training track.

18 MEMBER PHILLIPS: And what concerns
19 me is if we cannot identify the reasons, I mean,
20 they may be very valid reasons, Congress may just
21 cut the budget, you know, knee-jerk reaction.

22 And so, I think it would be important

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1 to some way we can determine, you know, what
2 those numbers are and why they are and are there
3 alternate beneficial programs that are
4 occurring?

5 DR. KELLY: And we heard from both the
6 Department Ed, VA, some of the VSOs that some of
7 our campuses were not necessarily welcoming or
8 supportive.

9 Our servicemembers going back to
10 those campuses are different from their peers.
11 And that was one of the issues that we tried to
12 address again by building that connection and
13 also making some of the recommendations in the
14 Task Force.

15 MEMBER DRACH: Doctor, what impact,
16 if any, do you see this new TAP having on DTAP?

17 Now, I know a lot of this is in the
18 future. For example, the implementation
19 October 2013, October 2014.

20 So, a lot of the wounded, ill and
21 injured that are transitioning now are not going
22 to get much benefit out of some of this. They

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1 may get some out of some of the other.

2 But from some of the site visits that
3 I've been on, and I haven't been on all of them,
4 obviously, we're hearing - I'm hearing that some
5 of these wounded, ill and injured are going
6 through DTAP, but they're not going through TAP.

7 And DTAP, you know, is minuscule
8 compared to TAP in terms of all the services and
9 benefits.

10 And how will you assure that the
11 wounded, ill and injured in the future will be
12 part of this TAP even though as they go in,
13 obviously they're going to start in the cycle,
14 but now we've got a cadre of people that are in
15 the transition process.

16 So, how do you see this impacting,
17 if at all, the current cadre of wounded, ill and
18 injured?

19 DR. KELLY: Well, first of all we have
20 a problem with the terms that we use. Because
21 when a lot of people say "TAP," they automatically
22 think of the Department of Labor Employment

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1 Workshop. They are not considering the entire
2 Transition Assistance Program.

3 Some people think that TAP is
4 pre-separation counseling, because that was the
5 only piece that was mandatory. So, we have some
6 confusion out there on what TAP really is about.

7 In reference to DTAP, that is a VA
8 benefits contribution to the program. Right
9 now as we're rolling this out, you have both the
10 legacy briefings by VA, including the separate
11 DTAP. So, you have a VA benefits briefing, you
12 have the additional DTAP.

13 And the redesigned TAP you have DTAP
14 included in their revamped VA benefits briefing
15 I, and then you have the VA benefits briefing II,
16 which actually is the discussion of enrolling in
17 eBenefits, as well as how to file for disability
18 claims, et cetera, and all the other benefits
19 that VA offers.

20 So, you have - right now you have
21 some inconsistencies across the installations,
22 because we're rolling this out in a spiraled way.

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1 So, VA has some facilitators
2 delivering the new VA benefits briefings. At
3 other installations they have facilitators who
4 are providing the legacy briefing. But
5 everyone with no exception by the new policy, the
6 new DTM, has to - everyone has to go through
7 pre-separation counseling and the VA benefits
8 briefing.

9 MEMBER DRACH: But what about the -

10 DR. KELLY: Either legacy, or the
11 new.

12 MEMBER DRACH: Does that include the
13 DOL Employment Workshop?

14 DR. KELLY: The DOL Employment
15 Workshop is also mandatory by the VOW Act, but
16 there are exemptions to the VOW Act as allowed
17 by Congress.

18 And one of those exemptions, we
19 built this very carefully and Denise Dailey was
20 very, very strong in the advocacy of this group,
21 that wounded warriors who are enrolled in other
22 transition assistance programs that focus on

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1 either school placement or job placement, can be
2 waived from the DOL Employment Workshop, but
3 it's - they have to agree to be exempted from the
4 workshop.

5 So, it is still open to them.

6 MEMBER DRACH: Well -

7 DR. KELLY: So, if you mean TAP, the
8 DOL Employment Workshop, they can be exempted,
9 but they have to agree to be exempted. And
10 that's what we did with all of the waivers to the
11 DOL Employment Workshop, now waivers the
12 exemptions that were put into policy.

13 MEMBER DRACH: Well, my concern is
14 that DTAP since its inception in the early `90s
15 has been consistently a standalone program.

16 DR. KELLY: Yes.

17 MEMBER DRACH: It's not been
18 integrated into TAP.

19 And I may be misreading something
20 here. I don't see DTAP being integrated into
21 TAP. I see it still focused as a standalone
22 program and -

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1 DR. KELLY: No. No, VA as - and I would
2 prefer to let VA speak to this, but I do know that
3 the DTAP portion was rolled into the four-hour
4 briefing that VA now offers in VA benefits
5 briefing 1.

6 So, it has been integrated into the
7 TAP GPS.

8 MEMBER DRACH: Well, you may be the
9 wrong person to talk to on this, but it's still
10 going to be - it's a four-hour briefing, you
11 know.

12 And DTAP is so, in my opinion, so
13 inadequate because it misses so many things. It
14 doesn't talk anything about disability rights.
15 It doesn't talk about protections under the
16 Americans with Disabilities Act. It doesn't
17 talk about ten-point veterans preference. It
18 doesn't talk about special appointing
19 authorities to get into the federal government,
20 you know.

21 It's a veterans benefits briefing
22 and, I'm sorry, I think it just falls far short

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1 of doing what you're proposing to do here or are
2 doing there, which I think is great. Thank you.

3 DR. KELLY: But I'll carry that - I'll
4 carry that back to my VA counterpart.

5 MS. DAILEY: We can get them in. I
6 suspect if you give me their names, I can get them
7 in to brief what they are doing in the GPS in the
8 overall redesign in detail.

9 DR. KELLY: Yeah, that would be
10 excellent.

11 MS. DAILEY: Yes, we can do that.

12 MEMBER MALEBRANCHE: Dr. Kelly.

13 DR. KELLY: Yes.

14 MEMBER MALEBRANCHE: There's also
15 this - maybe this is part or grew out of this,
16 but there is this Veteran Success on Campus Gap
17 Analysis Working Group -

18 DR. KELLY: Yes.

19 MEMBER MALEBRANCHE: - that
20 Department of Education and VA are working.

21 Is that as a result of this or part
22 of this, or is that flowing into this?

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1 DR. KELLY: I think this was one of
2 the compelling functions of it, yes. And those
3 best practices, Department of Ed has already
4 done some - held some convenings to hear inputs
5 from the universities.

6 And Curt Coy at VA is very much
7 engaged in that, but they also have an executive
8 order that required pieces. And that executive
9 order came after the recommendations were built
10 from the Task Force, but they are certainly -
11 they are certainly aligned.

12 MEMBER MALEBRANCHE: Okay, because I
13 think part goes back to what Dr. Phillips was
14 talking about. And they noticed that when they
15 were first looking about the number going in and
16 the number actually graduating and trying to
17 find out those purposes.

18 And the other thing I was going to
19 ask about this since this is somewhat new, is
20 this - and unit commanders or, I guess, or people
21 throughout the life cycle of soldiers, Marines
22 and servicemembers are going to look at this, is

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1 this built into the very initial basic training?

2 I mean, when you come in, this is
3 what you're going to - you will be having?

4 DR. KELLY: The services advised
5 against that, because during basic training
6 they're just trying to survive, get through
7 basic training. That is not the time to be
8 saying when you get out.

9 We're just trying to give you the
10 skills to get in, and maybe General Mustion can
11 speak to that with some authority, but the
12 services advised against that.

13 However, what I can tell you is that
14 anecdotally I understand that recruiters are
15 starting to use this to say we are going to help
16 you align once you get out of the military into
17 civilian careers.

18 General Mustion, do you have a
19 response to that?

20 MEMBER MUSTION: Where we start the
21 program is 60 days after you get to your first
22 permanent duty station. And that's a

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1 discussion that being with the chain of command,
2 the retention NCO or the career counselor
3 developing the early stages of the transition
4 program that Susan talked about and then
5 building on that. What are your career goals?
6 What are your career aspirations?

7 And then as you progress through
8 your career at about - it's really supposed to
9 be about every 180 days there is an engagement
10 with you and your chain of command, first-line
11 supervisor or the company commander, the first
12 sergeant and up.

13 Now, as far as accountability for
14 making sure it gets done, it's part of our
15 organizational inspection programs.

16 The brigade commander at the O6
17 level is held accountable for making sure that
18 it's being done and accomplished in a routine
19 manner.

20 And no later than 165 days prior to
21 a soldier's ETS date, a decision is made. That
22 decision is am I going to reenlist, or am I going

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1 to pursue transitioning from the Army?

2 And if it's transitioning from the
3 Army, that's when the workshops begin. That's
4 when some of the other - you start down that other
5 career paths that Susan spoke about.

6 And it's a measure of progress
7 integrated IT capability we have that allows us
8 to track have they completed this, have they
9 completed that, notes maintained in what we call
10 the ACAP 21 system.

11 So, we can track what's happened
12 with the soldier, the decisions that the
13 soldiers made, the engagements.

14 Tied also to GoArmyEd, which is our
15 enterprise education system, which allows us to
16 track how well the soldier is doing in completing
17 his education degree, his career track or his
18 education program, his progress in completing
19 that career program as the program gets ramped
20 up.

21 So, I think it's not perfect. As
22 Susan said, it's still a work in program, but

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1 we're headed in the right direction.

2 CO-CHAIR CROCKETT-JONES: I have a
3 question for you.

4 And those who are entering the IDES
5 and are preparing for their transition out for
6 medical disability, some of those folks rely on
7 a spouse to get through especially the folks, you
8 know, we see a lot of TBI folks who are having
9 memory and cognition issues.

10 DR. KELLY: Right.

11 CO-CHAIR CROCKETT-JONES: I'm
12 wondering basically once it - how this will be
13 open to spouses helping. I mean, if DTAP is
14 being sort of pulled into this, there is - it kind
15 of raises my concerns about eligibility for a
16 spouse to sit right seat/left seat with, you
17 know, their servicemember kind of, you know,
18 making sure that they take the notes and get this
19 done and know what they're supposed to do sort
20 of as homework.

21 DR. KELLY: Right. Well, we
22 reiterated in the DTM that spouses are

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1 encouraged to attend the Transition GPS
2 curriculum.

3 We are also seeing, though, that the
4 virtual curriculum is an answer for those
5 spouses also so that they can access that virtual
6 curriculum as they go through it, because this
7 is meant to be 24/7. You can access it at any
8 time because part of it you can do the exercises
9 - there are challenges in this curriculum and you
10 can complete that and then hold off completing
11 the rest of the module.

12 So, it's a skills building and we're
13 trying to make that available to the spouses
14 also.

15 We think virtual curriculum can be
16 a real - a real help with that. Also, even those
17 servicemembers with those cognitive
18 difficulties can access it, take it step by step.

19 But before they get certified, they
20 have to complete that assessment so that we can
21 know how this curriculum is meeting their needs.

22 And we are going to be very reliant

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1 upon that assessment tool. That's why we made
2 it without any personal identifying information
3 so that we can get the truly - get to ground truth
4 on the curriculum and constantly be improving.

5 CO-CHAIR CROCKETT-JONES: Is the
6 virtual stuff able to be repeated and repeated?

7 DR. KELLY: Yes, yes.

8 So, but we are only now having the
9 funding transfers from the interagency
10 partners.

11 It's actually going to be hosted on
12 Joint Knowledge Online, JKO. That's where
13 military members go now to get their joint
14 military training.

15 So, this training will be seen part
16 of military training. So, again, that's a step
17 that we're trying to embed it into the military
18 culture. This is a part of what you're expected
19 to do.

20 And the servicemembers will be able
21 to access that. And even after they separate,
22 they should be able to access it as veterans

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1 also.

2 So, those are some of the things that
3 we're working on. Again, I do not want to over
4 promise. And I want to make clear that we are
5 just now getting started in rolling this out,
6 getting staff trained, getting the program in
7 place, finalizing - we have most of the
8 curriculum finalized, but still finalizing some
9 of the special tracks and putting the assessment
10 processes in place, getting those data captures
11 in place.

12 So, wish us good luck. And if
13 there's any other questions, I will definitely
14 take those other questions to VA.

15 Denise, I'll give you the names for
16 that and then I hope to be back again.

17 MEMBER MUSTION: Susan, can I ask a
18 question?

19 DR. KELLY: Yes.

20 MEMBER MUSTION: I mean, I applaud
21 what we're doing to prepare soldiers for
22 transition. And I understand the partnership

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1 that is supposed to exist with DOL.

2 I'm not exactly sure it's a perfect
3 partnership just yet, but what are we doing to
4 measure the effectiveness of the program 12
5 months after the soldier separates from the
6 service?

7 DR. KELLY: There are -

8 MEMBER MUSTION: Because what's
9 missing in all this is the connection of a
10 soldier to a job or the soldier to a specific
11 opportunity.

12 DR. KELLY: Both DOL and VA have
13 stepped up to that to surveying our veterans at
14 certain time points. Perhaps at six months, at
15 12 months. They are putting that process in
16 place right now.

17 MEMBER MUSTION: What's the measure
18 of success?

19 DR. KELLY: the measure of success
20 for the Department of Defense is for military
21 members to meet career readiness standards.
22 That is the culture change that we're

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1 inculcating.

2 The long-term outcomes are captured
3 in those other performance measures that I
4 discussed for each one of the interagencies, DoD
5 - I mean VA/Department of Education in reference
6 to course completion, how well our Post-9/11 GI
7 Bill is actually being used, VA/DOL in reference
8 to outcomes for military members.

9 We're looking at the trends in UCX,
10 because there are lots of external factors
11 impacting the use of unemployment compensation.

12 So, there are several pieces that
13 we've identified and report to the president
14 that we'll be looking at.

15 But for the Department of Defense on
16 this side if they meet career readiness
17 standards, if we have prepared them well to meet
18 the career readiness standards so as they go out
19 the door they have a solid, individual
20 transition plan.

21 And which is why we also made it one
22 of the commander's focuses.

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1 MEMBER REHBEIN: The general just
2 made a good point. It doesn't matter which
3 track they go down whether it's education,
4 whether it's employment, whatever it might be,
5 the end result, the measurement of success is the
6 job.

7 DR. KELLY: It's the job -

8 MEMBER REHBEIN: It's not -

9 DR. KELLY: - but it might not be an
10 immediate job. It can be a job after they've
11 gone through the course of study -

12 MEMBER REHBEIN: Having spent -

13 DR. KELLY: - even a four-year
14 degree.

15 MEMBER REHBEIN: Having spent the
16 major portion of my life on a university campus,
17 we see large numbers of young people that come
18 to the university, do well, graduate and then
19 discover that they are in a field where there are
20 four applicants for every job.

21 Will that sort of information be
22 made available to the people that are entering

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1 the education track trying to project -

2 DR. KELLY: Is that -

3 MEMBER REHBEIN: - as they -

4 DR. KELLY: Is that made available to
5 any student entering our universities?

6 MEMBER REHBEIN: Much more now, yes.

7 DR. KELLY: Okay.

8 MEMBER REHBEIN: Because we see so
9 many young people out there with 60, 70, hundred
10 thousand dollar loan bills and minimum wage
11 jobs.

12 DR. KELLY: But that's exactly why we
13 built in the MOC Crosswalk and also the
14 Department of Labor touches upon that using that
15 My Next Move in combination with O*NET to look
16 at what is the labor market in the area to which
17 you're going, what is the career field that are
18 going to be growing or declining over the next
19 several years.

20 MEMBER REHBEIN: And that
21 information will also be then involved when the
22 military member is choosing the course of study

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1 -

2 DR. KELLY: That is exactly -

3 MEMBER REHBEIN: - in the education
4 track.

5 DR. KELLY: That should be the
6 launching point.

7 MEMBER REHBEIN: Yeah.

8 DR. KELLY: That's exactly right.

9 MEMBER REHBEIN: Okay.

10 DR. KELLY: When they should be
11 choosing if I'm going to go into higher education
12 or if I'm going into career technical training
13 and what career field I want to go into, that's
14 exactly why we built those pieces in that MOC
15 Crosswalk.

16 Because it's not only a career field
17 nationally. It's the labor market where you're
18 moving to that you want to know about. And the
19 Department of Labor builds that through the
20 Bureau of Labor Statistics and also from
21 industry, what industries are growing, I said,
22 or declining.

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1 But a core piece of this is how do
2 we align the training and the certification and
3 even the licensures that they get as a military
4 member with what's required in those career
5 fields and are the states going to recognize
6 those certifications and those licensures and
7 those trainings to give them credit for that
8 rather than having to go back into the
9 universities or the institutions to get
10 additional training that they're already really
11 met through the military training.

12 And that is a big - that is a core
13 piece to this. And that's exactly why Mr.
14 DiGiovanni is here from Readiness to talk to you
15 about the efforts in credentialing and licensure
16 with a separate task force.

17 I mean, DoD saw that as - saw it as
18 such a big undertaking that there's a separate
19 task force for that.

20 MEMBER REHBEIN: And in answer to
21 your question are young people getting that
22 guidance, yes.

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1 The guidance counselors in the high
2 schools if they're worth any part of their
3 paycheck, are telling the young - telling kids,
4 okay, if you go into that field of study, the job
5 market is pretty small. You not only have to
6 graduate. You have to be the best.

7 DR. KELLY: Well, that's why we -

8 MEMBER REHBEIN: And so, they are
9 helping - they are helping steer people away from
10 those fields where, yeah, you get the degree, but
11 then it doesn't do you any good.

12 DR. KELLY: Yeah. Or if it's really
13 a degree with your passion, you have to recognize
14 what the risks are.

15 But that's exactly why within DoD we
16 took on building the education track. And we
17 built that upon the expertise of the education
18 counselors that are at the installations.

19 So, as the Task Force was building
20 this, then we discovered that some of the
21 services had cut those education officers. And
22 now, we're scrambling to bring them back,

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1 because we built this upon their expertise that
2 there should be individual counseling going on
3 also throughout the military career.

4 MEMBER DRACH: I'm sorry. David's
5 comments bring out the importance of dual
6 tracks, because you mentioned earlier in your
7 presentation the labor market information, LMI,
8 which is part of the employment track.

9 DR. KELLY: Right.

10 MEMBER DRACH: So that these
11 individuals are being given information on labor
12 market information so that they can help
13 possibly choose a career.

14 But if they need the education track
15 to gain the education needed to pursue that
16 career, then they may not be getting the LMI if
17 they're only in the education track.

18 Now, that being said, one of the
19 problems that I've seen historically is that
20 veterans and non-veterans go to college to
21 pursue a degree in which they want. Has no
22 relevance to what the real world of work is.

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1 Plus, 80 percent of all college graduates are
2 working in fields that they didn't study in.

3 So, you know, it's kind of - it's a
4 double-edged sword.

5 DR. KELLY: Uh-huh. But, again, if
6 you've ever had the opportunity to sit through
7 the curriculum, you will see it is all
8 interlinked.

9 It was built as the agencies being
10 interdependent upon each other to deliver the
11 curriculum. And the curriculum has threads
12 that go throughout each one of the tracks.

13 So, you have the MOC Crosswalk.
14 That's reinforced in the Department of Labor
15 Employment Workshop. That sets them up for the
16 tracks of their choosing.

17 Anything else? Ms. Dailey?
18 Chairman?

19 MS. DAILEY: I just wanted to - there
20 has always been a concern about long-range
21 effectiveness of the programs. And I just want
22 to make sure I understand.

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1 The DoD's measure is getting
2 individuals through these tracks, qualifying
3 them before they leave, ensuring they've got the
4 information, they've been through the tracks and
5 they've provided those deliverables.

6 That's going to be DoD's measure,
7 correct?

8 DR. KELLY: That's going to be DoD's
9 meeting the career readiness standard.

10 MS. DAILEY: Okay.

11 DR. KELLY: But also as well as the
12 ongoing assessment coming from the
13 servicemembers -

14 MS. DAILEY: Correct.

15 DR. KELLY: - that the curriculum is
16 staying relevant to them -

17 MS. DAILEY: Correct.

18 DR. KELLY: - and that their
19 confidence has increased and it delivered to
20 them what they wanted.

21 So, there are two pieces of that.

22 MS. DAILEY: Okay.

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1 DR. KELLY: As well as the
2 performance measures, we're also the point of
3 contact to collect the performance measures
4 across the board -

5 MS. DAILEY: Okay.

6 DR. KELLY: - from all of the
7 recommendations from the Task Force.

8 MS. DAILEY: Okay.

9 DR. KELLY: Which are both, again,
10 short-term, mid-term and long-term.
11 Short-term being those career readiness
12 standards.

13 MS. DAILEY: Okay.

14 DR. KELLY: You have to start
15 somewhere and slowly start to gather that -

16 MS. DAILEY: Okay. So, DoD's got
17 that piece. And then VA and the Department of
18 Labor are going to look at employment success in
19 their education goals down the road after
20 DD214.

21 DR. KELLY: Correct.

22 MS. DAILEY: Correct. Okay.

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1 Then I have to say I kind of agree
2 with that, ladies and gentlemen, because, you
3 know, getting people employed is a Department of
4 Labor responsibility.

5 We only have as the Department of
6 Defense, so much we can do for them until they
7 get up to their DD214, but it's the economy's and
8 the Department of Labor's responsibility to get
9 them employed.

10 MEMBER MUSTION: Then make the
11 Department of Labor pay the unemployment bill.

12 MS. DAILEY: Well, interesting. No,
13 no, I know how high that is.

14 MEMBER MUSTION: The Service gets
15 stuck paying the bill. In the case of the Army,
16 it's a program that I'm responsible for.

17 MS. DAILEY: Right.

18 MEMBER MUSTION: 500 million dollars
19 a year.

20 MS. DAILEY: Correct.

21 MEMBER MUSTION: Because - and if
22 it's the Department of Labor's responsibility to

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1 get soldiers jobs, and sailors when they
2 separate, then make the entire unemployment
3 compensation bill a responsibility to the
4 Department of Labor.

5 Now, that's a broader issue. But if
6 you're going to hold us responsible for paying
7 the bill, then we're going to go out and find
8 soldiers jobs because what we're dealing with
9 now is not effective.

10 MS. DAILEY: Well, every employer has
11 that dilemma. Every employer pays unemployment
12 to the people that they no longer employ.

13 So, yes, it's an interesting
14 cultural effect, I agree, but I personally never
15 wanted to see the Department of Defense
16 employing people post-DD214 when our job is to
17 train them to fight our current wars.

18 MEMBER MUSTION: Denise, I don't
19 disagree with you at all on that.

20 DR. KELLY: Write your congressman or
21 your senator.

22 Well, I will tell you that we - the

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1 Transition Assistance Program, the redesign,
2 was just reviewed by the Defense Business Board.
3 And they very clearly drew the line that
4 employment belongs to - does not belong to the
5 Department of Defense. It is not the mission.
6 It is - it belongs to other agencies, other
7 federal agencies.

8 But that, again, I have to iterate
9 that there's never been stronger cooperation
10 across the interagencies in this particular
11 arena than now. And we are having daily contact
12 with all of our interagency partners.

13 And hopefully you'll be able to see
14 that implementation plan, get a copy of that
15 eventually once we actually get it over to the
16 president.

17 Okay. Thank you.

18 MS. DAILEY: Thank you.

19 DR. KELLY: And now, again, the core
20 part Mr. DiGiovanni in reference to
21 certification and training and licensure and the
22 work that's going on behind the scenes of all of

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1 that.

2 MR. DIGIOVANNI: Good morning.

3 Let me first thank you all for what
4 you're doing for veterans. As a 26-year veteran
5 of the United States Air Force, I really
6 appreciate the efforts of what you're doing
7 here.

8 So, real quickly my responsibility
9 is military training and education policy across
10 the Department of Defense. And I'm going to
11 kind of ad-lib just a little bit here because of
12 the questions that you asked about.

13 So, very good questions about how do
14 we institutionalize what it is that we need to
15 do as far as preparing our members of the armed
16 forces for transition.

17 From my office perspective we're
18 looking at what we call three lines of action.
19 The first one is exactly what someone said, which
20 is right after you finish your initial
21 functional level training. So, you get your
22 qual in whatever it is that you're going to do

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1 in the military.

2 Then, we're looking at is there an
3 opportunity to either certify or license you in
4 something based upon the military training that
5 you just received.

6 So, for example, the Army at Fort Lee
7 as soon as you graduate from - and I don't know
8 what the technical term is. Maybe you can help
9 me, General, but essentially it's their - the
10 folks that do welding and back shop repair, they
11 graduate from that course at Fort Lee.

12 We've gone out to the American
13 Welding Society. They've certified the
14 instructors at Fort Lee to then give them an AWS
15 Certification in welding.

16 So, again, as soon as you graduate
17 if we're able to, we try to get you credentialed
18 or licensed, which then kind of sets you up for
19 transition as you move through the process.

20 The second line of action is
21 mid-career. And mid-career will vary, but many
22 of these licenses or credentials require a

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1 certain number years of experience.

2 So, once again what we're trying to
3 do from a training perspective is say, when you
4 have - and this goes back to the counseling that
5 the General has talked about - when you have
6 completed the requisite amount of experience
7 required to get again a license or credential in
8 something that you're doing in the military, you
9 would once again be advised, hey, here's an
10 opportunity for you to go out and get a license
11 or a credential in this area. And here are some
12 opportunities that you can use from a funding
13 perspective to get that done. So, it could be
14 tuition assistance. It could be the GI Bill.

15 The Navy has graduated in the last
16 five years, over 56,000 members in their
17 Department of Labor-certified apprenticeship
18 program. 56,000 sailors have gotten their
19 apprenticeship certifications from the
20 Department of Labor. Very, very outstanding
21 program.

22 The Air Force has a Community

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1 College of the Air Force. An outstanding
2 program. They went out and got their own
3 credentialing from an outside education
4 institution so that they could accredit their
5 training as it's completed.

6 And there's a big push within the Air
7 Force to get almost every one of the enlisted
8 members an associate degree based upon their
9 military training and experience.

10 So, then the third line of action is
11 what Dr. Kelly just got through talking to you
12 about.

13 So, as you're about a year out, once
14 again you're going to look at maybe 18 months,
15 maybe two years out, depends. Depends on, you
16 know, a lot of us when we're - and what's
17 interesting, the 18 to 22-year-old is really one
18 of the prime target audiences.

19 And if you look at the unemployment
20 of veterans 18 to 24 right now today, it's about
21 30 percent. It's huge. It's huge. And it's a
22 larger number, much larger number than the

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1 normal population.

2 So, the counseling that the General
3 talked about is extremely important. I can't
4 tell you, and, you know, those of you - there's
5 veterans here in the audience. But when you
6 talk to these veterans, they don't really think
7 about what they're going to do until it's almost
8 too late or until they've gotten out.

9 And most of them have a family.
10 Most of them have a car payment. And they get
11 out of the military and then, you know, what are
12 they looking at?

13 So, this is why we're focusing very
14 heavily on this DoD Licensing and Credentialing
15 Task Force.

16 It got stood up by the President.
17 We're focusing - that task force is focusing on
18 five career areas; manufacturing, IT,
19 healthcare, transportation and logistics.

20 And someone asked about jobs. What
21 we did was we did an analysis that said how many
22 - of the occupations within the military, where

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1 are the areas of growth in the private sector?
2 Where can you get commensurate pay to the pay
3 that you received in the Department of Defense?
4 And where is there going to be a reasonable
5 expectation of getting a job?

6 So, can you go to - I think two slides
7 past this one. So, this slide right here shows
8 you the top 10 - more or less the top 10
9 occupational areas within the military by
10 service and then with a crosswalk back to - go
11 ahead go back. With a crosswalk back to a
12 Department of Labor standard occupational
13 category.

14 So, besides infantry, and you would
15 expect the infantry numbers to be pretty large,
16 I mean, these are the top 10 occupations out
17 there where we think there is great opportunity
18 for employment.

19 And of those, the top five of the
20 criteria I just said, aircraft mechanics,
21 automotive mechanics, healthcare workers and
22 truck drivers. Those are the five areas that

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1 both from an economy perspective, from a job
2 availability perspective, from an expectation
3 of getting decent compensation, that's what the
4 analysis showed.

5 So, I show you this only because -
6 and I've shown this in a couple other venues
7 mostly to industry to say, look, here's the most
8 populated occupational codes in the military.
9 And I guarantee you there's a demand signal for
10 those folks out in the industry for these people.

11 MS. DAILEY: Mr. DiGiovanni, could
12 you say those again, please?

13 MR. DIGIOVANNI: The five areas?

14 MS. DAILEY: Yes, please.

15 MR. DIGIOVANNI: Sure. So, the five
16 areas were aircraft mechanics - and, again, if
17 you look at the numbers and you can see it's also
18 based on the most populated career fields in the
19 military.

20 So, aircraft mechanics, you can see,
21 well, there's no doubt that the Navy and the Air
22 Force are pretty heavy in those areas.

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1 The next one is automotive
2 mechanics. Again, if you look at the - and these
3 are the people who are separating each year from
4 the military with that particular occupational
5 specialty. Okay. So, automotive mechanic is
6 the next one.

7 Healthcare workers - and I would say
8 when you look at this, these are mostly corpsman
9 or medics. So, I mean, big numbers.

10 The next one is supply and
11 logistics. I mean, look at those numbers. And
12 the last one is truck drivers, transportation.

13 And it's not just your Class - not
14 just your tractor-trailer, but also your Class
15 B license which is essentially delivery vehicle,
16 which most - almost every one of your
17 transportation drivers in the military with
18 almost little effort can go out and get a Class
19 B license.

20 And the other thing I'm finding is
21 particularly in the oil industry there's a huge
22 boom in Montana and North Dakota for oil. They

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1 can't get people up there to drive.

2 And what they're looking for is
3 off-road members, which our military members are
4 highly qualified to do.

5 So, we've partnered with the
6 Teamsters, for example, to provide free
7 training, which I'll talk about in a minute, free
8 training to military members and then with
9 guaranteed employment in the oil fields either
10 in the northern part of the country or in Texas.

11 Those are the two places where
12 there's a huge demand for people in that industry
13 level, but they can't get people to do it.

14 And I had a telecon two weeks ago
15 with Edmonton, Canada with their Economic
16 Development Council. They can't get enough
17 people up there to work in their oil fields
18 either.

19 So, they - I think he said there was
20 a three million population province with like a
21 hundred thousand jobs, and they can't fill them.

22 And the other thing that he told me,

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1 which I'm not so sure - I got to check my ears
2 again, but he said the average wage was \$200,000
3 a year.

4 I was like, really? That's what he
5 said. I was like, wow.

6 MEMBER DRACH: The trucking industry
7 for as long as I can remember, has been very, very
8 aggressive in reaching out to veterans and
9 transitioning servicemembers because there's a
10 - first of all, there's a critical shortage of
11 truck drivers. Second of all, they're already
12 trained.

13 There's, I guess, roughly, I'm
14 rounding off, 12,000 truck drivers -

15 MR. DIGIOVANNI: A year.

16 MEMBER DRACH: - coming out.

17 The big impediment has always been
18 the CDL. So, you get these 12,000 people can
19 drive probably any 18-wheeler that's on the
20 road. But because they haven't - they don't
21 have a CDL, what's being done to ease the
22 transition?

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1 I know some states have established
2 some reciprocity. But, again, if I don't have
3 my CDL, you know, I can't go to work.

4 MR. DIGIOVANNI: I love those kind of
5 questions, sir. Thank you for that. Actually,
6 there's been quite a bit of work in that area.

7 So, in fact, yesterday I sent a note
8 to a senator and a congressman from the state of
9 Arizona who are just about ready to be the 35th
10 state in the nation who has provided a military
11 CDL compensation bill which then allows military
12 members to come in with a one-page piece of
13 paper.

14 So, 35 states have done this -
15 actually, 34. Arizona will be the 35th state in
16 the Union that can come in with a one-page piece
17 of paper.

18 It has pictures of different kinds
19 of trucks at the top of it. Your commander
20 circles the kind of truck that this person has
21 experience in, says how much - how many months
22 that they've driven that truck, signs it at the

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1 bottom. You take it to the DMV. They go, thank
2 you very much, and they waive the road driving
3 skills test for you.

4 So, 35 states - well, 34, about to
5 be 35 states already do that, which really helps.

6 The other thing that the federal
7 government did was there was a DOT law that said
8 you had to establish domicile in a state to get
9 a CDL.

10 So, what they did is they basically
11 in last year in 2012, there was a Military CDL
12 Act of 2012. And it basically said for military
13 members, that is no longer a requirement. You
14 do not have to establish domicile to get a CDL.

15 So, if you're in the state of - if
16 you're at Fort Hood, Texas, you can go to the
17 state of Texas DMV, show them your military
18 skills waiver paperwork, take the written test,
19 and you can get a CDL in the state of Texas.

20 Which then allows you - and there's
21 a lot of reciprocity between states. So, then
22 you can take that CDL and go - so, if you're going

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1 to Iowa, that's where you live, then you take
2 that Texas CDL and go, here you go. And they'll
3 give you a CDL license.

4 If there's some differences, they
5 make you take the test again. But for the most
6 part there's reciprocity and you can do that
7 while you're in the service and not have to
8 establish state residency.

9 MEMBER DRACH: This is a side note.
10 And I don't want to detract from anything that
11 DoD is doing, but the American Legion deserves
12 a big thanks for all the leadership that they
13 have displayed in this whole area of licensing
14 and credentialing. They've done a tremendous
15 job.

16 MR. DIGIOVANNI: You're on the mark.
17 And Peter Gaytan and I, who is executive director
18 of the American Legion, we are like that. Very
19 tight relationship and you're exactly right.

20 I mean, there's no way the
21 Department of Defense could get out and get the
22 word out as well as members of the American

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1 Legion. They're doing an outstanding job in
2 just basically helping us get the word out about
3 what needs to be done. Thank you, sir.

4 So, I just feel that just so that you
5 have an idea of what it is that we're working on,
6 the five areas that I talked to you about,
7 there's actually a language in 2012 which told
8 the Department of Defense to do pilot programs
9 of which they said do about three to five.

10 And so, we picked those five areas
11 and right now we have over 2,000 people enrolled
12 in our pilot programs all looking at getting
13 certifications and licensure.

14 A lot of them across those three
15 lines of action, and most of them not in
16 transition.

17 Most of them are either coming out
18 of initial training or in that second line of
19 action where they're mid-career.

20 There are some that are transition,
21 but the majority of that 2,000 are people that
22 are actually not in transition. They're just

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1 going out to get their license or credential.

2 MEMBER EVANS: So, information
3 technology is not one of the top. I am really
4 surprised.

5 MR. DIGIOVANNI: Well, let me talk to
6 you about another program that we're doing. And
7 this is from the White House.

8 So, in May of last year the White
9 House said, we want you to focus on five career
10 areas for pilots.

11 So, IT was one of those.
12 Manufacturing was another. Healthcare, supply
13 and logistics and transportation.

14 So, three of the five are common, but
15 IT is unique to the White House Task Force. And
16 interesting enough, the IT pilot is focused on
17 wounded warriors.

18 And what they've done is they've
19 partnered with - the White House has an IT within
20 - an IT, I guess, advisor within their technical
21 - the Office of Science and Technology Policy.

22 So, he has partnered with a company

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1 that has basically gone out and got over a
2 thousand scholarships from industry that will
3 take people in the - military members in the IT
4 community, give them some gap training and then
5 employ them.

6 And that IT pilot is about ready to
7 kick off. They've actually from a wounded
8 warrior perspective, they've already been
9 working that program.

10 We're now going to institutionalize
11 it within our White House directive.

12 So, we just sent out - my office just
13 sent out a warning order to the Services - to the
14 service MNRAs about probably three weeks ago.

15 The wounded warrior piece that's
16 probably the strongest on this program is the
17 Marine Corps, and also the Guard and Reserve.
18 That's who I see be the most active - Army Guard
19 and Reserve.

20 But the pilot has not kicked off yet,
21 but they're not - those guys aren't waiting.

22 Okay. Let's go back to the - so, the

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1 other thing I want to talk to you about is this
2 is a change to Title 10 in 2012. And it's a
3 pretty fantastic change.

4 Basically, what it said, and it's
5 documented in Section 1143 Paragraph (e), what
6 it says that if you are a military member and you
7 have served honorably for 180 days and you are
8 within 180 days of separation, you may
9 participate in a job skills training program as
10 your primary duty.

11 That's huge. Now, my office is
12 responsible for writing the policy for that. I
13 will tell you that there are a couple of caveats
14 that we've put on this particular authorization.

15 The first one is in order to be
16 released, the first commander with UCMJ
17 authority has to approve that release. Which
18 means that from a mission perspective that this
19 will not affect the mission of that unit.

20 Okay. I mean, you're smiling and
21 you need to be.

22 MEMBER DRACH: It's wider than the

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1 Grand Canyon.

2 MR. DIGIOVANNI: So, but on the other
3 hand I had to - we had to do something to make
4 sure that, you know, essentially you didn't take
5 four-year enlistments and make them
6 three-and-a-half-year enlistments.

7 So, there had to be - the mission has
8 to come first. And that is our mission. the
9 second thing that we've asked them to do is if
10 you're going to come to your commander with a
11 request, then it needs to be a program that's
12 accredited, certified, either recognized by the
13 Department of Labor, by the Department of
14 Education, a certified apprenticeship program
15 of which there are many from the Department of
16 Labor.

17 So, you've got to come - you can't
18 just go to like Acme Trucking Company and say,
19 hey, I want to go do Acme Trucking Company
20 training, no. It needs to be something that has
21 probably two things associated with it.

22 One, a very high probability that if

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1 you participate in that job skills training,
2 you're going to get a job. They're going to
3 offer you a job. And two, it has to be at little
4 or no cost to the member.

5 So, for example, the UA, the
6 pipefitters union, has exactly that program.
7 And so does the Teamsters.

8 So, the kind of program that we're
9 going to let people go out and do is going to be
10 one where they're just not going to go take their
11 GI Bill and burn it and get nothing for it.

12 They have to have a very high
13 probability of getting a job. And it has to be
14 at little or no cost to the member.

15 MEMBER DRACH: Now, would your policy
16 memo or your guidelines or is there somewhere
17 built into this tracking system so that at some
18 point in the future you'll be able to find out
19 how - or tell us how many service members
20 applied, how many were approved, how many were
21 denied?

22 MR. DIGIOVANNI: As far as this

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1 program, since the DoDI is still young, I will
2 say the answer is yes.

3 How's that? The answer is yes. I
4 think you're right. We do need to find a way to
5 make sure that we track how many people are
6 actually being approved for this program.

7 MEMBER DRACH: So, if you come back
8 to us in March or April of 2014, you'll be able
9 to have some data for us?

10 MR. DIGIOVANNI: I hope so.

11 MEMBER DRACH: All right.

12 MR. DIGIOVANNI: The DoDI - well, the
13 problem is, as you know, the Department of
14 Defense has structured processes by the six
15 months process.

16 I have a draft written. It's been
17 through my review first. It's been through
18 legal review. It's about ready to go out for
19 corps. It will probably take about three to
20 four months for that to get put in place.

21 So, I would say we might have some
22 preliminary data by this time next year.

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1 Preliminary. We'll have to see what I get.

2 The other thing that we're doing
3 with this program, and the Special Operations
4 Command has done an outstanding job with this,
5 is they've looked at high-profile internships
6 using this authority. And it's focused on
7 wounded warriors.

8 So, the SOCOM Care Coalition has
9 done an outstanding job of taking this authority
10 and then surgically placing their wounded
11 warriors into very high-profile internships
12 with the same kind of criteria I talked about,
13 which is high probability of getting a job at
14 little or no cost to the service member.
15 Outstanding program, you know, just - it's a
16 model.

17 CO-CHAIR CROCKETT-JONES: How can we
18 proliferate this program to the big masses of -
19 everywhere we go there are folks who are in
20 federal internships, small numbers, mainly
21 because there are just not enough, I mean, in
22 some of these areas there just are not enough

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1 federal organizations that are present to
2 provide much in the way of internships for the
3 transition units of wounded, ill and injured.

4 And I know SOCOM has used this to
5 create non-federal internships. We cannot find
6 anyone who is willing to use this in that way
7 outside of SOCOM.

8 How can this be proliferated or is,
9 you know, if that is a successful program, why
10 can't we get, I mean, we're trying to hear why
11 this hasn't been disseminated as an authority
12 program to give other service members in the same
13 position some internship potential.

14 MR. DIGIOVANNI: There's a couple of
15 reasons.

16 First, the Services wouldn't take
17 any action until we had at least published. And
18 the law required that the Secretary of Defense
19 promulgate regulations. That's the last line
20 of the law.

21 So, the first step was we actually
22 had to do something to say, here's the guidelines

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1 for how you implement this new authority under
2 Title 10.

3 That Directive-Type Memorandum
4 actually piggybacked on the TAP Directive-Type
5 Memorandum and it was published in November of
6 last year.

7 So, the first step was, okay, we've
8 published guidelines which then allows them now
9 - gives them the authority to execute.

10 Before that time, we also went out
11 and got a Deputy Secretary-signed memo which
12 allowed SOCOM to go forward with their program.
13 So, we did kind of a dual track thing based upon
14 an earlier request from SOCOM to use this
15 authority.

16 So, the next step now is to publish
17 the Department of Defense instruction which then
18 provides further implementing guidance to the
19 Services and how they can get it done. So, I
20 think we're still kind of early in the use of the
21 authority.

22 The second thing that I've done is

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1 at every - and I - because of the state nexus of
2 particularly licensure, I've had an opportunity
3 to speak to the National Governor Association
4 and also the National Lieutenant Governor
5 Association. At both those forums I've brought
6 this authority up and said two things.

7 One, if there's an opportunity in
8 state government to place these folks, take
9 advantage of it.

10 And the other thing I asked them to
11 do is as you work with the industries in your
12 state, make them aware of this opportunity as
13 well.

14 So, I think that the two things that
15 we need to do as a department are, number one,
16 get the Department of Defense instruction
17 published so that there's full implementing
18 guidance on how to do it.

19 And the second step is to do
20 everything that we can through a strategic
21 communication outreach program to make sure the
22 people get informed about this authority.

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1 And right now we're still early in
2 the implementation process, but I think those
3 two steps will go a long way toward achieving
4 that objective.

5 CO-CHAIR CROCKETT-JONES: Yes, I
6 would just like every - well, just as a
7 statement, in the same amount of time that we
8 have seen this concept of compressing the IDES
9 timeline down to a very - get it as clean as
10 possible, there is this push to compress this
11 IDES timeline down.

12 And sometimes that makes it a little
13 bit stressful for the wounded, ill and injured,
14 actually, and sometimes it relieves them of the
15 wait, but we are - I see a lot more effectiveness
16 at compressing a timeline to the benefit of the
17 Services, and I do not see nearly the push to -
18 there are folks who will get - who will be out
19 without ever having a chance to take advantage
20 of something that was determined to be fine in
21 November.

22 They'll be out before anything ever

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1 gets done to let them have the advantage of the
2 decision that this policy was made.

3 And I find it - I'm just expressing
4 a frustration on behalf of those wounded, ill and
5 injured who are feeling that, you know, the rapid
6 compression of their IDES timeline was
7 prioritized and people are jumping through fiery
8 hoops to make their timelines on that IDES.

9 I wish I felt that there was the same
10 sense of urgency at making the instruction and
11 the guidelines available to the people who are
12 trying to get them into these -

13 MR. DIGIOVANNI: Well, I will tell
14 you that the service manpower reserve affairs
15 people, their secretariats, I've worked closely
16 with them now for months, they know about the
17 authority.

18 I gave them the DTM in November,
19 which gives them the opportunity to move
20 forward. And I will do everything that I can to
21 continue to push that.

22 I mean, having - personally, I've

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1 been to several focus groups with wounded
2 warriors and I know exactly what you're talking
3 about. Exactly. You're right.

4 MS. DAILEY: Mr. DiGiovanni, we had
5 them in here last - in February and they're
6 waiting on you to publish the DoDI.

7 Are you saying they don't have to
8 wait on you, that they can set up these -

9 MR. DIGIOVANNI: According to the
10 attorneys, and this is where I get frustrated
11 too, the publishing of the Department of Defense
12 Directive-Type Memorandum satisfies the
13 legislative requirement to promulgate
14 regulations.

15 MS. DAILEY: Okay. I've got that on
16 the record.

17 MR. DIGIOVANNI: And that's what I
18 told them.

19 MS. DAILEY: And I will - I will
20 redistribute that to them, and to the Warrior
21 Care Policy Office that also said, nope, waiting
22 on your publication as of our last meeting, which

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1 was about a month ago.

2 MEMBER PHILLIPS: Suzanne, to
3 address your comment which I 100 percent, 110
4 percent agree with, perhaps this committee could
5 make some sort of recommendation to allow some
6 sort of retroactive post-discharge ability to
7 access these programs, you know, at least if it
8 was in the pipeline, I mean, something like that
9 we could talk about.

10 MR. DIGIOVANNI: I will tell you that
11 if you, I mean, I speak to the Teamsters and the
12 UA, which I think have got two of the model
13 programs for this kind of - for this kind of
14 authority. I mean, they're happy to engage now
15 even if you're out and separated. I mean,
16 they're happy to do that. They want to do it.

17 All I need is some, I mean, I could
18 use some help from you all. If there's some
19 people that have gotten out or are out of the DoD
20 system that I could hook them back up to
21 Elizabeth Belcaster who is my Teamster contact.
22 She's passionate about making that happen. I

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1 just need to know who I need to put them in touch
2 with.

3 CO-CHAIR CROCKETT-JONES: Well, we
4 should -

5 MEMBER PHILLIPS: Well, we need to
6 publish that.

7 CO-CHAIR CROCKETT-JONES: Yes, that
8 should be published, you know. There are
9 advocacy agents, AW2, Safe Harbor. There are
10 folks who are tracking the people post-DD214.
11 And they should know that these opportunities
12 are available.

13 MR. DIGIOVANNI: And Matt Caulfield
14 is my - is the UA rep for pipefitters and welders.

15 They're ready to execute. And
16 basically what they're doing is they're using -
17 they're using union dues, a portion of the union
18 dues to pay for the education. That's how
19 they're financing it. And they'll do it for
20 free.

21 MEMBER EUDY: Sir, a question for
22 you.

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1 As we've done a lot of our site
2 visits, at certain site visits we've been
3 informed that private and public sector
4 employers have had reductions in available work
5 hours within the past few months due to different
6 actions inside government that are in or out of
7 their control.

8 Have any of these items or
9 reductions in work hours by workforces, what's
10 your view, sir, from the policy level?

11 Is it starting to impact the options
12 of these programs? Are you going to find that
13 service members of different areas that we're
14 using in these, you know, key skill fields are
15 going to end up finding that there's even less
16 employment as a result?

17 You know, I remember it was in, and
18 correct me if I'm wrong, I believe our Iowa visit
19 there was a large employer that was, I think, an
20 - not agricultural, but a grocery store
21 support-type chain or something that had done a
22 reduction. And that was a major hire for vets

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1 that were getting out, but they had just started
2 doing the reduction of work hours.

3 MR. DIGIOVANNI: I will be honest
4 with you. Anecdotally, I haven't seen it. And
5 I will tell you that I have held their feet to
6 the fire at least twice.

7 So, let me give you two examples.
8 The first one is a manufacturing sector. So,
9 the White House Task Force that we've been
10 working on. And we put that pilot in place in
11 May of last year.

12 We talked to several large
13 manufacturers. And they all said, we have jobs
14 and we can't fill them. The demand signal is out
15 there.

16 And what's interesting is getting
17 highly technical tradesmen, that's what they're
18 looking for and they're just not available. So,
19 in the manufacturing sector I haven't seen that.

20 The other thing that I would say is,
21 are you familiar with what Walmart has done?

22 Okay. So, Walmart said, if you come

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1 to us and you're within, you know, if you've
2 separated and you're within one year of
3 separating from the service, we will hire you,
4 period. We will find a job for you.

5 They said another hundred thousand,
6 but I will tell you, I mean, I attended a meeting
7 with the CEO and he said, if you're a veteran and
8 you're within one year of getting out, we'll hire
9 you. We'll find a job for you.

10 And these are not all, you know,
11 Walmart greeter jobs. He said, we're looking at
12 things in our warehousing function, you know, in
13 our logistics function. So, it's not just, you
14 know, go be a greeter or a stock shelver.

15 So, and they also said that they
16 would - I think it was 50 - no, what is it? 10
17 billion dollars buy US over the next five years.

18 And the White House actually had a
19 big roundtable with about two-thirds of -
20 actually, the First Lady spoke to this business
21 roundtable which had - which basically
22 represented about two-thirds of our gross

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1 national product, these companies that were
2 there. There was about a hundred of them.

3 And she told them the same thing.
4 See what Walmart did? You all need to do the
5 same thing.

6 So, I will tell you this
7 Administration is actively engaged in working
8 that issue.

9 MS. DAILEY: Well, on the ground we
10 just spent - we had three visits to Walmart. We
11 had three visits to Arkansas, the Land of
12 Walmart.

13 (Laughter.)

14 MS. DAILEY: Well, two and .1. And
15 they're all eager. A National Guard and Air
16 National Guard community that's eager to employ
17 their service members and a community-based
18 warrior transition unit which covers a region,
19 all want to be employed in Arkansas and pretty
20 much unaware of that and all waiting on the
21 published guidance.

22 That's all I hear when I'm out there.

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1 And I've been - we've been to three National
2 Guard headquarters, Iowa, Des Moines, Arkansas
3 and North Carolina.

4 If they're embracing these
5 programs, they aren't discussing it with us when
6 we ask them for their transition plans and how
7 they're transitioning their service members,
8 not just the wounded, ill and injured.

9 So, there's marketing to be done in
10 this business of their waiting on you. You've
11 given them authority to move forward.

12 I'm the one pushing it and I'm the
13 executive director of this task force, which
14 really isn't my job, but I'm the one out trying
15 to kick this can down the road and get them to
16 move forward.

17 MEMBER PHILLIPS: Yeah, to follow up
18 on that, I mean, the 30 percent unemployment,
19 it's appalling.

20 MR. DIGIOVANNI: It is.

21 MEMBER PHILLIPS: I mean, where are
22 we not connecting the dots? How can we help, I

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1 mean, this task force?

2 MR. DIGIOVANNI: I think what Dr.
3 Kelly talked to you all about is one of the keys.
4 I mean, as I said anecdotally when I talked to
5 these folks - and, look, we've all been 18 to 24
6 years old, right?

7 So, I mean, you're not thinking
8 about - you're not necessarily thinking about
9 your future. You're thinking about what am I
10 going to do tomorrow?

11 And so, the more that - and this is
12 why I think these three lines of action that
13 we're working on is extremely important.

14 Because as Dr. Kelly said the sooner
15 that we can say, look, you have a valuable skill
16 that we just spent a lot of money to train you
17 in, go out and get a license or credential so that
18 when you leave the military, you have something
19 other than your DD214 and your military training
20 transcript to show somebody that may not
21 understand at all the military jargon or the
22 training courses that you received.

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1 But if you have an outside license
2 or credential, you have a higher probability of
3 connecting with their HR section, because it's
4 something that they know.

5 The other thing I've asked them to
6 do is to say tell me what the industry standards
7 are.

8 So, in those five areas if I'm going
9 to focus on a license or credential for somebody,
10 what's the golden ticket? If I show up in your
11 HR, if I have - if I, you know, if I'm in the power
12 - if I'm going into the energy industry, and I've
13 asked them to give me these, and they did, what
14 certification do I need so that if I walk into
15 your HR office you go, oh, I know what that is,
16 hired.

17 So, we've asked the industry, tell
18 us what are these golden certifications and
19 licensures that have immediate recognition in
20 your HR hiring shop?

21 I mean, that's what we're trying to
22 do to get this thing cranked.

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1 MEMBER MALEBRANCHE: Is there - are
2 you looking at the different skill producers
3 such as I was thinking in particular because I'm
4 healthcare, but San Antonio where we are
5 training folks to be like certified nursing
6 assistants?

7 I saw you have the EMTs, but for some
8 of the other professions like what we used to
9 call 91 Charlies. I think they're 91 Xs now, but
10 are you looking at having them come out of those
11 schools in the military before they separate
12 while they're in the military, getting those
13 programs credentialed so that they could have,
14 you know, if they chose to, they could have a
15 license?

16 Because I recall talking to some
17 different service members. Some of the
18 services were paying for them to go get their CNA
19 license or certification. Others were not.

20 But when they're in these programs
21 that we are training them in, why wouldn't we
22 look at making that program to where they can get

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1 certified long before they get out so they have
2 - right. I think, Dr. Phillips, you're
3 capturing what I'm trying to say too, but they
4 could have this accredited training, they can
5 have the certification.

6 Then when they get out, they've got
7 it. They might have to do a state reciprocity
8 piece, but are we looking at that at all through
9 this legislation implementation?

10 MR. DIGIOVANNI: Not under this one.

11 I think what I see right now in San
12 Antonio is - and there is a variation between the
13 Services.

14 So, example, if you are an Army
15 medic, you're required to pass the EMT basic.
16 If you're an Air Force medic, it's optional.
17 And if you're Navy, and the Captain already
18 answered the question about the Navy. The Navy
19 doesn't require it.

20 So, I think some of it is you can go
21 after the accreditation. Which, by the way, is
22 a hard process. And the only service that's

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1 done that is the Air Force.

2 That's why I pointed out their
3 program. I thought it was extremely
4 interesting that the Air Force of the four
5 services, actually went out and got an
6 accreditation from an outside institution.

7 I think the short-term answer to the
8 medical side is to standardize the testing, the
9 national level testing so that when you graduate
10 from that course regardless if it's accredited
11 or not, if you can pass the national
12 accreditation - so, for LPN, for example, or for
13 - and I think almost all of them have to get a
14 license for RN or for a doctor.

15 But on the LPN side of the house or
16 the EMT intermediate or advanced, we should go
17 ahead and encourage them all to take that test.

18 MEMBER MALEBRANCHE: Well, the part
19 I guess because I was wondering, because this way
20 they would have experience.

21 And from the VA side, we hire people.
22 They have to have the national or state

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1 credential. And this would be a very nice
2 transition from active duty to veteran status
3 with the skills and abilities and things that
4 they, you know, had.

5 But it would be nice to accredit the
6 schools at the very beginning instead of the very
7 end of their career where they're going to
8 change. At least they have a fallback program
9 or something that they can do that they're
10 comfortable with. So, just a thought.

11 MR. DIGIOVANNI: I will take that
12 back, I mean, you know. Go ahead, General.

13 MEMBER MUSTION: Karen, there are ten
14 different specialties in the Army. They have
15 medical community or basic medic is one of those.
16 And also in conjunction with bringing all the
17 service schools down to the center, Fort Sam, to
18 get accreditation upon completion of basic
19 training or their basic MOS-producing course for
20 both enlisted, as well as the officers so that
21 they get the initial accreditation and they
22 continue through continuing education, whatever

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1 else has to be - has to occur so that when a
2 soldier separates, already have the credential.

3 Just in line with what you said, but
4 there's about ten other 10 MOS's, or 10 other
5 specialties. Truck driver is one of those.
6 And trying to sort that out, some of the MP
7 communities, I mean, we've got guys that do great
8 things in the MP community, but they can't get
9 licensed in particular states.

10 So, TRADOC is blowing their way
11 through that and has made some headway to make
12 sure that credentialing happens earlier. And
13 then it just continues to build as you go through
14 your career.

15 MEMBER MALEBRANCHE: I think the
16 other issue too, though, is all the services are
17 different.

18 MEMBER MUSTION: Yes.

19 MEMBER MALEBRANCHE: And he's at the
20 DoD level, which is why I'm bringing this up.

21 MEMBER PHILLIPS: And I think what
22 you're saying, I mean, I don't want to put words

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1 in your mouth, but rather than looking at
2 reciprocity, look at the quality of the
3 programs. Choose the best quality programs and
4 low-hanging fruit and provide dual
5 certification from the starting gate rather than
6 having to wait for reciprocity.

7 MEMBER EVANS: So, when we moved to
8 San Antonio, moved course skills down to San
9 Antonio, we felt - and I was the senior nurse
10 working at course skills, we felt the Army had
11 a really good curriculum for medic. And we
12 wanted to have our corpsmen standardize and have
13 them to take the EMT.

14 Because Army is the only service, as
15 I said, you shall. Air Force it was optional.
16 And Navy said no, because we currently contract
17 that service for all of our commands. And so,
18 that's why they said hospital - and so, you know,
19 I thought I had it under the radar. And of
20 course it got caught.

21 And we were just going to put the
22 corpsman, try to - at the beginning. Because I

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1 think the curriculum is at the beginning of
2 training. So, we were just going to have, you
3 know, corpsmen going to that training and
4 building to the curriculum.

5 But, anyway, so it's based on what
6 the Services as they see what the need - and so,
7 to try to move that process where all, no matter
8 what uniform it is, it's a difficult challenge.

9 I think maybe once we get San
10 Antonio, you know, speaking one language there,
11 then I think we'll see that. Eventually they
12 will all come out with the same certification and
13 then that will help them as they transition to
14 the civilian sector.

15 MS. DAILEY: Okay. So, ladies and
16 gentlemen, I apologize. I haven't corralled
17 you. You haven't had a break, and I've got
18 another briefer standing by.

19 We really kind of need to wrap. We
20 really appreciate you being here, Mr.
21 DiGiovanni.

22 MR. DIGIOVANNI: Just call me Dion.

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1 MS. DAILEY: Dion. We do want to
2 highlight the fact that, you know, the Services
3 are pointing the fingers at each other. They're
4 pointing them at you, and you're pointing it back
5 to them.

6 What is the status of your
7 publication? A month? Two months? Six
8 months? A year? Is it out of P&R yet? Does it
9 have a Department of Defense number on it yet?

10 MR. DIGIOVANNI: It's funny that you
11 ask, because last night I reviewed the second
12 time that I've looked at the document.

13 So, I spent, you know, I spent
14 several hours going through the document about
15 a week ago. It's now been back to- through the
16 OGC to get their chop.

17 And I would say that no later than
18 the first part of next week it will be out for
19 corps.

20 MS. DAILEY: Okay. So, formal
21 coordination with the Services signed off by the

22 -

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1 MR. DIGIOVANNI: Well, they've
2 already looked at it once. So, I would say
3 they've already had some informal chops on it
4 already.

5 It's a matter of getting it through
6 - I think the next step is we have to take it to
7 what - they're called Washington Headquarter
8 Services Edit.

9 So, they do their magic, you know.
10 They do their kind of grammar review.

11 MS. DAILEY: Right, right.

12 MR. DIGIOVANNI: So, that's the next
13 step. Then once the Washington Headquarter
14 Services Edit is done, then it goes out via - and
15 he's smiling, because he knows - it goes out for
16 what they call SD-106 coordination.

17 MS. DAILEY: Yes.

18 MR. DIGIOVANNI: And that is the
19 formal coordination.

20 MS. DAILEY: Okay, okay.

21 MR. DIGIOVANNI: Normally, yeah, I
22 would say two to three months.

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1 MS. DAILEY: Yeah, I've done DoDIs.

2 MR. DIGIOVANNI: So, you know.

3 MS. DAILEY: I know. I'm just trying
4 to figure out where is it in that DoDI space?

5 MR. DIGIOVANNI: WHS edit -

6 MS. DAILEY: Okay.

7 MR. DIGIOVANNI: - is the next step.

8 MS. DAILEY: All right.

9 You know, again I don't know how to
10 clear up this finger pointing back and forth.
11 They want your pub, you've given authority to go
12 ahead.

13 MR. DIGIOVANNI: I will go out and
14 talk to the MNRAs again.

15 MS. DAILEY: Okay, okay.

16 And Warrior Care Policy Office also
17 is promulgating that information also on whether
18 these types of internships -

19 MR. DIGIOVANNI: The problem is -
20 well, no, I won't say it.

21 MS. DAILEY: So, thank you very much.

22 MR. DIGIOVANNI: Thank you.

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1 MS. DAILEY: Very quick break, ladies
2 and gentlemen, please. And then Dr. Bannick is
3 here to talk with us about current trend surveys
4 on our wounded warrior population. Thank you.

5 (Whereupon, the proceedings went
6 off the record at 9:48 a.m. for a brief recess
7 and went back on the record at 9:59 a.m.)

8 MS. DAILEY: Okay. Ladies and
9 gentlemen, I officially get an F for managing our
10 time today, but very important discussion and
11 very important people to have this discussion
12 with.

13 So, thank you, Dr. Bannick, for your
14 patience and for my subsequent briefers to the
15 Task Force.

16 It's important - I don't want to
17 shortchange Dr. Bannick here. Because if I do,
18 I shortchange my members.

19 We do a lot of work out on the
20 installations, Dr. Bannick, and we do focus
21 groups which is qualitative information, ladies
22 and gentlemen.

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1 And you've asked me, I mean, how do
2 we get the good news stories? How do we balance
3 our qualitative information which we synthesize
4 in a very scientific manner, very methodical
5 manner and it is validated by a lot of the surveys
6 that we do see.

7 That's why I brought in all the
8 surveys from the Army, the Air Force, the Navy
9 and the Marine Corps last time so that we have
10 a balance to our qualitative focus group
11 information. So, we have a way to understand
12 why certain trends go in that direction and we
13 have qualitative information to validate some of
14 those trends.

15 So, here is the - I'm going to let
16 Dr. Bannick talk about some history on it a
17 little bit. Remind my members, if you would,
18 Dr. Bannick, about how it came about it and what
19 it encompasses.

20 However, shortly, this is one of the
21 largest comprehensive surveys of wounded
22 warriors in all of DoD. So, there is a lot of

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1 survey material out there.

2 Each one of the services are kind of
3 running surveys, and this is kind of the overall
4 DoD survey on what we call service members
5 post-operational deployment.

6 And I will turn it over to Dr.
7 Bannick. Thank you.

8 DR. BANNICK: Thank you very much.

9 It is truly a pleasure to be here to
10 talk about this arcane field of surveys. And it
11 is in that it's an attempt to measure reality by
12 sampling it, and then relying on statistics.

13 And so, if I - oh, I do this, don't
14 I? All right. So, the purpose here is that I'm
15 coming back for the second time.

16 The first time was to talk about our
17 survey results in general, tell you what we have
18 been finding over time and whether or not these
19 findings have changed.

20 I'll reiterate a few of those
21 points, but specifically I'm coming back today
22 to talk over some of our data and, quite frankly,

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1 the numbers. How do we derive our findings
2 based on the ends, the counts, the observations?

3 So, my purpose here is to come back
4 and present the data. But in order to do that,
5 first this is in your notes, this is what we have
6 been asked to focus on.

7 So, our survey is a broad-based,
8 overarching survey that was predicated on the
9 Secretary of Defense's call to the Assistant
10 Secretary of Defense and Undersecretary of
11 Defense for P&R back in 2007 to find out what's
12 going on across the Services based on the
13 articles that appeared in the Washington Post
14 about February 2007.

15 So, between February of 2007 and May
16 of 2007, we worked with the Services, put
17 together a survey instrument to try to assess a
18 couple of things focusing on our service members
19 returning from operational deployment.

20 And back then, we focused only on
21 those coming back on air evac. I'll expand on
22 that, but focusing on those that came back on air

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1 evac from operational deployment.

2 What are they telling us about their
3 experiences relative to what we are hearing in
4 the Washington Post?

5 So, back then the focus and then the
6 Dole-Shalala Task Force Panel corroborated a lot
7 of the findings, but it was service members in
8 medical hold, experiencing frustration, poor
9 facilities, access-to-care problems. Not a lot
10 of focus on their medical needs, not a lot of
11 focus on their personal needs to get better,
12 reintegrate back into their units and all that.

13 Of course, subsequent to that time,
14 the Army developed the Warrior Transition Unit
15 programs, and expanded that and really focused.
16 The services did the same thing, where the Army
17 Surgeon General and then the services as well
18 expedited their access-to-care standards.

19 And so we've been monitoring this,
20 as the title slide said, monthly and then later
21 on quarterly, last year, for 65 months. So
22 we're providing some of the results, based on

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1 this survey.

2 Again, trying to assess reality out
3 there, worldwide, we developed a telephone
4 survey instrument to reach out to the
5 servicemembers, and there were a couple of
6 stipulations. The target population were those
7 who were returned from operational deployment,
8 and then, specifically, was there evidence that
9 they had a medical problem? So our focus is
10 right there.

11 And I say that because, later on,
12 when we start talking numbers, I start talking
13 about our survey numbers of servicemembers in
14 MEB. The focus is those that are in MEB that
15 were previously deployed, had a medical
16 condition, and that's what our survey is about.
17 There are others that are in the Medical
18 Evaluation Board -- I'm sorry, the Disability
19 Evaluation System beyond those who were
20 operationally deployed, and that's where you
21 start getting into numbers and questions and all
22 that.

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1 So our focus initially was on newly
2 arrived air medical evacuees. We are surveying
3 them within 30 to 45 days of coming out of
4 country, out of deployment. They may be in
5 Germany, they may be back in the States. For the
6 most part, they are flowing through the system.

7 We expanded the survey after about
8 16 months because we were finding a couple of
9 things. Most of these returning servicemembers
10 weren't able to tell us much about the disability
11 evaluation system. They were newly arrived.
12 And so they could tell us their experience,
13 predominantly being at Walter Reed, and then
14 later on Fort Bragg -- and I'm talking large
15 numbers, now, that were predominantly at these
16 locations, and they were predominantly Army --
17 and I'll show you down below how our numbers come
18 out.

19 So we expanded the survey, and we
20 focused again on "Okay. How do we define
21 somebody that was operationally deployed and has
22 a stated medical condition of some sort?" So we

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1 certainly followed up on the Air evacs one year
2 later. That gives them time to experience the
3 military health system, disability evaluation
4 system, access to care, VA referrals, anything
5 like that. So one year later.

6 VA referrals specifically, we look
7 into our utilization records, our claims
8 records, the documents we get back from VA, and
9 we look at those that we referred, how do they
10 rate? Not their care with the VA. That's not
11 our business. It's how do the servicemembers
12 rate our support for their getting care in the
13 VA?

14 And then those that completed a
15 post-deployment health assessment, which occurs
16 normally right before departing theater or
17 shortly upon arrival, but we were looking back
18 at those that completed that form one year ago
19 from the time we surveyed. So if we're doing a
20 survey in April, we're looking at air evacs data
21 that we have in March, previous month, and then
22 those that completed a post-deployment health

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1 assessment one year ago, March. Okay?

2 So that gives the servicemembers
3 time to experience the MHS, Military Health
4 System, to use the system and tell us if they're
5 having problems or not. And then those that
6 completed the post-deployment health
7 reassessment that normally occurs three to six
8 months following deployment.

9 So one of the tricks that we get into
10 is, how many of these do we get? Are they good?
11 And, when we look at the forms, every one of these
12 that I'm talking about there is a professional
13 medical judgment that care was needed. Some
14 sort of care was needed. They wouldn't be on the
15 air medical evacuation if they didn't need care
16 exiting theater. They wouldn't have that VA
17 referral if they didn't need care.

18 And when they complete a
19 post-deployment health assessment or a
20 post-deployment health reassessment, the
21 servicemember states medical problems, social
22 problems that they might have, and then the

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1 medical provider for the service then checks off
2 and says "Okay, you need a referral for social
3 work, a chaplain, primary care, orthopedics,
4 behavioral health."

5 So, all these that are our universe
6 that we look at, are those that come back from
7 operational deployment, have a medical need
8 expressed by one of these events here, and then
9 we look back through the data to make sure that,
10 in fact, they touched the military health
11 system, they had an outpatient visit, they had
12 an inpatient stay, received prescriptions,
13 something to that nature, that they touched the
14 system.

15 And then, we survey them. And we
16 survey them about a number of areas, number of
17 domains.

18 We do survey them and ask about are
19 you in medical hold, warrior transition unit,
20 awaiting medical board? Different terminology
21 for different services.

22 Do you believe that you've been in

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1 that situation? If so, we'd like to ask you some
2 questions. We do this on the phone.

3 Do you believe you've been evaluated
4 for continuance in the military in your current
5 occupation? And we talk about the disability
6 evaluation system. Some very basic questions.

7 They say, yes, I think I've been
8 evaluated. Then we ask them, do you know if
9 you've been assigned a PEBLO? Do you know if
10 you've been in the Medical Evaluation Board
11 phase? And then later, the PEB.

12 We ask about their support for the
13 VA care. Did DoD support you? Were medical
14 records available at the time of your
15 appointment? Were the DoD medical records
16 available at the time of appointment?

17 We ask about support for the family.
18 Was your family supported? Did they get where
19 they needed? Your transportation.

20 And then, a lot of the questions are
21 about access to healthcare. Did you have
22 problems getting in for emergency care, getting

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1 appointments? Once you got appointments, how
2 long did it take to see the doctor? Rate your
3 physician. Your primary care doctor. Did you
4 see a specialist? Rate your specialist.

5 Most of everything we've asked that
6 we asked about in these domains are on a
7 five-point scale with one being poor, five being
8 outstanding and we really don't define it beyond
9 that.

10 We say one a one-to-five scale with
11 one being poor and five being outstanding, how
12 would you rate whatever that we've already
13 addressed to that individual.

14 So, there's the domains, the rating
15 scales. You can see the responses. The
16 responses, the returns down on the bottom most
17 relative to those that we send out are very
18 close.

19 Sir?

20 MEMBER MUSTION: My question is that
21 80,000 different service members?

22 DR. BANNICK: Yes, sir.

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1 MEMBER MUSTION: So, those are each
2 - when you re-survey a person or a soldier or a
3 sailor, you're counting it as second or third
4 survey for that particular service member,
5 you're not -

6 DR. BANNICK: Thank you.

7 MEMBER MUSTION: Okay.

8 DR. BANNICK: I need to step back and
9 ask Ms. Nelson back there who has assisted me on
10 the data, can you just tell me, and I'll
11 reiterate, the 80,000 are all unique, or do we
12 include the dupes for the air evac follow-up?

13 MS. NELSON: (Speaking off mic.)

14 DR. BANNICK: Okay. So, the answer
15 is there are a couple of thousand duplicates in
16 there from the follow-up predominantly unique.

17 And we do keep a running index of all
18 of our names. Again, this is a telephone
19 survey. We rely on DEERS data for phone
20 numbers. And then we rely on our own internal
21 systems to pick up phone numbers for those making
22 appointments.

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1 And we find with these service
2 members, especially the young ones, they have
3 multiple phone numbers and oftentimes cell phone
4 numbers - cell phones. So, tracking them is an
5 interesting phenomenon.

6 I say these numbers here as far as
7 we send out, we call, and then we get back,
8 because oftentimes you're asked the question,
9 what about non-response? What about bias?
10 What happens if more women answer than men?
11 What happens if more Army answers then - you can
12 see from these numbers here the Coast Guard and
13 the active component/reserve component split.
14 Very little difference.

15 When we do adjust, and I'll get into
16 it a little bit, when we do adjust by service and
17 cohort, cohort meaning one of those five ways we
18 group them, and a couple of other factors, our
19 percentages I'm going to report here which are
20 raw, are changed very little as in one percent
21 difference, because there is very little bias
22 going on in the survey groupings that we're

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1 analyzing.

2 Okay. Now, the question still is,
3 how close to reality are we and do you believe
4 it? I think that's really where we're going.

5 Next - oh, I've got to do it. So,
6 these are in here for the most part over time
7 especially after the first 16, 17, 20 months of
8 surveying, the results really have stabilized.

9 And most of those domains that I
10 talked about favorable rating, those that rate
11 a four or five on that one-to-five scale. So,
12 the top two. And I'll refer that - I'll use that
13 term, "the top two ratings," have been - really
14 did stabilize. And the bottom two, those that
15 rate a one or a two out of the five-point scale,
16 have also stabilized for most of the areas.

17 CO-CHAIR CROCKETT-JONES: Ken,
18 before you go on, can you define "medical hold"?

19 Is that including the transition
20 units? Is that everyone? The total of your
21 cohorts is medical hold?

22 DR. BANNICK: No.

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1 CO-CHAIR CROCKETT-JONES: No.

2 DR. BANNICK: No, there is a
3 percentage. We're surveying - on that other
4 slide, we're surveying air evacs, those that
5 have completed a PDHRA.

6 They are returning soldiers,
7 sailors, airmen, Marines that have a medical
8 condition by one of those cohorts, and then a
9 percent are in medical hold.

10 CO-CHAIR CROCKETT-JONES: Yeah, I'm
11 trying to say basically that this is not limited
12 to what is called by the Services particularly
13 like the Navy's medical hold.

14 When you use that phrase, aspects of
15 medical hold, you're referring to the larger
16 process, correct?

17 DR. BANNICK: Correct, but I worked
18 with the Services to come up with a terminology
19 that we used when we asked this question of each
20 of the service members.

21 So, when we survey them, we know
22 their name, their rank and their service, the

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1 callers do.

2 So, we call them by their rank.
3 When we talk to them, we say, okay, for Navy you
4 might know this term as in medical hold. Army,
5 you may know this as warrior transition unit,
6 warrior transition brigade.

7 So, we try to use - that's been truly
8 for the DES, IDES has been - is a major threshold
9 to get across. And I'll say it up front. This
10 has been going on since the beginning. Trying to
11 make sure that we're communicating with the
12 service member on the telephone about where are
13 you.

14 They seem to know they were involved
15 in something. So, as IDES has come on to play
16 and there's been very specific protocols of you
17 will be assigned to PEBLO, now we can see it.

18 We see it as we call them up. You'll
19 know this if you've been assigned a Physical
20 Evaluation Board Liaison Officer. Do you
21 recall - yes. Okay, great. Now, we're going to
22 ask you about have you been through the Medical

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1 Evaluation Board.

2 Does that kind of help you? Because
3 I think your question really is germane to the
4 - and this is why I'm trying to give this broad
5 brush approach before I answer the specifics on
6 the data, because our survey really is about
7 operationally deployed service members that
8 needed medical care.

9 And within that huge realm, who were
10 in medical hold. Who were in medical hold that
11 were in - who were in the DES, IDES overall, or
12 who were in while they were in the medical hold
13 process? And that's an interesting old
14 phenomenon. Who referred to VA?

15 And as you go through each of those
16 domains of questioning, the population numbers
17 get smaller.

18 We survey - we get about 1700 - I'll
19 get that right. We get about 1700 responses a
20 month. And so of those, 11 to 14 percent,
21 depending on the month, are in medical hold, to
22 answer your question.

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1 Six to nine percent depending on the
2 year are in the Disability Evaluation System or
3 IDES.

4 I say that, because we don't know
5 what they're in. They say that they're in MEB,
6 PEB, they've had a PEBLO.

7 Nowadays we're actually quite
8 confident they're in IDES. But in 2007, 2008
9 and 2009, we know we are picking up service
10 members even though IDES was developing and
11 maturing, that weren't.

12 13 to 15 percent have had pain
13 management issues that we've talked to about.
14 50 to 70 percent of who we survey are in - have
15 received outpatient care separate from the
16 others. So, it's a broad brush.

17 And, again, that's - my office's
18 responsibility is for providing - informing
19 decision makers of what's going on out there.
20 So, we present the data and we try to estimate
21 reality, I keep saying that, by sampling.

22 So, there are the numbers. The

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1 focus that we've been reporting for some time to
2 the Services, to the USD P&R, have been on two
3 areas. Disability Evaluation Systems,
4 specifically the MED ratings.

5 I'm not saying they're terrible,
6 because I don't have - I have never had a
7 benchmark.

8 What we're saying is of all the other
9 areas that get rated poorly or favorably, the MEB
10 kind of stands out as the one that has the highest
11 level of unfavorable ratings or the lowest level
12 of favorable ratings, the MEB portion. Less so
13 for the PEB.

14 And then with respect to outpatient
15 care issues, access. That really, quite
16 frankly, is consistent with other surveys that
17 we have, access to care.

18 It's not saying that they don't get
19 good care and they rate highly. They'll provide
20 those when they're in.

21 Sir.

22 MEMBER MUSTION: You may get to it

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1 later, but your comment about most negative
2 comments related to the process taking a while,
3 okay, I got that. I understand that.

4 But then your other comment about
5 insufficient, unclear communication in your
6 questions as you talk to the service members,
7 what aspect of not having enough information or
8 the information being unclear they say is their
9 biggest criticism or their biggest area of
10 unfavorable common.

11 We've heard that as we've gone
12 around. But as we talk to them, it's kind of all
13 over the map. And in many cases it comes back
14 to I'm just not satisfied with the rating. It's
15 not that I didn't like the -

16 DR. BANNICK: Excellent question.
17 And we don't have the information to tease out
18 frustration with what they think they're going
19 to get or they have gotten.

20 So, the question, the underlying
21 question is good in that I told you most of these
22 ratings are on a one-to-five scale.

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1 At the very beginning because of the
2 articles and the Dole-Shalala findings, for
3 medical hold in the MEB/PEB questions after we
4 received the rating from the servicemember, then
5 we ask, why did you rate that?

6 And it's an open-ended question.
7 So, people are recording this. And the
8 individual is told they're recording this. And
9 then, now you're giving a qualitative review.

10 You have a human being looking at
11 thousands of comments and trying to bin them into
12 groupings.

13 And the groupings that we have found
14 for unfavorable MEB ratings tend to be as we've
15 said here.

16 And that's - it's a thematic
17 grouping. And anyone will tell you it's as much
18 art as it is science.

19 It's not like counting workload,
20 visits and prescriptions and all that. You do
21 count - you count comments, but then a human
22 being is putting them into some sort of category

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1 and this is what we get.

2 The other thing, though, is, this is
3 what we've been getting over time. And then
4 when we compare current results, current quarter
5 results for the most part within one or two
6 percent, we're still seeing the same degree of
7 those comments.

8 CO-CHAIR CROCKETT-JONES: And you
9 also are reflecting that once they've received
10 their rating, the satisfaction goes a little
11 higher compared -

12 DR. BANNICK: Yes.

13 CO-CHAIR CROCKETT-JONES: - to
14 those who have not. So, the satisfaction with
15 their ratings isn't probably what's driving that
16 insufficient or unclear communication, you
17 know, group.

18 Because once they get them, their
19 satisfaction goes up rather than down.

20 DR. BANNICK: I'll phrase it slightly
21 differently, because I think the General
22 actually might be on something there because we

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1 ask them where they are in different stages of
2 the process.

3 So, we have now been able to
4 determine after five years of doing this that -
5 took us about three years of getting the data and
6 changing the questions enough to ask them that
7 we see now the pattern with the numbers piling
8 up.

9 These are really small numbers to
10 begin with. Less so for the Army. More so for
11 the other services.

12 But as these responses have piled
13 up, we've seen this pattern emerge that those who
14 state that they've been through this process,
15 not necessarily gotten a rating, but through the
16 process, so presumably they've gotten a rating
17 or they understand where they're going with it,
18 their ratings are four and five, the top two tend
19 to definitely statistically be different than
20 those others that are in the process.

21 So, does it mean that it's not an
22 issue of confusion or a protracted process

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1 anymore. I think I understand what's happening
2 to me, my future. And, you know, overall
3 experience was better, was good.

4 Does that help, because I don't -
5 CO-CHAIR CROCKETT-JONES: Yeah, I
6 think that when we go around, uncertainty drives
7 a lot of anxiety. So, getting the rating
8 regardless of how they feel about the rating,
9 getting the rating relieves a certain portion of
10 that anxiety. It's now they know where they
11 are, they know what the next steps might be, they
12 have some answers, you know, they have a landing
13 site sort of in sight.

14 So, I think that, you know, we hear
15 that the point of time when their PEBLO no longer
16 has a view of their packet is when they plummet
17 off a cliff of uncertainty. They can - no one
18 knows anything. And I guess it's DRAS moment is
19 really the moment of pain and suffering.

20 So, I'm thinking that that's being
21 confirmed by this by saying those, you know, that
22 second line there with those who have received

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1 results rate their MEB satisfaction higher.
2 It's because they've got the rating.

3 DR. BANNICK: So, I'll step back now
4 and actually put in a plug for the other survey
5 that's been going on, the DMDC-sponsored survey.

6 It's been on hiatus for a year. I
7 understand it's going to start up again in June,
8 but first that one specifically targets those
9 that are in the MEB phase. Secondly, the PEB.
10 And previously, those that were in the
11 transition phase.

12 And goes through, I think, the
13 protocol and are you aware of, were you advised
14 of your rights and benefits, you know? Each of
15 those.

16 It's a very detailed survey. Very
17 detailed. Certainly much better than this.
18 This is a broad brush, 3,000 mile trying to get
19 a handle on that. And we give these data to the
20 Services, and they can, you know, find out from
21 their own military treatment facilities. I
22 will say - so, then that's the DMDC survey.

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1 I can corroborate that 2011 DMDC
2 survey on the one issue of overall rate your MEB
3 experience, my percentages of 50, 53 in the top
4 two are very close to what I saw when I looked
5 at those reports. Not the other questions,
6 because I didn't ask them, and they were highly
7 rated.

8 So, I'm stepping back. I'm
9 thinking I think I have something here for that
10 one question.

11 I talk with my Army colleagues and
12 I get the same response on the MEB overall rate,
13 and theirs is a very detailed - previously it was
14 a very protocol-oriented were you advised of
15 your rights.

16 I think it's been changed, but I'm
17 hearing again last week that for that one area,
18 the ratings I get are matching all on the MEB
19 question.

20 So, there's advantages to this kind
21 of broad brush monitoring overall from the DoD
22 level compiling results down to the Service and

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1 to the MTF level overall, you know, over time,
2 and then the Services doing their more specific
3 fact-finding, okay.

4 So, MEB and then access to care I've
5 already talked about. Okay. So, we're still
6 dealing with background information, but I'm
7 actually answering some of the questions.

8 This is a slide that shows medical
9 hold waitings over time. Six different
10 question areas. Rate your lodging, your
11 ability to manage your duties, we say
12 non-medical attendees, but your friends and
13 family, support given to them, your overall
14 medical hold experience, your healthcare while
15 on medical hold and your basic needs,
16 servicemember.

17 So, we ask this question via
18 telephone. And then we monitor those that are
19 rating top two, the four and the fives shown in
20 the top set of lines. And those that are rating
21 a one or two on the bottom line.

22 Now, part of the data call

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1 specifically said, give us more detailed data
2 for those that are on medical hold specifically
3 related to the non-medical attendees and the
4 overall medical experience. Give us more data.
5 Tell us the Ns that you're getting and tell us
6 the percentages of those.

7 So, if you look at - this chart here
8 shows everyone we've surveyed since 2007.
9 We've truncated the left side to start at - no,
10 we haven't.

11 Later on we'll truncate it to
12 quarter four FY08 just because there's a lot of
13 variation going on. Those are mostly air evacs
14 back there.

15 So, when you start following it from
16 here forward, you see pretty stable the last
17 couple of months.

18 Now, this is an estimate of reality.
19 It's a survey. The cohorts that we survey, we
20 survey a hundred percent air evacs, follow-up
21 air evacs.

22 Those that completed a PDHA from all

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1 services with a medical referral. Those that
2 completed PDHRA with a medical referral. And
3 all those touched the system in some way.
4 Hundred percent census, but you're still
5 estimating reality out there because hundred
6 percent don't answer and so you have to worry
7 about that.

8 So, this is what we're getting over
9 time. So, that's why we say for the most part
10 medical hold seems to be stabilized. Don't know
11 if we're going to see much more than that.

12 And the two areas in particular, the
13 blue line and the purple line, purple, the blue
14 top two ratings are kind of in the pack. They
15 don't stand out as being extremely high or
16 extremely low in the top ratings.

17 And the same thing with the bottom
18 ratings, but then we provide more data to you and
19 tell you.

20 Now, when you look at - when you look
21 at data like this over time, people want to know
22 was it good or bad? And we can say, well, good

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1 ratings, much higher than the poor ratings.

2 So, we say favorable ratings are
3 pretty high. They're pretty decent.
4 Unfavorable ratings are pretty low. Especially
5 some of them that are down here at five percent.
6 Don't see a problem.

7 Then the next question is, well,
8 yeah, but is it significant? Is there a real
9 trend here?

10 So, there's a couple of ways of
11 measuring trends. One is we can look at the very
12 first point, and the very last point and say
13 statistically is 42 percent lower than 55
14 percent.

15 So, you're just doing an analysis of
16 two sets of data here. That's three months'
17 worth of surveying. Actually, the very, very
18 first quarter was just two months, but all the
19 others are three months. So, it's do these two
20 data points differ? You can do that.

21 You can do, well, is the most current
22 month statistically significantly lower than

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1 the preceding quarter? We can do that.

2 Or a third way which we prefer, is
3 to do the whole time period. Truncate it where
4 you're getting a lot of change.

5 Doesn't necessarily mean good
6 change or bad change. Just, you know, we're
7 going to have routine variation in our
8 estimates, but look for some point and assess the
9 whole line. And, in fact, that's what we do.

10 We take all the data points, every
11 single response in that quarter on that item and
12 all the others, and we run what's called a linear
13 regression. And we plot out the data points for
14 a straight line.

15 And then we - you can statistically
16 test does that line have a slope of zero or other
17 than zero?

18 If it's other than zero, is it
19 positive? Which you want favorable ratings to
20 be upward, positive. And you want negative
21 ratings to be - unfavorable ratings to be
22 negative.

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1 As long as they're in those
2 directions, then you can say statistically,
3 significantly different the slope is down, nice,
4 up, great or it's going the wrong way. So, there
5 are ways of testing it.

6 CO-CHAIR CROCKETT-JONES: What about
7 by cohort?

8 Do you see any significant - any data
9 that's different by cohort?

10 DR. BANNICK: I will -

11 CO-CHAIR CROCKETT-JONES: You're
12 getting there?

13 DR. BANNICK: I will talk to that,
14 yes.

15 CO-CHAIR CROCKETT-JONES: I'll be
16 patient.

17 DR. BANNICK: I know Denise is going
18 to wave a flag along the way, but I am watching.
19 I don't know when you want me to end.

20 So, cumulatively, that was one of
21 the big issues. Ah, you're telling us that this
22 quarter we're doing poorly or compared to last

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1 quarter. Well, how are we doing overall?

2 So, this presents those data. And
3 so, the top two ratings are in the green. The
4 bottom two ratings are in the red and the pink.
5 The I don't know, they're kind of squishy on
6 their answer in the yellow.

7 So, when you have a tight yellow,
8 that's really great. When you have a wider
9 yellow, you're wondering if they're hedging a
10 little bit.

11 So, you can see the cumulative
12 ratings are substantial. And then on a given
13 quarterly basis it may be 26 plus 43 or something
14 like that through the routine variation.

15 So, I talked to you a little bit
16 about statistical analysis of assessing whether
17 or not something is significantly different.
18 Different in time or different between groups.

19 So, talking about these areas, we
20 gave you the words here for how we tested this
21 type of data. And others can verify it or do
22 other things.

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1 And so, to show you an example when
2 we're plotting out all the data points
3 cumulative over time and we assess the slope, our
4 favorable ratings, top two positive.

5 So, here for Quarter 1 at FY12, the
6 only statistically significant difference on
7 slope was on the one question Q7 about basic
8 needs. It was positive. So, that's a whole
9 string of data. When you draw that line through
10 it, use your Excel spreadsheet and run it through
11 there, the slope was statistically positive.

12 Go to Quarter 2. We've added one
13 more quarter of data. It's not statistically
14 different from zero.

15 We're estimating, but it doesn't
16 look like it's statistically significant from
17 zero. Third quarter. Fourth quarter.

18 Okay. Now, so, when you look at
19 those jagged lines previously, you can kind of
20 sense sometime that if it looks like the line is
21 up and then it's down, but you're counting all
22 the data points, you watch that downward slope

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1 and maybe statistically significant might be
2 pulling it down.

3 Then when it comes back up again -
4 so, you see when we're comparing over time all
5 the data. And then here, this is T2
6 statistically significantly going in the wrong
7 direction, the unfavorable direction by a little
8 bit, but it hadn't been previously.

9 So, that means the last couple of
10 quarters may be pulling it down and we need to
11 watch it.

12 But again when you're watching this
13 variation going up and down, we really do need
14 to watch this over time.

15 It doesn't mean folks shouldn't be
16 acting on it. You see a couple of points going
17 in the same direction. I think we need to worry
18 about some things, or at least check into it.

19 So, these are statistically
20 significant with all the data points over time.
21 The areas that we are asked about here are on the
22 bottom. Those are the two data points from the

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1 fourth quarter in 2008 to - so, they can be
2 statistically different, right?

3 But you draw the line across that
4 with all the data points. Then the whole slope
5 may not be different. So, there are two ways of
6 doing that.

7 So, we ask - you ask about are there
8 differences in cohort? The answer is, depends
9 on what part of the data we're looking at.

10 So, we tell you again the words about
11 how we do the significance testing, whether or
12 not it's significantly different from 0.05. In
13 other words, a five percent possibility that we
14 could be wrong just by chance when you're
15 estimating. And that may not be acceptable.
16 Some may say, I want to be 99 percent. Right now
17 this is on a five percent probability that we
18 could be wrong by chance alone.

19 So, when we look at all the data,
20 where you see Xs there are statistically
21 significant differences between groups that
22 does not - and when we assess the difference, we

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1 just look for across the five cohorts, is there
2 a difference?

3 Now, we don't test each one. Is air
4 evac different from follow air evac? Air evac
5 different from PDHA?

6 The testing that is entailed there
7 is easily done on computers, but the rigor is
8 actually it becomes harder and harder to do
9 because there's a multiplier effect going on.

10 So, we just - we test through chi
11 squared a difference amongst those groups. And
12 then we can tell you and you could look at the
13 data. Which one seems to be the highest?

14 Is it PDHRA, which is - answers your
15 question higher on certain areas, or is it
16 someone else? Is it a service, you know,
17 overall?

18 But these are all testing all the
19 data through all - since we begun. Since
20 quarter four '08. All the data.

21 Now, we were asked to present data
22 on FY2012 only for those question areas down

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1 below and is there a statistically significant
2 difference.

3 The answer is, yes, there is. Not
4 on all those, but we were asked to look at service
5 pay grade and component. There's a
6 statistically significant difference on
7 service, but amongst the services for those two
8 questions.

9 Now, the Disability Evaluation
10 System. Going back, these are the data since
11 Quarter 4 FY08. The top two ratings of PEB, top
12 two ratings of the MEB, which is the one we tend
13 to focus on. The numbers are greater.

14 The bottom two ratings for MEB and
15 PEB, the Ns. I could have done that earlier.
16 So, these are everyone that we surveyed that
17 quarter that expressed that they're in the
18 Disability Evaluation System somewhere.

19 And specifically, we've identified
20 MEB and PEB. And we give you a range of Ns, 232
21 to 399 responses.

22 Why the range? Well, depends on

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1 which question. Typically those answering the
2 MEB are the larger number, because there's more
3 in that.

4 And PEB, fewer people further along
5 in the system tend to be the smaller one.

6 Okay. So, you can see on average of
7 all those we survey and all those that respond
8 to being in the MEB or PEB phases, we're getting
9 about 400 or so a quarter across the world
10 answering questions about MEB. About 400.

11 So, then you start parsing that out
12 looking for differences amongst services,
13 looking for differences amongst the cohorts.

14 The numbers start getting small.
15 The numbers tend to reflect the surveying that
16 we're doing though, which in other words Army
17 tends to be the biggest stakeholder, the
18 Marines, then the Air Force and the Navy. And
19 we'll get into that.

20 Again, cumulative results over
21 time. Lots of green showing there. But,
22 again, the MEB part of it with about 25 percent

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1 cumulative. We're showing you it's been in the
2 30 percent overall, but now we have another
3 issue.

4 This is still a survey and these
5 people are telling us what they're in. Do we
6 have anything better?

7 We didn't until summer of last year
8 when we had access to the veterans tracking
9 application. We are doing an analysis for
10 Health Affairs and the Warrior Care program
11 people.

12 That helped us identify at the
13 individual level, those that had MEB referral.
14 Those that completed their phases and all that.
15 There was more detailed data.

16 We took those data which were
17 through June of last year, and went back to
18 around 2007. But remember 2007 it was just
19 growing. So, there are very few in there.

20 And we compared it to those who
21 answered the question, are you in the MEB phase?

22 And you can see the results down

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1 there. Overall we were getting 80, 82, 76
2 percent of those that we surveyed in 2010. 82
3 percent. Those that we surveyed and responded
4 they were in the MEB phase, we found 82 percent
5 in the veterans tracking application database.

6 So, now the question is, why not a
7 hundred percent?

8 Well, a couple of things are going
9 on. One, the servicemember really doesn't
10 know. Nothing we can do about that, because we
11 don't target MEB folks.

12 We target servicemembers
13 operationally deployed in one of those cohorts,
14 but equally, likely they are in the Disability
15 Evaluation System and they're not carried in the
16 VTA at that time.

17 So, you see the numbers increasing
18 until you get to 2012. The VTA database that we
19 had only went through June, you know.

20 So, I really would say somewhere
21 between 80, 85 percent match. So, now we're
22 talking external validity.

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1 From a survey person, this is great
2 stuff. Because through a totally independent
3 effort with real data on real people and knowing
4 exactly where they are to the extent that the
5 database is accurate, we're matching up pretty
6 good.

7 So, we do feel that our results in
8 sampling are hitting the right people at the
9 right time and we're getting pretty good
10 estimates of what we think reality is out there
11 within the confines of our data.

12 So, Disability Evaluation System,
13 you can see the ratings of the MEB experience on
14 the one-to-five scale. Top two, bottom two.
15 Top two is favorable. That's what you want to
16 see.

17 So, going back through fourth
18 quarter FY08 in Quarter 1 `12, it was - the slope
19 was positive by 0.35, the beta, it was a
20 positive, but you'll see this positive result
21 slowly changing until it's no longer
22 significant.

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1 The data are being pulled down again
2 by - it's not saying it's bad. It's just saying
3 that there's no longer highly favorable ratings.
4 It's the slope cumulatively seems about the
5 same.

6 Same thing on the PEB experience.
7 It goes from positive to negative. But then by
8 the fourth quarter, it's not negative anymore.

9 So, this is all the data. We were
10 asked to look at 2012. The data are down below.
11 Those are the data points. You can see them,
12 okay.

13 Going back, are there differences
14 amongst the groups? We show you where there are
15 differences with all the data to date. And then
16 specifically looking at 2012, the only
17 difference happens to be in pay grade.

18 Officers O3 to - O4 to O6, I think,
19 had the lower ratings here on both of those, but
20 - so, that's the only statistically significant
21 difference for 2012.

22 And then it kind of makes sense now

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1 because we're looking at more confined data set
2 in specific areas. So, you're looking at four
3 quarters worth of data.

4 So, are there meaningful
5 differences? Well, I would say to you that the
6 general slopes that we've presented here are
7 meaningful.

8 They're meaningful in not changing
9 over time, or they're meaningful in the areas
10 that we've talked about.

11 Are the results meaningful as far as
12 differences in the groupings? Statistically,
13 yes, they are meaningful. Statistically, they
14 are meaningful. And we just summarized a few of
15 these right here.

16 Clinically, are they meaningful?
17 Amongst services are they meaningful? Are the
18 data so small, the numbers are so small in some
19 cases. Does it help?

20 I think they are meaningful in that
21 they give to the Services an area to do more work
22 on.

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1 Not necessarily to work on
2 improving. To do more research on other areas.

3 But I will also say through other
4 surveys and through working with my colleagues,
5 I think we have a fair assessment of these areas.

6
7 And so, there's specific backup data
8 there both as specifically for you, as well as
9 background to the survey.

10 MEMBER EVANS: I think when you say
11 "meaningful," you know, to do more research, I
12 wonder how we show this to - so, if you were a
13 commander in charge of one of the programs, what
14 would they glean to improve?

15 Or if you were a commander in charge
16 of an MTF, what would you glean to improve?

17 I think that's what we -

18 DR. BANNICK: I think it's a really
19 good question, because this is a high-level
20 survey and how does this help me at Lejeune, you
21 know, with what it is I'm responsible for?

22 Well, you've seen the numbers,

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1 you've seen the broad breadth of the scope of
2 this survey and it is worldwide, right.

3 So, now trying to compile all those
4 numbers to provide meaningful data down to the
5 MTF is something that we have to work on.

6 So, we do present these results down
7 to the MTF as they accumulate to our service
8 colleagues so they can see at the MTF level where
9 a particular facility is doing better than the
10 average or worse than the average on the top
11 ratings and the bottom ratings relative to all
12 DoD.

13 So, the Service can look at the data
14 and go, hmm, Facility X here seems to be lower
15 on medical hold ratings, but is doing great on
16 outpatient care, outpatient access. So, what
17 do we want to do about that?

18 So, those data are available. They
19 are cumulative. And we have survey
20 representatives from each of the services and
21 JTF - then JTF CapMed that have access to our
22 database online. So, they can look at specific

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1 questions, specific MTFs or specific
2 intermediate commands to see if they've got
3 areas to focus on.

4 This what you're seeing here is what
5 I - we typically report up to the Services and
6 to - good question.

7 CO-CHAIR CROCKETT-JONES: Thank you,
8 Dr. Bannick. I don't want to get the - I don't
9 want to shortchange you. I think that it's all
10 going to take some time for digestion, but thank
11 you very much.

12 I think that it's been valuable to
13 us.

14 DR. BANNICK: Good. I know survey
15 data has that effect on people.

16 (Laughter.)

17 DR. BANNICK: So, thank you for
18 letting me present and talk it through. And if
19 you have any questions, I'll be glad to answer
20 them.

21 MS. DAILEY: Good. Thank you, Dr.
22 Bannick. We'll see you next year.

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1 CO-CHAIR CROCKETT-JONES: I think we
2 can power right on to Ms. Donna Seymour, the
3 Acting Principal Director for the Office of
4 Warrior Care Policy.

5 Ms. Seymour will be presenting
6 responses to our fiscal year 2012
7 recommendations specific to their office.

8 She will also be presenting
9 information on the Education and Employment
10 Initiative, E2I, and Operation Warfighter.

11 Please find Ms. Seymour's
12 information under Tab L, which you should have
13 gotten a supplemental during your break.

14 (Pause in the proceedings.)

15 MS. SEYMOUR: Good morning. We're
16 live. Okay. Good morning, Recovering Warrior
17 Task Force co-chairs and members.

18 Thank you for inviting me to speak
19 with you today about the great work that's being
20 performed by the Office of Warrior Care Policy.

21 We appreciate the opportunity in
22 this forum that allows us to discuss our

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1 implementation plans for the various
2 recommendations that you've made in your FY2012
3 report, and we can talk about the ongoing
4 progress that we're making in many of the areas
5 that support recovering servicemembers, their
6 families and their caregivers.

7 I'm going to have to be two-handed
8 here. DoD's full response to the 35
9 recommendations of your FY12 report will be
10 submitted to the House and to Senate armed
11 services committees by August - or, excuse me,
12 by May 31st, but today I want to address the 16
13 recommendations that you've specifically
14 requested in your invitation.

15 After addressing each of those 16
16 recommendations, I will also provide responses
17 to the questions that you had regarding
18 education and employment initiative and the
19 Operation Warfighter programs.

20 The issuance process in DoD is
21 complex. As many of you know, it takes time to
22 ensure that we have well-written policy that is

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1 formulated, takes into account all stakeholder
2 contributions and considers the impacts to all
3 stakeholders.

4 I'm pleased to report that DoD has
5 published two of the instructions recommended by
6 the Task Force.

7 The Office of Warrior Care Policy
8 published DoD Instruction 1300.25, Guidance for
9 the Education Employment Initiative, and
10 Operation Warfighter on March 25th of this year.

11 As you know, the Services can
12 publish their own implementing instructions as
13 well.

14 The Air Force issued Air Force
15 Instruction 34-1101, Air Force Warrior and
16 Survivor Care on June of 2012.

17 The Policy and Oversight Workgroup
18 of the Interagency Care Coordination Committee
19 called the IC3, is addressing the third
20 instruction recommended by the Task Force.

21 The Workgroup co-chaired by VA and
22 DoD has drafted an interagency instruction for

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1 complex care coordination that is currently
2 being reviewed by the IC3 members.

3 DoD and VA leadership consider this
4 collaborative effort a very high priority. We
5 will follow through.

6 Improved communication with
7 servicemembers, families and caregivers is
8 essential for effective management of
9 expectations and understanding of the
10 complexities of the Disability Evaluation
11 System especially during a time of great stress
12 that comes with being wounded, ill or injured.

13 A draft Bill of Rights for wounded,
14 ill and injured servicemembers is being
15 coordinated to support and protect every service
16 member's fundamental human, civil,
17 constitutional and statutory rights.

18 The Bill of Rights will address the
19 recovering service member's responsibilities
20 and help family members and caregivers
21 understand rights and responsibilities as well.

22 The Bill of Rights will also support

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1 improved command climate by ensuring we remain
2 focused on being supportive of the recovering
3 servicemembers, their needs and the needs of
4 their families and caregivers.

5 We are using many sources to ensure
6 that the Bill of Rights is comprehensive and yet
7 focused, is written in plain language and is
8 easily understandable and useable.

9 Once approved, we will widely
10 distribute it both in paper and electronic forms
11 using a number of distribution mechanisms.

12 While DoD non-concurred with the
13 Task Force recommendation to change the
14 definition of a Category 2 disability, we
15 believe that we are already meeting a
16 preponderance of the Task Force's intent.

17 A recovery care coordinator is
18 assigned to all wounded, ill or injured
19 servicemembers who meet the current definition
20 of Category 2, seriously ill or injured, or
21 Category 3, severely or catastrophically ill or
22 injured, when the servicemember is enrolled in

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1 a wounded warrior program.

2 Thus, a care coordinator being a
3 recovery care coordinator, an Army advocate, is
4 typically assigned prior to the service member's
5 enrollment in a Disability Evaluation System.

6 We believe this approach balances
7 the needs for our recovering servicemembers,
8 families and caregivers at a critical time and
9 within prudent resource constraints for the
10 Department.

11 MEMBER EVANS: So, I would challenge
12 you to relook that. Because what we find out in
13 the field is that that's not what's occurring.

14 So, if you take a soldier, they don't
15 get an AW2 advocate until - they will assign one
16 when -

17 MS. SEYMOUR: Proposed rating.

18 MEMBER EVANS: - at proposed
19 rating. And so, that's different from what the
20 definition says in the DoDI.

21 And additionally, the conflict that
22 we see between the RCCs and FRCs, again, I know

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1 we - I know WCP and others are looking at that.
2 And I know the definition for FRC is a Category
3 3, but there continues to be a conflict between
4 Category 2 and 3 in assignment of RCCs and FRCs.

5 So, I would - I would recommend that
6 definition is definitely - and that was probably
7 why - one of the reasons the Task Force proposed
8 that you look at Category 2.

9 CO-CHAIR CROCKETT-JONES: The other
10 thing was that we saw folks who were pulled into
11 a treatment plan that was going - that wound up
12 taking more than 12 months, they were not
13 considered Category 2, they were dislocated from
14 their families and wound up being dislocated for
15 more than 12 months.

16 And the idea that you can tell
17 someone you're not seriously injured, you don't
18 need extra support, but it's going to take over
19 12 months for us to get you back to your family,
20 those are - that's a serious conflict.

21 I mean, families - especially since
22 this is 12 months of recovery that sometimes

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1 follows over 12 months of deployment. So, we're
2 talking about keeping families separated
3 because of their Category 1 and not meeting the
4 bar to get their families relocated, not meeting
5 the bar to get, you know, TDLs - is that the
6 displacement, you know, covering the cost of the
7 family visiting, not having even necessarily
8 places for the family to visit them or stay with
9 them, two months - I mean two years of
10 separation, you know, consider - I just - it
11 boggles the mind that someone could say - leave
12 with an infant and not see, you know, be
13 separated from their child until they are, you
14 know, practically in preschool and we say, but
15 it doesn't require any, you know, you're not that
16 serious.

17 MEMBER EVANS: So, if you take the -
18 it further, I mean, if you take the sailor that's
19 sitting down at Norfolk or San Diego and they're
20 there for over a year, they don't qualify because
21 they're Category 1 to have an RCC because of the
22 definition of a Category 1 and 2.

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1 So, we have a purpose for
2 recommending that. And I would ask that you go
3 back and revisit that non-concur.

4 CO-CHAIR CROCKETT-JONES: Because I
5 think that when I look at this implementation,
6 it doesn't cover the gaps that motivated us to
7 make the recommendation.

8 MEMBER MALEBRANCHE: I think the
9 other thing is - I noticed on one of them earlier
10 you said kind of you're awaiting the
11 implementation or guidance from the Complex
12 Interagency Care Coordination.

13 I think this fits that too, because
14 your - different servicemembers from the
15 different services for DoD and VA have gotten
16 together to look at this.

17 And I think this rather than a
18 straight non-concur, is take into consideration
19 this guidance, because I think that group has for
20 exactly these sorts of reasons. So, maybe just
21 a suggestion.

22 MS. SEYMOUR: Okay, thank you. We

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1 will look into that further and I'd like to talk
2 with the Task Force probably more specifically
3 about what you found so that we can pinpoint the
4 issues. Thank you.

5 The Office of Warrior Care Policy
6 provides quarterly training for recovery care
7 coordinators, advocates and non-medical care
8 managers working with the Services to balance
9 DoD-wide and specific service curricula.

10 As an example of the best practice,
11 Navy Safe Harbor send additional subject matter
12 experts to this RCC training.

13 We average four courses per quarter
14 cycling through the student population about
15 every two years for refresher training.

16 We are investigating alternatives
17 to in-class training as well such as distance and
18 computer-based learning so that we can expand
19 our training opportunities, ensuring timely,
20 initial and periodic refresher training.

21 The Marine Corps Wounded Warrior
22 Regiment uses computer-based training to

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1 enhance senior leadership's ability to lead
2 wounded, ill and injured Marines. So, we
3 believe this is certainly something we should
4 look at as a feasibility.

5 The Warrior Care Policy Office
6 collaborated with the Army Medical Department
7 Center and School to identify the needs of squad
8 leaders and platoon sergeants who do not
9 function in the role of a recovered care
10 coordinator and do not require the full training
11 complement.

12 Additionally, DoD and the Army
13 Warrior Training Command are coordinating on the
14 development of training modules to provide
15 awareness of roles and responsibilities of the
16 various coordinators in the field.

17 We completed a review of existing
18 curriculum in October of 2012, and we will review
19 compliance with that by the end of July.

20 We then will update the curriculum
21 by the end of the fiscal year in preparation for
22 fiscal year 2014 classes.

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1 As part of the congressionally
2 mandated Physical Evaluation Board Liaison
3 Officer management study, the Office of Warrior
4 Care Policy has evaluated the content and
5 effectiveness of PEBLO communications to
6 recovering servicemembers, families and
7 caregivers.

8 Initial report confirms some
9 service-specific variation in training
10 standards and learning objectives, but all four
11 services are providing information and
12 counseling.

13 Our goal is to publish standard
14 training objectives and learning objectives by
15 June 30th of this year to ensure DoD-wide
16 consistency.

17 Warrior Care Policy has developed
18 communications tools to increase information
19 available to recovering servicemembers, their
20 families and caregivers about available
21 resources and benefits.

22 These information tools will be

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1 incorporated into initial IDES in-briefs for all
2 servicemembers and caregivers as part of the
3 updated PEBLO training objectives and learning
4 standards. We continuously review these
5 materials for improvement.

6 Let me give you some examples of how
7 this information is currently made available.

8 The Navy provides transition
9 services information during PEBLO counseling
10 and transition assistance program classes. VA
11 program contact information is also provided at
12 that time.

13 The Marine Corps Wounded Warrior
14 Regiment regularly educates Marines and
15 families in post-separation benefits in
16 one-on-one settings and provides information
17 via electronic print and social media.

18 All Army soldiers entering IDES are
19 referred to pre-separation counseling,
20 including VA benefits orientation and a
21 disability workshop.

22 At completion of the referral stage,

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1 soldiers meet with a VA military service
2 coordinator who provides additional information
3 on prospective VA benefits.

4 Air Force non-medical case managers
5 and recovery care coordinators advise
6 recovering servicemembers, their family members
7 and caregivers on potential benefit changes and
8 assist in connecting them with veteran centers
9 and other federal and state resources.

10 VA representatives co-located with
11 or near airmen and family assistance centers
12 provide briefings on VA benefits and
13 post-transition services.

14 CO-CHAIR CROCKETT-JONES: Can I ask
15 you about that national Resource Directory
16 widget? Because I know it might shock you to
17 find out that when we've asked at 15 installation
18 visits, we've had one out of hundreds of people
19 that we've talked to, one person has ever heard
20 of the National Resource directory. And one
21 other person who after our question went and
22 looked at it, and said it was out of date for

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1 their zip code.

2 What's the widget and how, you know,
3 I don't even know what a widget is. So, could
4 you explain that one?

5 MS. SEYMOUR: Certainly. We're
6 going to talk about that also as we move through.
7 There is a slide that talks about the National
8 Resource Directory.

9 And we are launching a campaign this
10 year to get the NRD widget put on prominent
11 websites. We'll be working with Senate and
12 congressional members to get it put on their
13 websites.

14 We'll also work it -

15 CO-CHAIR CROCKETT-JONES: So, is it
16 basically a link?

17 MS. SEYMOUR: It's basically a link.
18 In laymen's terms, it's a link.

19 And we will also work with - work
20 that into our PEBLO training standard
21 curriculum.

22 Our implementation plan for this

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1 item goes hand in hand with the previous item.
2 We will include information about the
3 Exceptional Family Member Program and the
4 potential for loss of TRICARE Extended Care
5 Health Option benefits in our standardized PEBLO
6 training.

7 As a more immediate response,
8 though, the Services are addressing the issue
9 each in their own manner.

10 The Navy Bureau of Medicine PEBLOs
11 ensure that recovering servicemembers and their
12 families and caregivers have contact
13 information for TRICARE benefits counselors.

14 Army recovering servicemembers are
15 not covered by the Extended Family Member
16 Program or the Extended Care Health Option, but
17 those soldiers with family members in either of
18 these programs need to understand that benefits
19 may change if the servicemember is separated or
20 retired as a result of disability evaluation
21 process.

22 Army will continue to refer the

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1 soldier and the family to the Soldier Family
2 Assistance Center and to a TRICARE benefits
3 counselor who can discuss these benefits in
4 depth with the soldier and their family.

5 Air Force military treatment
6 facilities plan to brief the servicemembers upon
7 entry into IDES to inform the EFMP, families and
8 caregivers about the potential loss of TRICARE
9 Extended Care Health Option Benefits upon
10 completion of IDES if discharged.

11 MEMBER DRACH: Ma'am, I'm sorry.
12 Can we go back to the NRD just for a second? A
13 lightbulb just went off.

14 One of the other issues with NRD is
15 its name. Has no relations to wounded warriors,
16 military or anything.

17 If you Google almost any associated
18 word with wounded warriors, NRD does not pop up.

19 Are you giving any consideration to
20 changing its name to be more military-centric?

21 MS. SEYMOUR: That is also one of the
22 recommendations that you've asked me to speak to

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1 today.

2 We non-concurred in the
3 recommendation to change the name. We are
4 getting over a hundred thousand visits to the
5 National Resource Directory each month. So,
6 there may be some other actions that we could
7 take that would have it more accessible via a
8 Google search or something like that even though
9 the name doesn't contain the words "wounded
10 warrior" or -

11 MEMBER DRACH: Any idea who the
12 hundred thousand hits are coming from since
13 we're not seeing anybody at the site visits that
14 know about the NRD?

15 So, it's not coming from the
16 wounded, ill and injured or their family
17 members.

18 MS. SEYMOUR: We are using Google
19 statistics and we could provide the Task Force
20 information on what we have there.

21 DoD agrees that services should make
22 every attempt to keep families together during

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1 the disability evaluation process. And we
2 continue to collaborate with our VA partners to
3 improve the process accelerating timeliness to
4 minimize family separation while carefully
5 balancing our quality of care and services.

6 Each of the services offers unique
7 opportunities and solutions to meet the needs of
8 the recovering servicemember.

9 I've heard that you have issues in
10 this area. So, this is probably another area in
11 connection with the other that we will look into
12 further.

13 Members of the Navy Reserve are
14 afforded two options for dealing with injury.
15 They may be placed in medical hold status at one
16 of two sites.

17 While that is often distant from
18 family members, it affords the recovering
19 servicemember full pay and allowance.

20 The servicemember may also be placed
21 in line of duty status and located at their home
22 of record in the immediate vicinity of family

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1 members and caregivers with pay and allowance
2 commensurate with line of duty program
3 guidelines.

4 The Army used the Joint Travel
5 Regulations to authorize transportation and per
6 diem for designated individuals who are
7 authorized to visit servicemembers, including
8 those that are wounded or injured in combat
9 operation or in a combat zone or when
10 hospitalized in a medical facility in the U.S.
11 for treatment of that wound or injury, and
12 soldiers continue to receive evaluation, care
13 and transition services commensurate with their
14 needs and closest to their support network, a
15 warrior transition unit or community-based
16 warrior transition unit for the Reserves.

17 CO-CHAIR CROCKETT-JONES: Well, I
18 think that one of the things that we probably
19 want to impress upon folks is that this is a
20 balancing - sort of balancing two priorities.

21 Folks going to community-based
22 warrior transition units really - they need to

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1 be sure that they actually have the support of
2 family and the medical ability to access the
3 medical care properly.

4 There is some consternation when
5 they get sent and then get pulled back. So, we
6 know that this is not an easy deliberation.

7 So, we just wanted - I think the Task
8 Force, and they can correct me if I'm wrong, I
9 think the Task Force basic concept was that if
10 we - once we make that determination that they
11 need to be housed somewhere away from their
12 family when we know it's going to be an extended
13 period of time, we have to get - we have to do
14 a better job of getting families in support to
15 them. Not pushing them out too soon to get to
16 their family, but taking some time and weighing
17 out medical care access and family support as two
18 parts of the equation that both need to be
19 considered.

20 MEMBER EUDY: To follow along with
21 that point, something, ma'am, that I feel should
22 be looked into on your office's behalf is across

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1 all the services there are differences in the
2 amount of days that it takes for implementation
3 of the items in the JFTR based on the color of
4 suit you wear. Whether it's blue, green, it
5 doesn't matter, and it shouldn't be happening
6 like that.

7 You may have a servicemember of
8 every single branch with a different injury - or
9 the same injury, excuse me, across all branches.
10 And whether it's the payout process, the
11 turnaround time for orders, there is no reason
12 in one service that a family member is able to
13 make it bedside and another one is not just based
14 on service specifics or idiosyncrasies of
15 processing.

16 And also, standardization amongst
17 the written documentation for movement of
18 inpatient regardless of service branch from a
19 military treatment facility to a VA facility for
20 polytrauma, making sure that the regulations are
21 equivalent across the services regarding the
22 original ITOs, or the - I'll just use a general

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1 term. The emergency family travelers that
2 brought those three members to bedside.

3 In the cases of our VSI
4 servicemembers, moving then to VAs which in some
5 documentation may be looked at as a lower level
6 of care or outpatient type of care. Again,
7 making sure that it's equivalent across all the
8 services.

9 MS. SEYMOUR: Okay. Thank you for
10 those comments. We will go back and take a
11 relook at that area.

12 MEMBER EVANS: So, you will have to
13 go back to the Casualty Affairs, because each
14 service, they run their Casualty Affairs
15 differently.

16 So, that's who - the generation of
17 family orders will come out of that area. So,
18 I - that would be interesting to the Task Force
19 to see how we can standardize that process.

20 I think that would be a huge - and
21 I'm not sure if WCP would have the ability to go
22 and change that.

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1 MEMBER EUDY: I think my concern was
2 just the differences in implementation of JFTR.

3 We have one common document we're
4 looking at, that everyone is then turning it into
5 their own process for implementation on the
6 ground for their service.

7 MEMBER EVANS: Okay.

8 MS. SEYMOUR: Again, we'll -

9 MEMBER EVANS: It would be
10 interesting to get some more information on it,
11 because I know each service is generated through
12 their Casualty Affairs. And so, we have to look
13 at that process to each of the services.

14 MS. SEYMOUR: Okay. We can
15 certainly partner with the right folks to look
16 into that further. Thank you.

17 DoD is not convinced, this is your
18 point, that changing the name of the NRD is going
19 to increase the usage.

20 Again, we're seeing about a hundred
21 thousand visits to the site each month. We will
22 get you some metrics on what those visits

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1 represent.

2 The BNRD is hosted by the Veterans
3 Affairs with major contributions from VA, DoD,
4 Department of Labor and of course other
5 agencies.

6 We have engaged in many ways to
7 ensure the success of the National Resource
8 Directory.

9 We worked with the National Capital
10 Region InfoNet to have NRD commercials posted
11 throughout the InfoNet kiosks. Those are
12 located in prominent federal buildings such as
13 the Pentagon, Mark Center and many other
14 buildings here in the National Capital Region
15 understanding that we may need to do some work
16 outside of the National Capital Region.

17 CO-CHAIR CROCKETT-JONES: I would
18 say it's just my intuition that the people inside
19 the National Capital Region are the least likely
20 to need the NRD.

21 I mean, what we hear when we talk to
22 folks at Walter Reed and do our installation

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1 visit, is that these people have more access to
2 more programs than anywhere else that we go. In
3 fact, there may be saturated and over-tapped for
4 various programs.

5 So, when we go out to the middle of
6 nowhere and no one has heard of it, no one finds
7 it when they Google, no one even when asked what
8 they think it is by name, no one has any ID
9 recognition whatsoever.

10 I mean, really, the one person that
11 we had who had heard of it, was a cadre member
12 who had been in this region at one point.

13 That's the big, huge zero. It's
14 pretty astounding considering what I take to be
15 its cost given its collaborative effort.

16 I mean, I think that if we found out
17 how much it cost in total considering
18 collaboration from every department and I can't
19 imagine what people would say if then they
20 balanced that cost against a zero recognition.

21 I mean, zero when we go out. And
22 this is among folks who sometimes have been

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1 inside of a warrior transition unit for years.

2 I'm just - even the folks who are RCC
3 trained, zero. It's pretty astounding. I
4 mean, you'll have to - you have to go a long way
5 to convince me that commercials in the National
6 Capital Region are going to have much of an
7 impact on that zero.

8 I mean, I'll wait and see what the
9 installation visits next year say, but this is
10 in particular an area in which I am thoroughly
11 unimpressed by the efforts that have been made
12 or even what's on this list. Just saying.

13 MS. SEYMOUR: Message received.
14 Thank you.

15 We are also - we talked earlier about
16 organizing that campaign to get the NRD widget
17 loaded onto prominent websites. We're working
18 with our corporate partners as well in that.

19 We do continue to distribute the NRD
20 postcards and other marketing materials. The
21 NRD demonstrations have been added to the
22 quarterly Recovery Care Coordinator Training

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1 Program as well. And we'll get you those Google
2 analytics/information to show those hits.

3 We continue to look for ways to
4 improve the NRD and work with the VA and other
5 federal partners to ensure its continued
6 success. So, we'll look into -

7 MEMBER MUSTION: You mention that
8 you're sending out postcards about - who are you
9 sending them to; do you know?

10 MS. SEYMOUR: I don't have the
11 specific people that we're sending them to, but
12 I know we're using the marketing materials.
13 When we visit installations, when we, you know,
14 meet with congressional members, when we do the
15 RCC training, we're handing them out there.

16 MEMBER MUSTION: Okay. Thanks.

17 MS. SEYMOUR: So, we probably need a
18 wider distribution campaign.

19 MEMBER DRACH: So, when Admiral
20 Mullen was chairman of the joint chiefs, he
21 issues - I forget exactly what it was called, but
22 he sent something out to all the services suggest

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1 - not suggesting, telling them that they should
2 be using and implementing and publicizing the
3 NRD. And I think the other was military.com.

4 Any thoughts about perhaps a
5 reissuance of that?

6 MS. SEYMOUR: A reissuance of
7 something that General Mullen -

8 MEMBER DRACH: That Admiral Mullen
9 had put out. Maybe the current chairman could
10 put it out again.

11 MS. SEYMOUR: We could certainly look
12 into that and that would be part of our campaign
13 to market it.

14 MEMBER DRACH: Okay.

15 MS. DAILEY: And also, Ms. Seymour,
16 I've been doing focus groups with DoD members for
17 a very long time.

18 So, you know, I saw this in 2002,
19 2004, 2005 when my task force at the time was
20 asking servicemembers about Military One
21 Source.

22 And, you know, it was really tough

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1 in those first few years to find a family member
2 who knew about Military One Source, but the
3 trajectory after a while went way up.

4 And so, I think there might be a
5 lesson learned over in MFNP, Military Family and
6 Community Policy - Military Community and Family
7 Policy, Norah Cross over here, and they've got
8 Military One Source charter. And, you know,
9 that - it was the same thing in the first
10 beginning years of Military One Source.

11 Couldn't find anyone who knew it,
12 but after a while a contractor got some traction.
13 And so, there might be some lessons learned over
14 in Military Community Family Policy on that.

15 CO-CHAIR CROCKETT-JONES: I also
16 want to say that in general if zip codes that are
17 way out there in the hinterlands are not aware,
18 you know, people aren't using the NRD, that
19 they're going to become low priority for keeping
20 it up to date.

21 The places that are going to be
22 updated most rapidly are the places where it's

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1 most used. That's generally how website
2 updates happen.

3 Which means the people who need it
4 the most don't know about it. And when they get
5 there, it's the least up to date.

6 It just seems like a lot of gears and
7 bells and whistles that are missing the target.

8 MEMBER MALEBRANCHE: I think the
9 other thing when Denise was talking about
10 Military OneSource, almost everywhere on this
11 last group of site visits they all knew Military
12 OneSource. That was one thing they did know.

13 So, maybe some kind of connectivity
14 there. I mean, I'm not sure how all that works.
15 But I think as far as the marketing -

16 MS. DAILEY: There is, yeah.

17 MEMBER MALEBRANCHE: But it might be
18 -

19 MS. SEYMOUR: There's already a
20 connection, but we can look into that further.

21 MEMBER MALEBRANCHE: Okay.

22 MS. SEYMOUR: DoD agrees that placing

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1 Reserve component recovering servicemembers on
2 Title 10 orders is a timely - in a timely manner
3 is important.

4 Army Reserve has a pending request
5 to allow them access to Active Duty Orders
6 Program.

7 When fully developed, the module
8 would allow a single access point that is
9 automated and traceable.

10 The system ensures that packets
11 submitted for active duty, medical extension and
12 medical retention processing will have one
13 access point and one routing chain and can enable
14 submission to multiple processes with only minor
15 modifications.

16 The system will speed up the review
17 process. And, consequently, the orders
18 process. Thus, reducing the need for INCAP.

19 The Army National Guard is working
20 to expand their program to cover all guardsmen.

21 Other options currently available
22 to rapidly place guard soldiers on Title 10

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1 orders are the active duty medical extension and
2 medical retention processing programs.

3 Soldiers must be on active duty in
4 order to be seen at nearby military treatment
5 facilities. Therefore, the state sometimes
6 utilize their own funds to place the soldiers on
7 orders to attend medical appointments.

8 The Air Reserve component case
9 management division has been established to
10 assist in expediting medical continuation
11 orders, identifying cases for referral whether
12 Title 10 orders or not, and working alongside the
13 medical branch and warrior and survivor care
14 division to meet the needs of the wounded, ill
15 and injured airmen.

16 Working toward rapid issuance of
17 Title 10 orders is a primary function of that
18 division.

19 DoD has published a new instruction
20 on education employment initiative. We talked
21 about that earlier. And the instruction on the
22 vocational rehabilitation and employment

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1 counseling for servicemembers transitioning
2 from IDES is in coordination and should be
3 published by the end of this fiscal year.

4 DoD and VA have expanded their
5 existing Memorandum of Agreement so that all
6 recovering servicemembers receive vocational
7 rehabilitation and employment counseling upon
8 entering IDES. This allows pre-separation
9 access to the VA program.

10 Additionally, DoD coordinated with
11 VA to provide vocational rehabilitation and
12 employment services at the earliest opportunity
13 to active duty servicemembers, including
14 National Guard and Reserve members on active
15 duty orders. Servicemembers in IDES are also
16 referred to VA VR&E counselors.

17 The VA placed 105 counselors at
18 military installations in fiscal year 2012 and
19 is actively hiring 95 additional counselors
20 working with the Services to provide physical
21 space and access to servicemembers at 47 bases
22 during FY13.

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1 MEMBER MALEBRANCHE: If I could just
2 make a comment to that on the site visits that
3 we did, it was really heartening to hear that
4 they are - the servicemembers and our groups and
5 all were actually touching and I think that
6 co-location was such a great idea. I think it
7 really makes a difference.

8 So, it will be interesting with 95
9 more, but it did seem like that was working well.

10 MS. SEYMOUR: Thank you for that
11 feedback. It is a best practice.

12 Military departments use DoD policy
13 to guide referral into the integrated disability
14 evaluation system.

15 The Office of Warrior Care Policy
16 monitors return to duty rates as a benchmark for
17 inappropriate IDES referrals and reports of
18 gradual decline in RTD rates overall.

19 In January 2013 the return to duty
20 rates represented the smallest proportion of DoD
21 IDES cases. About seven percent, a nine percent
22 decrease since January of 2012.

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1 We provide bi-monthly briefs to the
2 Disability Improvement Working Group and the
3 Benefits Executive Council, both of which
4 provide oversight of the IDES process.

5 Navy/Marine Corps servicemembers
6 are continuously evaluated for appropriate
7 placement on either light duty, short-term duty
8 restrictions or limited duty, longer term duty
9 and assignment restrictions or IDES referral
10 based upon the service member's medical
11 condition, the anticipated prognosis for
12 recovery and the impact on their ability to
13 perform the duties at their rank, grade or
14 office.

15 Army continues to have a low rate,
16 four to nine percent, of soldiers who are
17 returned to duty after being evaluated in the
18 IDES process and continues to refine fitness for
19 duty standards as needed to maintain current
20 processes that ensure an adequate review prior
21 to referral into the IDES.

22 Since March of 2012, the Air Force

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1 has had a pre-screening process in place to
2 minimize inappropriate IDES enrollments. In
3 May of 2012, the DoD and VA Secretaries tasked
4 the Departments with implementing a paperless,
5 searchable claims case file for IDES. The
6 Departments began testing an IDES electronic
7 case file transfer capability in September of
8 2012. We tested it at four military
9 installations, five DoD PEB locations and two VA
10 Disability Rating Activity Sites.

11 In January of `13, the testing was
12 suspended for Army and Navy while the VA
13 determined requirements to develop an interface
14 between this ECFT, the case file transfer
15 system, and the Veterans Benefits Management
16 System, VBMS.

17 The interface is expected to be
18 completed in late 2013 and will eliminate manual
19 downloading of IDES cases from ECFT to Virtual
20 VA or VBMS and instead auto-populate the case
21 files from ECFT into VBMS. That will save both
22 manpower and increase efficiency. The Joint

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1 Executive Committee is meeting in October of
2 2013 and is expected to decide on expanding the
3 ECFT implementation.

4 We will reinvigorate the IDES
5 customer satisfaction survey process in fiscal
6 year 2013. DoD has revised the survey
7 instruments to incorporate feedback and
8 guidance from Congress, from the Government
9 Accountability Office, and the Defense Manpower
10 Data Center, as well as lessons learned from the
11 previous surveys.

12 Key areas of change include the
13 elimination of the transition phase legacy DES
14 and the family member surveys. DoD has also
15 decreased the quantity of questions in the MEB
16 and PEB surveys and developed new questions that
17 are expected to yield actionable results.
18 These changes have been made to advance DoD's
19 efforts in determining the extent to which IDES
20 is meeting customer satisfaction goals. An
21 additional of these changes will be a reduction
22 in the survey cost and the burden on survey

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1 participants.

2 DoD is continuing to explore
3 alternative approaches to measuring
4 satisfaction. We have submitted proposed
5 survey instruments and supporting renewal
6 process documents to DMDC for formal review, and
7 we anticipate the revised surveys will be
8 administered in the spring of 2013.

9 This item was considered as part of
10 our Consolidated Disability Evaluation System
11 study for Congress. The results of that study
12 are being briefed to and reviewed by senior
13 leadership prior to submission to Congress, and
14 so I feel it would preempt leadership's decision
15 making for me to discuss this further at this
16 time.

17 Congress directed that the PEBLO
18 study determine the adequacy of current ratio
19 and staffing levels. The current PEBLO ratio is
20 based on data provided by the military
21 departments as of December of 2012. The
22 military departments are completing a manpower

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1 study that will be used to determine the optimal
2 PEBLO ratio necessary to meet installation level
3 mission requirements. We are staffing an
4 interim PEBLO report with senior leadership now.

5 The PEBLO addendum report which will
6 address specifically the PEBLO ratio, is
7 anticipated to be delivered to Congress in
8 February of 2013.

9 MEMBER EVANS: Will we invite her
10 back to have a follow-up?

11 MS. SEYMOUR: I'd be happy to do so.

12 MS. DAILEY: I suspect we'll be
13 seeing lots of Ms. Seymour, and I think it will
14 be fun for everyone.

15 MS. SEYMOUR: The pleasure will be
16 mine.

17 CO-CHAIR CROCKETT-JONES: In the
18 development of the staffing models, I know we've
19 seen an alternate model with administration
20 assistance rather than all PEBLO staffing. Is
21 that all part of this comparison in your study,
22 the manpower study?

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1 MS. SEYMOUR: The specifics of that
2 study, because we are still in staffing, I can
3 get you a better response after the meeting on
4 that.

5 CO-CHAIR CROCKETT-JONES: Thank you.

6 MS. SEYMOUR: Currently all service
7 PEBLOs inform recovering servicemembers that
8 legal counsel is available.

9 DoD will publish new training
10 objectives and learning standards for all PEBLOs
11 and the training courses by June 30th of this
12 year, along with the Recovering Servicemember
13 Bill of Rights.

14 We think those two things will help
15 improve the information that PEBLOs provide to
16 servicemembers, their families and caregivers
17 so that they know legal counsel and other
18 stakeholders are available to assist them.

19 MEMBER MUSTION: Could I ask a
20 question about the last one, because one of the
21 observations that's been going around is that
22 MEB outreach lawyers or that legal support is

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1 very good. And the recovering warriors really
2 appreciate it. And it's been very helpful in
3 helping to resolve conflicts and concerns.

4 Can you explain why the Department
5 of Defense non-concurs with requiring that
6 engagement to take place?

7 MS. SEYMOUR: I think it probably
8 goes to the 100 percent being contacted by a MEB
9 outreach lawyer as opposed to us informing the
10 recovering servicemember that they are
11 available should they decide to contact them. I
12 think that is where our non-concurrence came
13 from.

14 So, it's whether the - it's a
15 proactive outreach or whether it's a contact
16 letting them know that the service is available.

17 CO-CHAIR CROCKETT-JONES: Let me
18 just say that in certain areas where contact is
19 discussed when we go around to our visits, this
20 is not the only area, but when it comes to legal
21 outreach, what servicemembers hear at this point
22 is, well, if you need an appeal, I think part of

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1 the issue is that the folks who are now giving
2 the information that legal is available, don't
3 always give the accurate information about what
4 is actually available. There is a disconnect in
5 what is available and what they are told is
6 available.

7 And I think our recommendation was
8 aiming at letting the folks in IDES get accurate
9 information from legal itself rather than
10 secondhand information which is sometimes - it's
11 a variable.

12 And on top of that much like when we
13 talk to folks about contacting family members,
14 contacting - legal has, you know, they
15 understand what we mean with positive contact,
16 but frequently if someone has sent an email, they
17 consider it contact. They have no way of
18 knowing if the email was received or opened or
19 understood.

20 And so, our concern here is that less
21 than accurate information is sent out and that
22 is considered contact. And we'd like to see

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1 something that aims higher and is accurate.

2 So, if you can take that back when
3 looking at your long-term over this issue.

4 MEMBER MALEBRANCHE: I think it's
5 worthy to note too in the places where we went
6 where there was a hundred percent contact of
7 those that we spoke to, there was a hundred
8 percent satisfaction whether they used them or
9 not.

10 The fact that they had this contact
11 and this professional support was like I was
12 really helped. It was a really good - it was
13 just a good thing to do. It was a good thing to
14 do. Good practice.

15 MEMBER EUDY: And a follow-up, ma'am,
16 to Ms. Crockett-Jones' statement regarding
17 servicemember responses, we find that they say
18 legal provides the most accurate information
19 because they see the IDES process from both ends,
20 from both the receiver and the sender, and then
21 getting it back, the repeals, everything.

22 So, the law side is more up to date

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1 in most cases than you may find a PEBLO even in
2 some cases that's been working for years just
3 because they deal with it in every single way and
4 every single day.

5 MEMBER PHILLIPS: A bit unfair to ask
6 you, but what would the downside be to have the
7 MEB contact do that for each one?

8 I know there's cost and - but if you
9 eliminated all the other forms of contact and
10 just required the MEB outreach lawyer to make the
11 contact, I mean, you might find a balance
12 somewhere.

13 And from our visits as everyone has
14 said, there's tremendous satisfaction when that
15 happens as compared to when it doesn't happen.

16 MS. SEYMOUR: I'd like to look into
17 this a little bit further and come back to the
18 Task Force given your comments here today and
19 follow up. Thank you.

20 Okay. That sums up the 16
21 recommendations that you asked that we address
22 here today, but you asked us some very specific

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1 questions with regard to the Education
2 Employment Initiative and the Operation
3 Warfighter Initiative.

4 MS. DAILEY: I'm sorry, Ms. Seymour.
5 Real quick on that last one. Something that you
6 all might want to consider across the board when
7 we talk to the lawyers, they don't all have
8 access to VTA.

9 Some of the lawyers do have access
10 to VTA. Some don't. So, that might be one way
11 to penetrate that market a little better.

12 MS. SEYMOUR: Thank you.

13 MS. DAILEY: On to E2I. Thank you
14 very much for putting out the - getting out the
15 DoDI. Great stuff.

16 One of the ways the Task Force loves
17 to see and is a big advocate for the publication
18 of Department of Defense instructions.

19 MS. SEYMOUR: Great. Thank you.

20 The Education and Employment
21 Initiative matches servicemembers with career
22 or educational opportunities and links them with

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1 professional placement assistance provided by
2 Department of Labor through their disabled
3 veterans outreach program specialists and other
4 resources available through the Department of
5 Labor.

6 DoD is unable to provide Department
7 of Labor metrics on placements at this time
8 though.

9 Some of the concerns previously
10 countered in working with the services include
11 a lack of overarching DoD policy and command
12 emphasis on participation which I believe we're
13 solving with the DoDI. And then we will be
14 working with commands as well to get that word
15 out.

16 And the second item was access to
17 non-federal internship opportunities. We are
18 working with the Readiness Office and the
19 Assistant Secretary of Defense's Office for
20 Readiness and Force Management on the ability to
21 offer non-federal internship opportunities.

22 Participation also is depended upon

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1 the recovering servicemember, their motivation,
2 their interests and their readiness to move into
3 a new phase of their recovery process.

4 Now that the policy is in place,
5 Warrior Care Policy expects utilization and
6 command support to increase for both of these
7 programs.

8 CO-CHAIR CROCKETT-JONES: So, am I
9 right to think that at some point down the line
10 we'll get an idea of placement rates, or did I
11 not hear you correctly?

12 MS. SEYMOUR: No, we would like to
13 have that information as well. So, we will work
14 towards that.

15 MEMBER DRACH: On the -

16 MS. SEYMOUR: That's just not
17 something that we have. That's Department of
18 Labor data.

19 MEMBER DRACH: On the challenges,
20 access to non-federal internships if I heard you
21 correctly, it's not really access to it, it's
22 issues related to potential problems with it.

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1 Because, I mean, there's
2 non-federal employers out there that are budding
3 at the bit to get involved in Operation
4 Warfighter.

5 So, access to those internships
6 would be as simple as reaching out to the Better
7 Business - or the Chamber of Commerce, the SHERM,
8 NFIB, there's a whole bunch of employer groups.

9 So, is it really access to the
10 internships, or the concern of fraud and abuse
11 or some other issue?

12 MS. SEYMOUR: You are absolutely
13 right in that there are many private firms that
14 wish to have opportunities for the wounded, ill
15 and injured.

16 The issue is both a legal and policy
17 issue that we're working within the Department.
18 And of course we want to make sure that those
19 opportunities are appropriate and that those
20 employers are prepared and understanding of, you
21 know, the situation of our recovering
22 servicemembers.

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1 MEMBER DRACH: So, a mom and pop store
2 out there that wants to do an internship right
3 now could not do it; is that still correct?

4 When will non-federal internship
5 employers be able to participate?

6 MS. SEYMOUR: I don't have a date for
7 you on that, because the Warrior Care Policy
8 Office does not own that policy. So, that's why
9 we're working with the Readiness and Force
10 Management organization to provide the right
11 policies, put the right policies in place so that
12 we can partake in those types of opportunities.

13 MEMBER DRACH: So, it would be
14 premature to talk to any private sector
15 employers about internships under OWF at the
16 present time.

17 And the second part of the question,
18 does this include non-profits?

19 MS. SEYMOUR: You know, I believe it
20 does include non-profits. And I would say that
21 it's never too early to talk about
22 opportunities, because these things take time to

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1 plan.

2 So, I would not want to shut down
3 those avenues just because we don't have the
4 right policies in place at this time.

5 I'm sorry, there was another
6 question?

7 MS. DAILEY: I'm sorry, I just was -
8 Mr. DiGiovanni who was in here a little while ago
9 is handling that piece. You're not going to
10 find it under the OWF program. It's going to be
11 a separate program, yeah.

12 Because all she's got is the federal
13 internships and the E2I program. Mr.
14 DiGiovanni is the man for the rest of the
15 opportunities.

16 MS. SEYMOUR: Thank you.

17 That concludes my prepared remarks.
18 Again, I want to thank you for the opportunity
19 that you provided today for me to address these
20 specific recommendations.

21 I'm interested in hearing your
22 perspectives. I'll follow up on the actions

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1 that we have discussed today and prepare to
2 answer your questions.

3 MEMBER EVANS: I just - I have one and
4 I don't know if it's a question, recommendation,
5 but I definitely would like to see over the next
6 year more collaboration and standardization
7 between the service programs.

8 It's just a challenge to be out
9 there, you know, talking to the warriors. And,
10 you know, you can be on one base and just
11 different services provide a lower services
12 provided to these individuals.

13 So, we really need to work on as much
14 as possible if I walk into a soldier room, it's
15 not different. I can hear the same type of
16 services being provided.

17 And I think your shop has the ability
18 to bring some of that together with the respect
19 to the different cultures, I understand
20 cultures, lived that for two years, but
21 definitely want to see standardized more and
22 more starting with the categories.

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1 The DoDI, I will recommend we look
2 at their recovery, that instruction to make sure
3 we are capturing what the intent of the law says
4 we should be doing.

5 So, there's a lot of things I hope
6 we can see improved over the next year.

7 CO-CHAIR CROCKETT-JONES: I think
8 that also the Task Force as it starts its next
9 years, we will be seeing the beginnings of the
10 effect of the Health Affairs emergence, I mean,
11 yeah, the multiservice market plans and
12 cross-service issues will probably become more
13 clear. They'll be more. There's more
14 potential for, you know, some head bumping on and
15 comparisons.

16 So, I hope the Policy Office is sort
17 of anticipating the need for rejiggering those
18 multiservice markets, you know, kind of emergent
19 and formulate and coalesce.

20 MS. SEYMOUR: I would agree with both
21 of your comments that we are - I believe the
22 Warrior Care Policy Office is uniquely

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1 positioned and that that is part of the mission
2 set for that office.

3 What would probably be interesting
4 and helpful is if the Task Force could help guide
5 us into which pieces of the process you're
6 finding the most variability and where you think
7 there could be the greatest gains for
8 standardization.

9 MS. DAILEY: And, ladies and
10 gentlemen, I wouldn't discount the influence of
11 the IC3. I would assume, Ms. Seymour, that IC3
12 when it publishes its two sets of guidance for
13 a unified recovery care plan, one single
14 recovery care plan, that's a big deal. That
15 will rejigger the RCP policy 1300 - yes,
16 significantly.

17 And so, the - when those are
18 published, we're going to see kind of a major
19 reshuffling and compliance through the
20 services, through your policy programs.

21 So, the influence of the IC3 is
22 significant. And we need to follow and track

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1 its influence and the changes that it will
2 engender.

3 MEMBER MALEBRANCHE: Thank you,
4 Denise. I was going to put a plug in for that
5 being the co-chair of the policy piece of that.

6 I think we still may even try to
7 pursue this joint policy as opposed to the, you
8 know, side-by-side VA directive and DoD, which
9 will be the more immediate, but I think there
10 will be a need for that because there's 127
11 policies that this one is overarching for.

12 And so, we're going to need your
13 office very much to look at whether those
14 policies are still pertinent and are not and the
15 fact that they overlap and don't undo each other.

16 So, we're going to need a lot of help
17 in that respect, but thank goodness that you're
18 there and hopefully that will be helpful. We'll
19 be looking to you for some more support.

20 MS. SEYMOUR: Thank you. We stand
21 ready to serve and I am proud and honored to be
22 there and be part of it. Thank you.

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1 CO-CHAIR CROCKETT-JONES: Thank you
2 very much. I think - do we have -

3 MS. DAILEY: I think this is it.

4 CO-CHAIR CROCKETT-JONES: It's
5 lunchtime.

6 MS. DAILEY: It's lunchtime and we're
7 either -

8 CO-CHAIR CROCKETT-JONES: Thank you
9 very much.

10 MS. DAILEY: Yeah, great. Thank
11 you, ma'am. Thank you, WCP staff. Nice to see
12 you guys. Welcome.

13 (Whereupon, the above-entitled
14 matter went off the record at 11:45 a.m. and
15 resumed at 1:02 p.m.)

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

2 1:02 p.m.

3 MS. DAILEY: We do have for our
4 members three more events this afternoon. Ms.
5 Crockett-Jones is about ready to introduce our
6 next panel.

7 The Center for Deployment
8 Psychology will be here at 2:45, and then from
9 4:00 to 5:00 we will wrap up with the Department
10 of Defense Yellow Ribbon Program and its
11 activities with our servicemembers.

12 so, ma'am, I want to turn it over to
13 you.

14 CO-CHAIR CROCKETT-JONES: Joining us
15 this afternoon as members of our non-profits
16 panel we have Mr. Mark Robbins and Lisa Morgan,
17 the Executive Director and Family Caregiver
18 Program Coordinator with the Yellow Ribbon Fund.

19 We have Ms. Tina Atherall and Ms.
20 Tricia Winklosky, I am hoping I am not butchering
21 names, Executive Vice President and Clinical
22 Health and Wellness Director for Hope for the

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1 Warriors. And we also have John Molino, the
2 Chief of Staff, wounded Warrior Project.

3 The panelists will provide us with
4 an overview of their respective organizations,
5 their work with recovering warriors and their
6 input on recovering warrior transitions to
7 civilian life.

8 The members have this information
9 under their Tab M. I will turn it over to you
10 all.

11 MR. ROBBINS: Good afternoon,
12 everyone. Thanks very much.

13 I'm Mark Robbins. I'm executive
14 director of the Yellow Ribbon Fund. And I want
15 to thank the Task Force for inviting us to
16 participate in this program and to give you an
17 idea of what we do to help injured servicemembers
18 and their families.

19 The Yellow Ribbon Fund was founded
20 in 2005. We're a 501(c)(3) non-profit
21 organization. And as I said, our mission is
22 simply stated as assisting injured

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1 servicemembers and their families.

2 We do it primarily at Walter Reed
3 National Military Medical Center and at Fort
4 Belvoir Community Hospital.

5 And over the last year or two we've
6 actually been expanding more in tracking a lot
7 of the injured servicemembers we've gotten to
8 know while they're in the hospital and getting
9 treatment back to their hometowns and continuing
10 to assist them in a lot of ways.

11 Our simple task as we look at it in
12 the office is we fill in the gaps. We understand
13 that the Government and military can't do
14 everything for everybody, but there are a lot of
15 things that fall through the cracks that we can
16 pick up and help with different things.

17 And just a simple example is in the
18 last year over at Walter Reed the Yellow Ribbon
19 Fund built a playground for the children and a
20 barbecue area for the families to use.

21 It's just something that you can't
22 expect the Government and military to do

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1 everything. Gave a great opportunity for us and
2 our supporters to provide something really
3 necessary and permanent for the families.

4 Our signature programs are housing
5 and transportation. The - we'll put the
6 families up in hotels when they come back to
7 visit their loved one in the hospital.

8 We have nine apartments that we
9 provide also for families to use so they can be
10 here on a more permanent basis with their loved
11 one.

12 And then we provide rental cars to
13 the families at no cost to them. And we have cab
14 rides that anybody can use whether a
15 servicemember or family member, to have an
16 opportunity to get away from the hospital off
17 base and enjoy the community and start
18 reintegrating themselves into community life.

19 Since 2005, we've made 6200 hotel
20 reservations for more than 13,000 room nights.
21 The hotels really are for family members coming
22 in to visit.

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1 The nine apartments as I mentioned
2 earlier, 13,500 nights for those apartments.
3 And they're used both by the injured and by the
4 families.

5 We have given 1800 rental cars for
6 68,000 days since 2005. Again, that's just a
7 family-only benefit that we can provide.

8 And 23,000 cab rides for the injured
9 and their families over that period of time.

10 We do a lot of mentoring, a lot of
11 support. We do a lot of one-on-one discussions
12 with the injured and their families very
13 informally.

14 It's not a real, you know, sit down
15 and do things. It's more of let's get to know
16 you, let's talk, let's find out what your hopes,
17 dreams and ambitions are and what can we do to
18 help.

19 And through our contacts and through
20 our board members and supporters and donors and
21 volunteers, we have more than 1200 volunteers,
22 by the way, we are able to do an awful lot for

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1 these - the servicemembers and their family
2 members to help as they think about going into
3 civilian life afterwards and once they're out of
4 the hospital.

5 On one side of things we have one guy
6 on our staff who's just a phenomenal number of
7 contacts.

8 And I was really convinced when
9 somebody said they ran into an injured
10 servicemember who likes to do woodworking and he
11 says to the staff, he says, hey, I know a guy who
12 does woodworking. I'll introduce him.

13 And so, they got together and just
14 again just another hobby thing to get them going.

15 We do provide scholarships through
16 Colorado Technical University. Each year we
17 select 25 injured servicemembers and 25 spouses
18 of injured servicemembers to get scholarships to
19 CTU online.

20 As I said earlier, we do follow up
21 with a lot of the injured servicemembers as they
22 go home.

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1 I have a staff person who does
2 nothing but makes phone calls to them and solves
3 problems for them.

4 1500 calls in the last 1800 - or last
5 18 months. And that just starts out with a few
6 phone calls to the injured and any contact
7 information we've collected on our own.

8 We don't get this through the
9 hospital through any other means. It's just
10 through our own programs and activities and
11 getting to know these men and women. And we help
12 them with their contacts, I mean, I'm sorry, we
13 got their contacts, we help them with other
14 things.

15 But in addition to that when we have
16 family members using our hotels and our rental
17 cars, we do collect their contact information as
18 well.

19 And as we go through the list of the
20 injured servicemembers, we're also calling the
21 family members.

22 And we find out a lot of interesting

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1 things with that, because we'll discover that
2 you call an injured service vet - or, I'm sorry,
3 injured veteran and he says everything is fine.

4 You make another call a few weeks
5 later, it just happens to be on the list maybe
6 mom or grandma was on that list and they said,
7 I'm really glad you called. My son's having
8 some trouble or my grandson is having some
9 difficulty. He would never ask for help.

10 And we have done things like putting
11 on, you know, getting electricity turned back
12 on, help point them toward contacts for jobs,
13 education, career opportunities, a lot of other
14 things just to kind of fill in that gap and find
15 out where the - what's missing and how can we
16 help.

17 So, again, 1500 calls in 18 months
18 from one staff member. We've done a great job
19 on continuing that contact with them.

20 MEMBER EVANS: Hey, Mark. So, how
21 are we getting that information back to the
22 service? How do you connect back to Army,

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1 Marine Corps, especially if you're finding that
2 you have a servicemember out there needing
3 assistance?

4 So, are you working closely with the
5 service -

6 MR. ROBBINS: In the case of after
7 they've gone home, then we really haven't
8 communicated that back to anybody. That's
9 really been something we've just done
10 internally.

11 Now, if there are other benefits -
12 a lot of the other benefits, things with the
13 hotels, apartments, rental cars, all that comes
14 through SFAC offices and others of the hospital
15 staff that confirms that that family is entitled
16 to a benefit or they don't have that benefit
17 coming in otherwise.

18 So, we actually - most of the things
19 we do in those areas, the housing and
20 transportation, is already vetted through so we
21 know that someone isn't double dipping, someone
22 isn't getting something they're not entitled to.

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1 Through our donors, we get thousands
2 of tickets to ball games, concerts, shows in the
3 area.

4 We host dozens of social events at
5 the hospitals each year. We provide civil war
6 battlefield tours through the Blue and Gray
7 Education Society and other groups. And just do
8 a lot of things just, again, to try to keep them
9 social, off the base sometimes, a few other
10 things that help them in their day-to-day life
11 and getting back together.

12 We have a special focus on our
13 caregivers. And this is something the Yellow
14 Ribbon Fund started a number of years ago.

15 And at the request of a life of an
16 injured servicemember, we got to know her
17 husband and her very well and they're in pretty
18 good shape in terms of family life, moving
19 forward, getting through the injuries. He was
20 double amputee and all.

21 But she pointed out to us how many
22 women at Walter Reed, and this was the old Walter

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1 Reed at the time, just had difficulty on the
2 day-to-day stuff and realized they were giving
3 everything they had, but nobody is really paying
4 attention to them.

5 So, that was a really big focus for
6 us and started with therapeutic massages. And
7 what seemed like a really simple thing turned out
8 to be one of the best things we've ever done,
9 because we started focusing on the caregiver and
10 allow her to have her 90 minutes with the massage
11 therapist in a private room with the lights down,
12 the music on, the hot rocks and everything and
13 really - and this is one thing I had to sell to
14 my board.

15 At first I said, yeah, let's try it
16 and see how it goes. And a few months later when
17 we had our budget discussions for the new budget
18 year, a couple of them were skeptical.

19 And so, we invited a couple of those
20 board members over to a massage day. And when
21 you saw a young wife with the weight of the world
22 on her shoulders before she had the massage, and

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1 90 minutes later coming back out, she was
2 transformed.

3 It was completely different and it
4 was those board members who sold it to the others
5 who said, you have to do this. This is where we
6 should be going to help the family members.

7 So, that's one of the great things
8 we did and then that expanded. We realized they
9 need their own networking, they need their own
10 support systems.

11 We started dinner and movie nights.
12 And this was, again, just for the caregivers to
13 get them out of the hospital a little bit.

14 Some of them were bringing their
15 young kids and we had kid matinee movies. And
16 then date nights came around because some of the
17 servicemembers said, gee, I'd like to go out with
18 my wife one night.

19 And so, they wanted to get out of the
20 hospital and we arranged for babysitting and
21 other things.

22 So, we were doing a lot of things to

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1 just really keep the family together. And then
2 as we started evolving as an organization, we
3 realized that was the whole key for us is
4 anything we can do to keep the family together.
5 And that was a huge plus.

6 I mentioned the other scholarships
7 with the Colorado Technical University. We're
8 starting a new scholarship program with
9 University of Maryland University College.

10 We just selected three caregivers to
11 receive full scholarships. Two are going to
12 complete MBAs. One is going to complete her
13 undergraduate degree. And we're actually
14 having a reception at UMUC later this month to
15 honor them and to kick that program off.

16 But that's a great program we're
17 putting together. And, again, just focusing on
18 the caregivers recognizing that in many cases
19 they may end up being the breadwinner in the
20 family. And to make sure they have the
21 education and background they need to help their
22 family. This is the direction we're going to

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1 help.

2 The Caregiver Resource Fair. We
3 did our first one a couple of weeks ago over in
4 Building 62 at Walter Reed. We've got a couple
5 dozen other non-profits that all provide
6 programs and services for the injured and their
7 families at Walter Reed and it was a great
8 success.

9 A lot of information was passed out
10 to the family members, but I think the best thing
11 we heard was that the staff there saw the list
12 we had compiled of all the non-profits and said,
13 can we have this too?

14 And so, we were passing that out to
15 the staff also to make sure that they knew all
16 the different groups, because there's a lot of
17 us coming in and out.

18 I know it's not easy to keep track,
19 but that was one way we compiled everything and
20 got it going.

21 Now, I'm going to turn things over
22 to Lisa Morgan. She's the coordinator of our

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1 Family Caregiver Program and she's a caregiver
2 herself.

3 MS. MORGAN: Okay. So, as Mark
4 mentioned, I am also a caregiver of an injured
5 Army captain and fiancée, soon to be married.
6 So, I have a unique perspective and I'm able to
7 kind of see both sides.

8 And I attend a lot of caregiver
9 meetings and I get to speak with a lot of other
10 caregivers.

11 And so while we are going through
12 this transition, we have not transitioned out.
13 He's still in his Medical Board, but I've talked
14 to some families who have transitioned out and
15 these are some of the gaps and snags that they
16 have mentioned.

17 The first two talk about the delay
18 in benefits. There's a three-month delay from
19 when you retire until the VA retirement pay and
20 the benefits kind of kick in.

21 So, that can be something that
22 although they should be prepared for, could

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1 create a little bit of financial hardship if they
2 have not prepared.

3 And then the last two talk about
4 ineffective AW2 and FRC reps. And why was it
5 ineffective is really because it's
6 inconsistent.

7 Some people get kept, you know, they
8 have people checking in on them all the time.
9 Our AW2 representative quite honestly doesn't
10 check in very often.

11 So, those that can navigate the
12 system on their own, I feel like maybe wouldn't
13 have too much of a problem, but those that need
14 a little extra help could struggle if they don't
15 have those people helping them through the
16 system.

17 So, what can the DoD do?

18 MEMBER MALEBRANCHE: One second.

19 MS. MORGAN: I'm sorry.

20 MEMBER MALEBRANCHE: On the medical
21 benefits that were delayed for injured veterans,
22 what exactly does that mean? Because that's

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1 kind of concerning.

2 What do you mean by medical benefit?

3 MS. MORGAN: So, basically the pay,
4 the retirement pay. They go without pay for
5 three months from -

6 MEMBER MALEBRANCHE: That was the
7 first one.

8 MS. MORGAN: Yes.

9 MEMBER MALEBRANCHE: But the second
10 one, that's also about the -

11 MS. MORGAN: Well, that depends if
12 their case manager helps them get set up in their
13 VA. If they, you know, get enrolled in the VA,
14 get the prescriptions, but not everyone has help
15 getting set up in their home VA once they go home.

16 MEMBER MALEBRANCHE: So, that's all
17 VA, not - they're not - I guess what I'm concerned
18 about is they're not going without medical care,
19 right?

20 MS. MORGAN: Like I said, we haven't
21 been through that exactly, but I know that what
22 they should do at Walter Reed is set them up with

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1 the prescriptions and things that they need to
2 get them through until they get home to their VA.

3 But we've heard some people have
4 had, you know, help getting set up, and some have
5 not.

6 MEMBER MALEBRANCHE: Okay. And then
7 when you say "ineffective," I'm assuming that's
8 the Federal Recovery Coordinator
9 representative?

10 MS. MORGAN: Yes.

11 MEMBER MALEBRANCHE: I know you have
12 identified that. I guess I'm also concerned
13 there.

14 What kind of ineffective - what do
15 you mean by ineffective?

16 MS. MORGAN: Basically,
17 inconsistency. I know that some people have had
18 AW2 reps and FRCs - I honestly - I'm not sure who
19 our FRC is or if we have one, because the
20 communication isn't always there.

21 So, like an AW2 rep might check in
22 on the service member frequently and see what

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1 they can do to help, or someone might not hear
2 from their AW2 rep, you know, very often.

3 CO-CHAIR CROCKETT-JONES: I can jump
4 in on this and confirm a little bit of this.

5 Sometimes people are experiencing
6 that their AW2 or their FRC is perhaps new-ish
7 and is maybe in the process of training or
8 pre-training because of - somehow they get
9 assigned people before they actually are ready
10 to be assigned folks.

11 I don't know if this is true of FRC,
12 but I know it's true of AW2. And or they are just
13 not up to speed on the - they are just not as
14 well-informed as the expectation would be. I
15 can confirm that.

16 MS. MORGAN: Yeah, there's a lot of
17 staff changes and things.

18 CO-CHAIR CROCKETT-JONES: Her
19 question is she's not - this is not just their
20 impression. Let me just put it -

21 MEMBER MALEBRANCHE: I just wanted to
22 - okay. We'll talk later about what we can do

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1 about that.

2 MS. DAILEY: And I do want to talk a
3 little bit about what you brought up, Ms.
4 Malebranche, is the medical benefits delayed for
5 injured veterans.

6 We hear this when we talk to the
7 OEF/OIF program management offices also. If
8 that warm handoff didn't occur, it's - by the
9 time they hit the OEF/OIF Program Management
10 Office, they were saying the prescriptions have
11 run out.

12 And for those elective surgeries
13 that we're putting off, you know, it may take six
14 weeks or eight weeks to get the appointment.

15 And by the time they get into the
16 OEF/OIF Program Management Office, you know,
17 there's a wait time for these type of specialty
18 services whereas if they're spending three
19 months on leave, a lot of that could have been
20 done and absorbed while they're on that
21 transition leave.

22 So, that warm handoff - and I'm sure

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1 that's kind of the out - the outcome of some of
2 these warm hand-offs not being efficiently
3 managed is that these things they want to get the
4 VA to take care of are delayed.

5 MEMBER MALEBRANCHE: So, it's
6 basically the non-warm handoff.

7 MS. DAILEY: I would say so.

8 MEMBER MALEBRANCHE: Okay.

9 MEMBER EVANS: And that's the genesis
10 of our checkoff list so that we can capture that
11 - do that handoff early before the member gets
12 to that point where he's not receiving his
13 benefits and there's a delay.

14 So, we try to create a checkoff list
15 and I think we've done well. We've identified
16 the gaps. We've captured some of these issues,
17 but I think we just got to look to make sure that
18 it's utilized throughout the services and is
19 truly working.

20 MS. MORGAN: Yeah, it certainly is
21 not every service member. I've talked to plenty
22 of families that have said, you know, that

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1 they've gone home and if they're a little more
2 independent, they can figure it out on their own.
3 But there have been some that have kind of had
4 hiccups.

5 CO-CHAIR CROCKETT-JONES: Yeah, I
6 can confirm too, also, like your experience with
7 the AW2. I just asked my husband to confirm it.

8 From the time he was assigned until
9 his retirement, the vast majority of contact he
10 had with the AW2 he initiated post-DD214, one
11 call.

12 And so, he's now - I can't do the
13 math. He retired in July. He's had one call.
14 And of course he's had hospitalizations, loss of
15 employment, all kinds of issues, but he is not
16 using the AW2 as his primary resource at all
17 because it's very inconsistent results.

18 MEMBER EUDY: Regarding your
19 statement on the previous - the three-month
20 minimum so you know and for the rest of the
21 benevolent panel that's up in front of us today,
22 on our site visits we discuss this fervently with

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1 all the warrior transition units from the
2 perspective of not only the employment and
3 education initiatives due to the processes that
4 exist whether, as an example, you know,
5 vocational rehabilitation, items that can help
6 cover those gaps or where we see - a key
7 partnership that Ms. Crockett-Jones and myself
8 point out a lot is where you have all these
9 different offices working together on the same
10 set of contact lists to help facilitate that
11 90-day gap.

12 So, regardless of your organization
13 that you don't get that call 20 days in, hey, I
14 need to get my bills paid or I need this met,
15 because there's programs that exist, but it's
16 getting those resources talking to each other
17 that we address every single site visit.

18 So, we're actively pursuing that gap
19 on that first one.

20 MS. MORGAN: Okay. So, what can the
21 DoD do to improve?

22 Some of the ideas we had were to

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1 educate the families on what to expect and create
2 a support network, financial counseling.

3 So, a lot of those do with education
4 and just communicating with the families.

5 Like Mark said, a lot of times the
6 families may now be taking up more of a bread
7 winning role or, you know, stepping forward when
8 maybe before they didn't.

9 So, I know a lot of people like in
10 my position I am not yet a spouse. So, a lot of
11 caregivers are parents or girlfriends or
12 brothers and sisters and don't know, you know,
13 the military chain of command, we don't know the
14 system, we don't know TRICARE and the
15 communication and education isn't always there.

16 Minimizing the three-month gap as we
17 talked about. Involving families in the TAPS
18 course.

19 The TAPS course is a good thing, but
20 I just don't know that it's being used in the most
21 effective way.

22 I know when my fiance went through

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1 it, it was about a year ago and he's still not
2 totally finished with his medical board.

3 So, I don't know that a lot of it was
4 relevant and I feel like the injured service
5 members hear a lot of information that isn't
6 relevant.

7 They get placed through the TAPS
8 course with people that are retiring because of
9 time or because of urge of separating. So,
10 sometimes it's not always information that they
11 need and it's a lot of information being thrown
12 at them.

13 But something I did just find out is
14 the Open TAP happening at Walter Reed. So, I
15 think it's the last Thursday of every month
16 they're having a refresher course.

17 So, I think that's great because now
18 the service member is maybe a year ahead of when
19 they actually need it are getting all this
20 information, but they can go get it again in a
21 little bit more condensed form. Just a one-day,
22 you know, brush up on what you need to know about

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1 your insurance and life insurance and things
2 like that.

3 So, I did just find that out. I
4 don't know if that's being communicated well
5 enough, because I happened to find out about it
6 at a caregiver meeting, but we try to get that
7 information out there because that would help a
8 lot.

9 And the last three deal with
10 improved contacts for jobs other than just the
11 DoD and government internships that are offered
12 a lot at Walter Reed, teaching how to transfer
13 the military skills, what kind of pay they should
14 be getting to kind of, you know, equal what they
15 were getting in the military, and focusing on the
16 jobs, work-from-home jobs and things like that
17 that will be better for them when they get home,
18 because a lot of government jobs aren't going to
19 be in the neighborhoods that these service
20 members return to.

21 MEMBER DRACH: Excuse me.

22 On the work-from-home jobs, are you

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1 seeing a big demand and are you seeing it from
2 the wounded warrior or from the caregiver or both
3 or what do you - a percentage.

4 MS. MORGAN: Well, it could be for
5 both. I know of some service members that are
6 interested in starting some of their own
7 businesses, some IT, some, you know,
8 work-from-home kind of things.

9 And I know that for caregivers,
10 especially those that have to take care of their
11 service member and they don't have as much
12 independence, it would be great for them to have
13 some work-from-home connections, but mostly for
14 the service member.

15 I feel like most of the internships
16 and opportunities that come to Walter Reed are
17 a lot of government and local to D.C. area jobs.

18 MEMBER DRACH: So, typically when you
19 talk about work from home, you're not talking
20 about - necessarily talking about starting your
21 own entrepreneurship and being an entrepreneur.

22 MS. MORGAN: No, it doesn't have to

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1 be.

2 MEMBER DRACH: So, if you're focusing
3 on caregivers, I know of several employers that
4 are really effective - or not effectively.
5 They're trying to effectively reach out to
6 caregivers, military spouses and others for
7 work-from-home jobs which a lot are
8 telemarketing -

9 MS. MORGAN: Yeah.

10 MEMBER DRACH: - but some are also
11 data processing, transcription services, so
12 forth and so on.

13 So, I think, you know, I think you
14 want to kind of distinguish between
15 entrepreneurship startups, which in many cases
16 start from working from home, as opposed to
17 people that need to work from home such as a
18 caregiver.

19 MS. MORGAN: Right. Yeah, not
20 everyone can do the 9:00 to 5:00 Monday to Friday
21 based on the needs of their service member and
22 schedule.

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1 So, we have had some of those
2 telecommunication-type jobs for caregivers come
3 through our office and we've got them out to
4 caregivers. So, we're definitely passing those
5 on when we see them, because it's a great
6 opportunity.

7 MEMBER MALEBRANCHE: One last
8 question, somewhat comment.

9 What do you have in terms of written
10 material or do you have any comprehensive - when
11 you talk about educating families.

12 And I guess the other thing is being
13 somewhat new to this yourself, how daunting are
14 all these acronyms for you?

15 (Laughter.)

16 MEMBER MALEBRANCHE: I mean, do you
17 have something to explain that?

18 MS. MORGAN: I had like a chart drawn
19 out for me.

20 MEMBER MALEBRANCHE: I figured you
21 must be doing your own because you're new at
22 this.

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1 MS. MORGAN: Yeah.

2 MEMBER MALEBRANCHE: And then you're
3 going to get that when you go to the VA too.

4 MS. MORGAN: Yeah.

5 MEMBER MALEBRANCHE: But I was just
6 wondering do you have something written or did
7 you - when you talk about educating families, any
8 one type of guide or that you found helpful?

9 MS. MORGAN: When you're in the
10 inpatient stage, there's a lot of people coming
11 into your room with business cards and, you know,
12 offering their assistance. And that's great,
13 but you kind of just - it goes over your head.

14 And then when you get to the
15 outpatient stage, there is an in-processing
16 where you go and see all the different
17 departments, which can be a little bit
18 overwhelming for the service members because
19 they're going from office to office to office.

20 And at that point, they could be on
21 medication and they're just trying to get
22 settled in, but there is a packet that they give

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1 you and like a half-a-day slideshow
2 presentation, just basic introduction to this is
3 your AW2 rep, this is the TRICARE office, this
4 is, you know, it's basic, but they give you, you
5 know, the slideshow to take with you.

6 And then it's just kind of a
7 follow-up after that. That gets a little
8 inconsistent.

9 Everyone should go through the
10 in-processing and get that information, but it's
11 kind of overwhelming at that stage.

12 So, I feel like we have the NMA
13 meetings and you always learn things at those.
14 And, you know, you go as you're ready. It's an
15 hour at a time and the command, you know, just
16 needs to make sure they're communicating with
17 the families.

18 CO-CHAIR CROCKETT-JONES: I have a
19 question for you.

20 Everywhere we go there is a lot of
21 frustration at drawing family members and
22 caregivers into programs for more information,

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1 making contact.

2 There's probably an over-reliance
3 on contact to the service member. But even once
4 they can get through, you know, talk directly to
5 a caregiver, getting those folks to come in for,
6 like, job fairs or training or benefits
7 briefings is very, very difficult.

8 What do you think makes the
9 difference? What gets someone over the hump and
10 gets them in there just in your experience?

11 MS. MORGAN: I would say more of the
12 informal setting like bringing it up at some of
13 the caregiver meetings where, you know, it's
14 more of just like an open dialog going on.

15 And then some of the representatives
16 from, you know, pain service or TRICARE will come
17 in and do just like a five-minute presentation,
18 give their business card and, you know, everyone
19 has a chance to ask them questions.

20 But I think asking someone to be at
21 a certain place at this time, you know, on this
22 day doesn't always work, you know.

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1 So, if you come to their meetings,
2 like kind of come to them and say, this is what
3 we can do to help you - and they have the
4 meetings, I think, every other week.

5 So, if you can't make one week, you
6 can usually make the next.

7 CO-CHAIR CROCKETT-JONES: And who is
8 the person that you most are comfortable in the
9 process?

10 If you need information on
11 something, where would you go?

12 MS. MORGAN: Usually another
13 caregiver. Someone who's been there a little
14 bit longer than I have, yeah.

15 (Laughter.)

16 CO-CHAIR CROCKETT-JONES: Thank you.

17 MS. MORGAN: I think that's all we
18 have. Thanks.

19 (Pause in the proceedings.)

20 MEMBER EVANS: So, let me ask the FRC
21 program, why do you feel that's ineffective?

22 Is it because the lack of

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1 consistency, lack of -

2 MS. MORGAN: We've never even been
3 contacted by - sorry. Hello. We've never even
4 been contacted by an FRC. I know I've heard some
5 people have and some people haven't.

6 So, I just - I don't know that they
7 work with every family.

8 MEMBER EVANS: Right. They don't.
9 I believe referral from the Service, right?
10 Don't we put the -

11 (Discussion off the record.)

12 MEMBER EVANS: Okay. Thank you.

13 CO-CHAIR CROCKETT-JONES: Turning it
14 over to you. Go ahead.

15 MS. WINKLOSKY: Hi. I am Tricia
16 Winklosky. I'm with Hope for the Warriors and
17 the Clinical Health and Wellness Director.

18 I am a 19-year Marine Corps spouse.
19 So, for me working with Hope for the Warriors,
20 I've been able to bring my professional
21 background as an art therapist and bring it to
22 the families that I have known and worked with

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1 for many years in the military community.

2 Tina Atherall here, our executive
3 vice president, do you want to introduce or
4 anything?

5 (Speaking off mic.)

6 MS. WINKLOSKY: All right. I want to
7 talk to you a little bit about Hope for the
8 Warriors and our programs and what we have to
9 offer coming from an organization that started
10 at a grass roots level, Camp Lejeune, North
11 Carolina, from some spouses that saw the need
12 that was there, but really growing and
13 developing into a professional - being able to
14 bring our profession to those families.

15 So, Hope for the Warriors. Our
16 mission, enhance the quality of life, restore a
17 sense of self and restore the family unit.

18 For the post-9/11 service members,
19 families and families of the fallen who have
20 sustained physical and psychological wounds in
21 the line of duty, we are dedicated to restoring
22 self, restoring the family unit and restoring

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1 hope for our service members and military
2 families.

3 Our core values. Hope for the
4 Warriors understands the challenges, pride and
5 joy of being military family for today, tomorrow
6 and years to come.

7 We will strive to meet the changing
8 needs of service members and their families.

9 A little bit about individuals
10 assisted last year. We have a total of 4,523
11 service members, veterans and their families
12 through our various programs and outreach
13 events.

14 Each month our team worked with
15 between 200 to 500 individuals as you see there,
16 to seek, advocate, encourage, empower, navigate
17 and assist the recovering warrior in the
18 transition from military to civilian life.

19 We have service member veterans,
20 about 3,800 at 84 percent of our assistance.
21 And then family members, about 733 or about 16
22 percent of our numbers there are with family

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1 members exclusive.

2 Programs. Our program pillars.
3 We have education/employment, outreach
4 advocacy, financial literacy and legal
5 aptitude.

6 Talk a little bit about education
7 and employment. We have a few programs there.
8 Our Above and Beyond Program provides guidance
9 to wounded service members pursuing
10 reintegration into the civilian sector.

11 This program is also extended to
12 family members of wounded service members. The
13 objective is to explore those next-step options
14 for those interested in civilian or military
15 careers, higher education, advance training or
16 a small business startup.

17 We do different kinds of things such
18 as one-on-one mentoring, three to four-day
19 seminars close to military installations or
20 aboard military installations, follow-up
21 coaching, step-by-step plans to help them
22 achieve and there's an entrepreneurial part to

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1 that as well.

2 We have spouse/giver scholarships.
3 Identifies, recognizes and rewards spouses and
4 caregivers for their strength, fidelity and
5 resolve despite adversity.

6 Scholarships aid in continued
7 education at a reputable, accredited
8 university, college or trade school for
9 spouses/caregivers as they assume the critical
10 roles in the financial well-being of their
11 families.

12 We also have a Veterans College
13 Initiative providing college outreach programs
14 to post-9/11 veterans on college and university
15 campuses to provide a variety of resources, to
16 facilitate access to quality education,
17 adjustment to academic life, assist with
18 post-graduation placement and other resources
19 college veterans may need.

20 Health and wellness. Several
21 there. The crux of our work, we feel at times,
22 is critical care coordination.

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1 Hope for the Warriors works daily
2 with wounded service members, their families and
3 families of the fallen to meet immediate
4 financial need coupled with clinical and case
5 management intervention.

6 Critical care coordination involves
7 integrated case management on various levels
8 engaging the individual wounded service members
9 and their families, the VA and/or the warrior
10 unit in which they are associated, medical
11 professionals if applicable, Department of
12 Defense and other non-profit organizations.

13 Family reintegration program.
14 Hope for the Warriors is joined with Holliswood
15 Hospital Military Wellness Program to develop a
16 family reintegration program.

17 The family reintegration program
18 supports wounded warriors and their families by
19 engaging them in a therapeutic experience
20 promoting family communication, recovery and
21 resilience.

22 The program provides education and

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1 skills training on PTSD, marital and family
2 individual sessions are provided, as well as
3 respite.

4 And then participants receive
5 ongoing follow-up and support after the
6 inpatient and the family reintegration program.

7 Hope and morale provides respite and
8 recreation opportunities for wounded service
9 members engaged in the long process of recovery.

10 Such events raise spirits, restore
11 hope, inspire commitment to recovery. All very
12 important factors in the long-term
13 rehabilitation success.

14 Participants are referred by
15 medical and VA caseworkers, warrior units,
16 program partners. This program also supports
17 unit homecomings, reunions and base events.

18 A Warrior's Wish. Wishes restore
19 the spirit of our nation's heroes, their
20 families and communities that support them.
21 Whether it is realizing a dream to sail, ride a
22 bike again or own a home adapted to specialized

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1 needs, Hope for the Warriors honors those goals
2 and desires of those members, the veterans and
3 their families.

4 Have outdoor adventures. Outdoor
5 Adventure Program provides adaptive
6 opportunities for wounded heroes to participate
7 in sporting activities in the great outdoors.

8 It offers this program to spouses
9 and families. In outdoor activities, we foster
10 family reintegration with an outdoor program for
11 both the military and military family groups as
12 well.

13 And then Team Hope for the Warriors.
14 Team Hope for the Warriors provides athletes of
15 all abilities the opportunity to engage their
16 competitive spirit at endurance sports.

17 Warrior team members receive
18 adaptive equipment training and raise support to
19 ensure they are defined by their achievements
20 rather than their injuries.

21 Community team members challenge
22 themselves to raise funds for America's heroes.

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1 They set new goals or simply support the
2 military.

3 Together, those team members are
4 united by a goal to improve the rehabilitation
5 of combat wounded service members, veterans and
6 families.

7 Our third pillar, outreach and
8 advocacy. Outreach engages the military family
9 by providing person-centered planning,
10 utilizing a network of programs within Hope for
11 the Warriors, as well as those supported by the
12 military government, community and other
13 non-profits.

14 Community outreach educates
15 communities nationwide on challenges and needs
16 of wounded service members, veterans and their
17 families.

18 This advocacy aligns with our
19 commitment that there's no sacrifice forgotten.

20 We work alongside DoD and the VA.
21 We want to continue to build their knowledge base
22 with detailed metrics regarding the trends and

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1 gaps that we see in the delivery of services for
2 our recovering warriors and their families
3 that's directly influencing the care that we
4 provide while our warriors are active duty or
5 retired.

6 Finance and legal aptitude. Our
7 final pillar there. Through critical care
8 coordination, clinical and case management
9 intervention, we provide referrals and
10 resources to help the veteran and family to make
11 informed and effective decisions to navigate
12 that transition from military to civilian life
13 specific to wounded warrior recovery issues.

14 Legal aptitude. Often by second
15 and third order effects and transitioning from
16 military to civilian communities and healthcare
17 systems, the service member and military family
18 seek to understand their rights and benefits.

19 Through referrals, advocacy case
20 management, Hope for the Warriors helps the
21 veteran and family and navigate these systems
22 striving towards positive long-term outcomes.

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1 Here's a snapshot of our programs
2 utilized in 2012. And one of the things that,
3 you know, we talked about with critical care
4 coordination you see is a lot of what our work
5 is here. However, you see a bit on the unit
6 support as well.

7 What I think is interesting when I
8 looked at this and these numbers, I thought
9 about, you know, sort of like a Maslow's, you
10 know, Hierarchy of Needs. This is where our
11 needs base is.

12 We're still right really here
13 whether that's where we meet the service member
14 and their family and what they need, but we also
15 have the opportunity to provide these other
16 avenues and that gateway in if they're not ready
17 to say you have a service member who doesn't
18 identify themselves as having that need whereas
19 the family member will call us and say,
20 absolutely, how can you help us? How can you
21 help my son or daughter? How can you help my
22 husband or my wife?

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1 So, this is very important to me to
2 see that this is still where a lot of that crux
3 of that work happens here for us, as well as in
4 unit support.

5 MEMBER EVANS: That's important.
6 That's interesting at 29 percent.

7 So, Congress provides DoD with a
8 happy budget to provide case management. And it
9 sounds as though your organization additionally
10 has to provide case management to our warriors.

11 So, I'm just trying to understand
12 where the gap as to we are not meeting that case
13 management.

14 MS. ATHERALL: Okay. So, this is my
15 part. And I despise PowerPoints. It's a real
16 challenge to get me to try to stand still. She
17 makes me do it. So, that's going to be my
18 section to address the case management.

19 Because for me, I'm a clinical
20 social worker and it just makes sense to me
21 person-centered planning, right? Individual
22 comes to you, assess what their needs are whether

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1 bio or psychosocial needs, right?

2 As a community mental health
3 provider, that's my job. That's my profession.

4 Why was it any different as a
5 non-profit working with military? You are my
6 system. The DoD and the VA is my system.

7 So, it's my job as a social worker,
8 it's part of my code of ethics, that I make sure
9 that the individual who's come to me for
10 something has their resources at their
11 fingertips.

12 If I'm not referring a veteran back
13 to the VA, I'm not doing my job. If I'm working
14 with a service member, a family member and I'm
15 not working with their chain of command, their
16 warrior transition unit, whatever it may be, I'm
17 not doing my job.

18 I think that those of us who have
19 stepped into the world of non-profit work
20 supporting the military community based on
21 overwhelming support post-9/11 and our own
22 stories, I mean, those of you who know Hope for

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1 the Warriors, you know we get impacted quickly
2 aboard Camp Lejeune with a personal story. And
3 then it was the needs of our - those of us around
4 us and we just started doing what we could do,
5 and people started throwing money at non-profits
6 to make that better.

7 So, what do we really do? We do case
8 management. What I do as a non-profit, I have
9 to make it so it's understandable to the American
10 public who support me by their donor dollars,
11 because I don't get government money, right?

12 And do you have a lot of money for
13 case management? Sure. But everything that I
14 heard you talk about before, I got to say I loved
15 your questions, by the way, because what it says
16 to me is you guys get it, the things that we see
17 on an individual basis, boots on the ground,
18 understanding the lifestyle. You get it. You
19 hear it. That's what my slides are supposed to
20 be going to.

21 I don't - I think that you can
22 utilize your non-profits that are that gateway

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1 back into the system. That's what we hope to do
2 is get them back to you for the long-term case
3 management.

4 So, what's my number one question?
5 Are you active duty military? Yes. Who's your
6 current command? Who's your current support
7 system?

8 I don't have one. Why not? Who is
9 that? I can't work with you until we work with
10 your system, right? Because that's who the
11 long-term care is.

12 It's the majority and the extent of
13 my case management. If I'm not working with
14 that team, if I'm not working with OIF/OEF
15 program managers, I'm not doing my job.

16 So, does that make sense in terms of
17 my case management?

18 MEMBER EVANS: No, that's what we
19 want to hear.

20 MS. ATHERALL: Yeah.

21 MEMBER EVANS: You're looping back to

22 -

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1 MS. ATHERALL: That's my job.

2 MEMBER EVANS: You're looping back to
3 the services.

4 MS. ATHERALL: Yes.

5 MEMBER EVANS: You're looping back to
6 the VA, and the service member fully realize
7 that, you know, we are here as a case manager,
8 but we're going to get the information back, get
9 you back to your service.

10 MS. ATHERALL: Right. Yeah, and so
11 my strength here is come run with me, you want
12 to come hunting, you want to come to New York
13 City. We'll introduce you to police and fire
14 that get it. You served after that day.

15 Now, after that, we're going to
16 spend a lot of time with you. And after that,
17 you're going to stay with me and we're going to
18 keep asking questions.

19 And eventually my goal is especially
20 on the veteran aspect, is to make sure they get
21 back to the VA.

22 So, one of the things that I spend

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1 a lot of time working with our team on is that
2 education part about how we're really building
3 that initial rapport, right? That trust back
4 into the system.

5 And if I don't trust who I'm going
6 to refer them to, which is a lot I think what
7 happens within our spouse system, that we know
8 better to make that referral then we're sure that
9 we're getting a really strong handoff, not even
10 a soft one. It's like a really strong hand.
11 You know they're going to take care of them,
12 right?

13 So, it's our job to understand that
14 big and, my gosh, is it complex. But I'm lucky
15 in the non-profit - why do I stay in the
16 non-profit community? Because I can be really
17 nimble and kind of weave in between everyone and
18 figure out everyone's system.

19 So, half the stuff that Tricia
20 talked about here, I may not even do half that
21 work.

22 If it's an outdoor adventure thing

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1 Wounded Warriors Project here, get them out on
2 their Soldier Ride.

3 Many of our service members that we
4 work with in intensive case management, I'm
5 referring to this organization over here to
6 actually be a part of that Soldier Ride. It's
7 not my job to be doing everything.

8 I just presented that I did, but half
9 of those things really are gateways in. Like,
10 look, okay, we'll dabble here. But the student
11 veteran work that we do, ultimately I want to get
12 them to Student Veterans of America. I want to
13 get them to their veteran outreach on campus.

14 I don't - I can't stay there long
15 term. I don't have that funding source, nor am
16 I confident that I'm going to have it forever,
17 right? That's the DoD and the VA. That's where
18 their long-term benefits are.

19 So, not to dwell on what you already
20 know, what I thought of -

21 MEMBER PHILLIPS: May I just ask -

22 MS. ATHERALL: Yes, yes.

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1 MEMBER PHILLIPS: I'll interject
2 very quickly. Thank you very much.

3 Just to build on what Captain Evans
4 was saying, what's curious to me is that we saw
5 tons of money at the program. And as Captain
6 Evans says, approximately one-third of the folks
7 are missing the critical care management
8 component and you are filling in that gap, as you
9 said. And thank you.

10 But you also are identifying very
11 quickly, I think, who they have to go to. So,
12 they're not being educated.

13 So, what can we do as a task force
14 to stimulate this better education process?
15 Not that I want to take away your job, but you've
16 identified -

17 MS. ATHERALL: Listen, I'm going to
18 be honest. Like, I - so, I get to say right now
19 my husband just retired in June. And he retired
20 after 21 years, you know, great Marine. He has
21 a whole hell of a lot of problems.

22 And he - it - on his - all of his

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1 post-appointment health reassessment forms,
2 people wrote off on those and said it was okay
3 that he didn't receive care, because he was in
4 command. CO, you know, current service member,
5 however it was stated. I laugh at it.

6 My point to bringing that - I tell
7 him he always provides me great material.
8 Because now that we're on the veteran side of the
9 house, I can't even get him to go to the veteran
10 service agency to file his claim yet and they're
11 completely competent.

12 So, I think that there's something
13 that we don't necessarily want to talk about.
14 And that is they don't want to hear a portion of
15 what's there to assist, right?

16 And it's not until we're absolutely
17 fractured and falling apart - you know, I worked
18 in substance abuse. Wasn't until my patients
19 were mandated did I get them into really cool
20 work, right?

21 And so, I find that as the
22 non-profit, that's kind of where I am right now.

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1 Like, they might come to me, because now they are
2 about ready to be homeless with their five
3 children or there's a restraining order.

4 Like, I have to have fluff work here,
5 because the American public really doesn't want
6 to hear the root and ugliness of the work that
7 we're doing, but they're coming to me and now
8 they're ripe and ready for me to deliver them
9 back.

10 So, I really wish I could say that
11 the system was completely broken. I don't think
12 it is.

13 I think that we have - and also we're
14 still working. Like these guys, men and women
15 are still in the fight. They're not ready yet.

16 And I've learned that by just
17 listening to our past combat generation say the
18 same thing, you know, because they're looking as
19 to why the legions aren't full, right? They're
20 not ready yet.

21 So, I don't know. I hope that I'm
22 kind of touching on things that make sense.

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1 CO-CHAIR CROCKETT-JONES: Do you
2 have a sense that maybe sometimes the family, the
3 caregivers are ready before the service members
4 are?

5 MS. WINKLOSKY: Absolutely.

6 MS. ATHERALL: That's our family
7 reintegration program. And so, here's my
8 story. If anyone knows Shannon Maxwell, I mean,
9 that's where our story started.

10 And we were at a combined thing. We
11 were talking with a doctor that runs this
12 inpatient program. And they were talking about
13 teaching yoga and meditation and acupuncture and
14 all these great things. We believe in that full
15 wellness, right?

16 And we both said, oh, my God. If my
17 husband came home and asked for 30 minutes to do
18 yoga, I'm going to kill him, because he just -
19 he left me exhausted.

20 I had nobody educating me on the
21 benefits of what was occurring when he went off
22 to this inpatient environment. That part was

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1 missing.

2 So, Shannon really challenged and
3 said, what are we doing to bring the families in
4 as a part of this?

5 We bring the families in and now
6 they're like I knew this two years ago. I knew
7 that we needed to be here two years ago. Guess
8 what. That's why we're not together anymore,
9 you know, that type of thing.

10 So, really what we're doing in this
11 family reintegration now may be dissolving the
12 family and just trying to get people to get
13 along.

14 And that is the reality of our world,
15 but I'm okay to talk about it because it's real
16 and it's what we have to be doing right now.

17 MS. WINKLOSKY: We've transitioned
18 our critical care coordination to include
19 family. So, it's not just a service member that
20 calls anymore.

21 We are taking family member calls
22 and working with them. And then we pull them in

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1 and see if we can get them to the service member.

2 So, we're working at different
3 avenues and really trying to meet them where they
4 are and to ally with that to make that process
5 work.

6 CO-CHAIR CROCKETT-JONES: Yes, you
7 might notice you're preaching to the choir on
8 this.

9 MS. WINKLOSKY: I know.

10 (Laughter.)

11 CO-CHAIR CROCKETT-JONES: You
12 mentioned something like yoga, meditation.
13 Yes, they're great for guys with PTS and TBI and
14 they can't remember to do it.

15 So, I often thought why have, you
16 know, maybe you need to train spouses to do it
17 with them.

18 MS. WINKLOSKY: That's right.

19 CO-CHAIR CROCKETT-JONES: Because if
20 you can establish sort of a whole family daily
21 pattern, you know, that daily regimen which
22 sometimes has almost better outcomes for

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1 functionality than the counseling does for some
2 folks, you know, pulling families in.

3 So, we talk about pulling families
4 in all the time to transition units. I'm going
5 to ask you the same question.

6 What is the difference - this is a
7 major frustration for transition units. What
8 gets a family member in? What do you think?

9 Because we - they try to send emails.
10 They plan events. They have little response.

11 MS. ATHERALL: Well, we - don't we
12 even just have that on the regular green side of
13 the house?

14 I mean, I've been a part of the
15 Family Readiness Office, you know, key volunteer
16 back in the day when we were actually, you know,
17 and you planned these great events and the circus
18 animals showed up and then nobody else was there.

19 So, you know, I think and even then,
20 you know, our own personal stories when we're
21 still a part of the womb and we're on that base,
22 we're not hearing. It's when we go home, home.

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1 Now, if anyone follows the RAND
2 study, that was one thing that I didn't
3 necessarily get from the report this year. But,
4 again, I'm working on the - and I'm the case
5 management part. I need to say something about
6 communities because, you know, I get to step in
7 two lanes as I became the token military spouse
8 for National Association for Social Workers in
9 New York state because I had a language and a
10 perspective that was different for them.

11 And I have a big thing now that if
12 as a social worker I need to be culturally
13 competent of other races and cultures that you
14 may come from, you need to be culturally
15 competent on my military and my military family.

16 So, in my work with - on the social
17 work side of the house, and I had one point and
18 I forgot where I was going with that already, but
19 I work a lot -

20 (Discussion off the record.)

21 MS. ATHERALL: I am like all over the
22 map half the time. So, part of what I'm

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1 challenged to do especially within the social
2 work community is - I got to go back to the
3 families, because I just lost my - how do you get
4 them in?

5 I totally lost my train of thought.
6 I know. I know. I hate when I do that - oh, it's
7 the home, home. It's the RAND study.

8 You know, it's 18 months. It's
9 after they're already home and you're no longer
10 a part of the commissary, the hospital, and you
11 actually have to figure out where to take your
12 child to a pediatrician.

13 That's where the work is, I think,
14 when they're ready to find you. But at that
15 point, you aren't entitled to anything.

16 I actually stood in front of like a
17 conference of 500 individuals that were there to
18 learn about family services for veterans. The
19 majority of the panel was the VA.

20 And I had to do the introduction
21 after someone was like we do this, and we do this
22 and we do this. And I said, I got to say one

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1 thing. Do you know that as a spouse of a retired
2 Marine, I am not - I don't go to the VA for care?
3 They didn't know that.

4 Now, do we want to talk about the
5 expanding programs within the VA? Absolutely.
6 And that is a great - that's a great change, but
7 I don't think I have the answer except to say that
8 we just try to do absolutely everything that we
9 can that makes them - that gets them interested.

10 And the truth of it is, it's when
11 there's a fracture and we are working within
12 that.

13 Now, some of the other things that
14 we're trying to do, making it look creative on
15 the resiliency part, like, starting running
16 groups and starting the yoga groups and doing
17 those other things that we know or what do we like
18 to do as spouses, cooking classes and coffee
19 groups and now I call it a reintegration coffee
20 group. And I actually then insert
21 psychotherapy and they don't know it.

22 My Above and Beyond Program, it

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1 looks - it's supposed to be civilian transition.
2 I have my social work stuff all in there, and they
3 have no idea, you know. My words.

4 So, I think it's being creative in
5 the way that we approach it. And it's not, you
6 know, it's going to be identifying really where
7 are the fractures.

8 So, I know that's not the best, but
9 -

10 CO-CHAIR CROCKETT-JONES: I'm not
11 surprised, but thank you.

12 MS. ATHERALL: So, not to take
13 everything up, what I really wanted to do was go
14 to your executive summary.

15 Because I thought - when I was
16 reading the report, I thought, okay, what's
17 important?

18 You guys already identified the gaps
19 and spot on with everything that was in that
20 summary. That's what we deal with on a daily
21 basis.

22 So, I thought it was maybe more

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1 important to say to you as a task force how I want
2 to work with the DoD and the VA and how I as an
3 organization, as a leader in this group wants to,
4 you know, everyone wants to give money to this
5 mission, right? So, let's get the money and
6 let's do the work.

7 They might think I'm hunting, but
8 I'm really doing intensive case management for
9 you in those gaps and then getting them back.

10 So, the first thing I saw on there
11 was the need for long-term on your restore
12 wellness and function. Need for long-term case
13 management services. The system is complex,
14 often needs advocacy. That's what we do.

15 And how do I do that? Now, within
16 the last year we did have case managers and we
17 had military spouses that knew how to navigate
18 the system.

19 They were the best ever, but then we
20 were starting to deal with some pretty
21 significant clinical stuff and I was getting
22 really nervous because we would have the suicide

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1 ideation intent and plan on a case management
2 call, and they weren't skilled to take that.
3 So, we needed to change things pretty quickly.

4 And so, one of the things that we've
5 done - and I look at us as we're like a teaching
6 hospital. We've partnered with USC School of
7 Social Work and we have military-concentrated
8 advance clinical social workers that are working
9 within our organization on ten-month
10 internships.

11 I see it as a benefit, because now
12 I get them for ten months and they're going to
13 know the system.

14 So, now when they go back out to work
15 in their community provider - that was my other
16 thing on community providers.

17 If they're going to hang that
18 shingle that they work with military families,
19 they're going to understand the system.

20 Because again as a social worker,
21 they need to be referring them back to their DoD
22 command, or they need to refer them back to their

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1 VA.

2 So, if there's a domestic violence
3 and they go into a community office, I'm going
4 to hope that one of my social workers was there
5 and they asked the right question, have you
6 served, not are you a veteran. Because if
7 you're active duty military, you're going to say
8 no, right? So, that's our - my biggest thing is
9 how do you ask the question.

10 So, my gift back is that the social
11 workers come in and they're doing some really
12 great long-term case management or short term,
13 maybe a little bit of crisis intervention, you
14 know. Psychological first aid is one of our
15 core evidence bases that we use.

16 I'm in New York. We were on the
17 ground in hurricane areas working with military
18 families. Active duty military families and
19 PFA was what we - our toolkit.

20 And then I have them at Fordham and
21 Columbia. We're hoping to expand into other
22 regions, but the USC program of social workers

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1 is a national.

2 So, I have interns in our North
3 Carolina office, we will in Annandale and then
4 in New York and Houston. I've got somebody
5 coming in Houston.

6 Okay. So, that's it. That's what
7 we do. We try to supplement - or if they haven't
8 found the right avenues, we're going to give them
9 back to you.

10 The families. Again, what we've
11 already talked about, one of my - the biggest
12 things is just having that protocol established.

13 If you - even if you refer a family
14 member to a vet service center and their veteran
15 has not accessed or signed up for benefits, that
16 family member is not going to get any help,
17 right?

18 So - or like I know I work with North
19 Shore-LIJ and they have a family program. They
20 require that the service member be a part of that
21 process. I don't.

22 You know, I'll work with mom, dad,

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1 sister, brother, whoever and we set a protocol
2 around that. Usually it's less than 12 weeks
3 that we'll work with them before we got to get
4 the service member or the veteran engaged.

5 So, it's saying that families do
6 count. We're going to get more information from
7 the families. And I believe you identified that
8 in your summary.

9 And then the last one, or I'll keep
10 talking forever, is the financial gaps. So,
11 another big thing is how many times have you seen
12 service members or veterans jumping from one
13 non-profit to the next?

14 Or better yet, that email that tugs
15 at everybody's heartstrings and you're sitting
16 back going I know that that family has had over
17 \$50,000 worth of support and they're not using
18 - they're not working with their care team,
19 right?

20 I mean, we see that - saw that a lot
21 out of Walter Reed in Bethesda. They weren't
22 even working with their inpatient or outpatient

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1 team. So, we will assist if you tell me to
2 assist.

3 So, you guys have done the budget.
4 You're working with the family or the service
5 member. I'll do what you ask me to do. And if
6 that means respite for childcare, I'll do it, but
7 not unless you ask me.

8 So, it really does come from - and
9 we do releases, all the right ones. Okay. So,
10 that's really it.

11 I think then my other thing to you
12 would just be maybe the one thing that hasn't
13 been talked about here is that we know, again,
14 from a personal story always living about 18
15 years on a military base and then going straight
16 from some real hard core back-to-back
17 deployments to a recruiting station, one that
18 was failing - anyone ever been on recruiting
19 duty?

20 Whew. Four kids and I was in
21 graduate school at the time, and my husband was
22 off the wall, you know, six, seven days a week

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1 in a very hard position.

2 Community didn't even know who we
3 were. They didn't speak the same language.
4 And I think that they're very eager and they want
5 to learn, but there is a really great way that
6 there could be some education with the different
7 professional organizations that are out there to
8 serve your community.

9 So, for example, on ASW we have a
10 veterans mental health training initiative.
11 New York state.

12 So, where are there some really
13 strong arms that we could do some cultural
14 training back to your community so that they are
15 making that referral back to you? That would be
16 one of my biggest things.

17 Because they - I had a VISN 3 come
18 and do an education brief to the division that
19 I'm the director of, Westchester, and they were
20 in awe over the information that she had to say
21 about the care that they provide for veterans.

22 You know, the VA is very scary to

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1 community providers. They don't understand it
2 let alone the DoD. And they really - people
3 really think that unless there's a large base,
4 that there's no military in their backyard.

5 You know, New York has a lot of
6 military all over the place. The UN, you name
7 it. So, that would be my - just my one little
8 pitch there.

9 As a community provider, I think we
10 are missing the mark or the community is missing
11 the mark on getting to you. They just don't know
12 how to access you.

13 MEMBER EVANS: Just a couple of quick
14 questions.

15 You're located here at Walter Reed?
16 Your organization is here?

17 MS. ATHERALL: So, we have offices in
18 New York, Annandale, Norfolk. We're aboard
19 Marine Corps Base Camp Lejeune. That's where we
20 started.

21 MEMBER EVANS: Okay.

22 MS. ATHERALL: Tampa outside of - we

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1 work a lot with the Care Coalition in Houston and
2 then San Diego. The thing is that I can work
3 with anyone anywhere.

4 MEMBER EVANS: Okay. And that's the
5 other question. So, you work with all services.

6 MS. ATHERALL: Yes.

7 MEMBER EVANS: Okay.

8 MS. ATHERALL: Yes. Is that it?

9 MEMBER EVANS: That's it. Thank
10 you.

11 MS. ATHERALL: Okay.

12 (Pause in the proceedings.)

13 MR. MOLINO: I'm always careful when
14 I walk in front of those lights, because I once
15 blinded a guy in the audience when the light
16 bounced off my head.

17 Good afternoon, everyone. And let
18 me begin by thanking the Task Force for inviting
19 the Wounded Warrior Project to join you and to
20 say a few words about the organization and about
21 the good work we do.

22 We divide the work we do into -

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1 that's it right there - into four major areas;
2 engagement, mind, body and economic
3 empowerment. I'll talk about them in that order
4 and be open to your questions.

5 First, a bit about our mission. And
6 I'm not going to read the slides to you. So,
7 I'll trust that you can read them.

8 Our purpose is three-part.
9 Obviously we want to make the public aware of who
10 we are and what we're doing and of course of the
11 needs of our injured service members.

12 We want to help service members help
13 each other. The peer portion of our operation
14 is very critical to us. It's our logo. We tell
15 the warriors that's what you're supposed to do.
16 You're supposed to live the logo.

17 When you come to us, you are the
18 warrior being carried. And in a very short
19 time, you end up carrying another warrior and
20 helping that individual to be a functioning part
21 of society and to be economically empowered.
22 And then of course we have direct programs and

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1 services to meet their needs.

2 We consider this a fairly big goal,
3 but that's what we want to do. We want to foster
4 the most successful and well-adjusted
5 generation of warriors in our nation's history.

6 On the engagement side, we began -
7 about a half dozen concerned citizens working
8 for various non-profits noticed that the
9 soldiers coming back from Landstuhl going to
10 Walter Reed, pretty much their gear hadn't
11 caught up with them yet. So, they showed up
12 wearing a hospital gown and little else.

13 And so, they got together and
14 decided it would be a great idea if they put some
15 backpacks together and put some sundry items and
16 sent it to Walter Reed.

17 Called Walter Reed. Are you
18 interested? Walter Reed said yes. They put 30
19 backpacks together, shipped them to Walter Reed.

20 When they called to find out if they
21 had gotten there, Walter Reed said not only have
22 they gotten there, but where's the next 30?

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1 And that's when they realized they
2 needed a little structure. They needed a little
3 organization, a little financial support to keep
4 this thing going.

5 Since then we have come up with
6 transition care packages which are given to
7 warriors who are wounded or injured forward. As
8 far forward as Landstuhl and actually all the way
9 into the battle space.

10 And we also have developed these
11 packages for caregivers. We have found that
12 caregivers would be sitting bedside and they
13 needed more of the assistance as well. So, we
14 helped them out.

15 I'm going quickly, by the way, and
16 I apologize for that. There's two reasons for
17 that.

18 One, the limited time and the
19 programs that we have. And secondly, my
20 exposure to Tina and the New York bit.

21 I grew up in Brooklyn. And so, it
22 brings it out in me when I'm exposed to somebody

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1 who talks as fast as she does that it's been -
2 I've trained myself to talk slowly after 20 years
3 in the Army. And now, she just kicked back all
4 those other - I'm going to need some counseling,
5 I think, after that.

6 (Laughter.)

7 MR. MOLINO: One of the things
8 that's not in my biography and that I mention to
9 audiences like this is I have three sons. Two
10 of them are on active duty and together have
11 deployed seven times. Both of whom qualify to
12 be alumni of Wounded Warrior Project. So, this
13 is personal, as well as professional for me.

14 Our outreach to warriors, we call
15 them alumni. You're not a member. Your
16 membership never expires. We don't charge you
17 any dues. Everything we do for and with the
18 warriors is at no cost to the warrior, no cost
19 to the family member.

20 There's no other shoe that drops.
21 When we get you committed, it's all free of
22 charge to any kind of - to the warrior or their

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1 family member.

2 This is the tip of our spear though.
3 This is where we first engage with the warrior
4 whether it be bedside or through the advertising
5 that we do that encourages them to contact us or
6 by word of mouth so that we can grow.

7 We currently have 35,000 warriors
8 enrolled. Our strategic plan tells us that in
9 five years we'll have a hundred thousand
10 warriors. And the commitment that goes with
11 that is astronomical, as you can imagine.

12 The first thing that most of the
13 warriors have when they come to us is some needs
14 with their benefits.

15 Either they're not happy with the
16 award they've gotten from the VA, or it's not yet
17 been awarded.

18 We have trained and certified
19 benefit counselors, senior benefit liaisons who
20 work with them to either resubmit or to finalize
21 their packages so that they get everything to
22 which they are entitled.

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1 And it's - we've all heard the press
2 recently about this issue and how laborious it
3 can be, but we provide a quality service to the
4 warriors and I know that they're grateful for it.

5 We are overseas. We're in
6 Landstuhl as a guest of the hospital command
7 there. And we are grateful to be there. And
8 that's where we make the initial contact with
9 many of the warriors with whom we engage.

10 It is one of the most moving
11 experiences you can ever have. If you ever have
12 the opportunity to be with the warriors or to
13 help them get on the airplane to fly back to
14 Walter Reed, you cannot help but be moved.

15 In addition to this, what we do in
16 Landstuhl is - and, by the way, I'm sorry. I
17 meant to say at the front end of this thing that
18 every program we have has been in response to a
19 gap that we saw or perceived and I will be
20 pointing out snags along the way.

21 But if I had to generalize the
22 biggest snag if you can help in that regard, is

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1 to convince the Department of Defense or work on
2 those procedures and policies that just get you
3 out of the way that facilitate our collaboration
4 with non-profits to a greater degree.

5 I do know that there are always
6 concerns about showing favoritism to one
7 organization or another. If you do it for this
8 organization, you have to do it for another.

9 Having sat in that building and
10 having had to confront the general counsel on a
11 couple of occasions, I know that it's possible.
12 You just have to convince them you want to get
13 to yes as opposed to find me a way to say no.

14 And there are ways to say yes legally
15 and ethically and in a principled manner, and
16 that would be of enormous help.

17 What we do in Landstuhl, the
18 hospital command has encouraged this and we are
19 happy to do it, is twice a year we bring warriors
20 there. A small team. Usually four warriors.

21 We'll go back over to Landstuhl,
22 we'll meet with the caregivers there, the

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1 medical professionals there just to say thanks
2 just to say you've never seen a warrior who's not
3 shop meat.

4 We leave here. You don't know if we
5 live or die. We don't remember you face to face,
6 but somebody filling your position was here and
7 saved my life. And now, I want to come back and
8 say thanks.

9 And the regenerative effect that's
10 had on the hospital staff at Landstuhl has been
11 phenomenal. We'd love to do that stateside.
12 Haven't been able to crack through yet to be able
13 to do that.

14 The Resource Center. We found the
15 need to develop a call center because of all of
16 our programs and all of the warriors coming in.
17 Nothing magical about this. It's the same
18 thing.

19 We gather as much information about
20 our brother and sister organizations, because
21 sometimes, very often, in fact, it is more
22 appropriate to refer them to another

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1 organization.

2 And, yes, of course we do refer them
3 back to the VA, back to the DoD programs. We
4 don't try to avoid that if that's the right
5 answer.

6 We have a Policy and Government
7 Affairs Department that does a minor bit of
8 lobbying, but what we fashion ourselves to do
9 more is more serious policy work.

10 So, we've worked with the Congress
11 on the recent caregiver legislation. We've
12 worked with them on other pieces of legislation
13 that are substantive and intended to help the
14 warrior and/or the caregiver going forward.

15 Most of our constituents, you can
16 imagine, are no longer on active duty. They're
17 now veterans back in society and working as
18 civilians.

19 In the mind arena, mental health is
20 key. We have found that's where the greatest
21 need is. That's where the stigma is. And we
22 feel we can help break through that stigma and

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1 help our warriors and their family members.

2 Our Combat Stress Recovery Program
3 is increasing in popularity, we're happy to say.
4 We know the need is there. And so, the warrior's
5 willingness to participate in it is phenomenal.

6 Most important to this is the spouse
7 and the family members to get them engaged as
8 well, because they're usually the one who gets
9 the warrior to fess up and admit that he or she
10 needs that kind of assistance.

11 And you know the numbers. You've
12 seen the stats about the size of the population.
13 And it only increases and it's only growing and
14 we see our role lasting for a good, long time.

15 Project Odysseys. Again, it's a
16 retreat getting to nature. We've heard a little
17 bit about similar programs from the folks who
18 preceded me.

19 It is an exercise where they are
20 active during the day. And then in the evenings
21 they sit together usually around a large
22 campfire and they talk through their experience.

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1 We always have a mental health
2 professional on board for our Project Odysseys,
3 frankly, because they're needed. The need
4 always presents itself during a Project Odyssey.

5 An opportunity, Project Odysseys
6 are not on active military installations. We'd
7 love to be able to bring Odysseys onto the
8 installations.

9 Up until about a year ago the VA was
10 providing the mental health professionals from
11 the vet centers to go on the Odysseys. Great way
12 to link up with their veteran population that
13 they're going to serve. About a year ago the VA
14 decided they weren't going to do that anymore.

15 We have a letter pending with
16 Secretary Shinseki that said you have recently
17 within the last 60 days come out, as has
18 Secretary Hagel, to say we want to collaborate
19 more with a non-profit, non-governmental
20 organization.

21 We said, here's your first
22 opportunity. Renew your collaboration with us

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1 on Project Odysseys.

2 We know from the clinical staff at
3 the VA, they want to get back to do this. They
4 are not happy that somewhere between them and the
5 secretary it was cut out. We're happy to get
6 back in the game.

7 What have we done in the meantime?
8 We worked with the Given Hour Organization to
9 ensure that we always have a clinical
10 professional onboard whenever we conduct an
11 Odyssey.

12 This fiscal year we'll conduct about
13 90 of these in the course of the fiscal year.

14 Restorewarriors.org. This was a
15 facility. It's kind of a self-assessment where
16 an individual can go in, listen to the stories
17 of some warriors who have actually been
18 diagnosed with post-traumatic stress or
19 traumatic brain injury, hear what they talk
20 about, what they've gone through to see if it
21 rings a bell.

22 There are some self-assessment

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1 tools in here. There are - and of course there's
2 always an outlet that says, call these numbers
3 if you need assistance and help.

4 We found it to be very, very useful.
5 We had it behind our firewall. You had to be a
6 registered alumnus to take part in this.

7 It has become so useful that we have
8 now moved it out in front of the firewall. So,
9 it's accessible to anybody in the public using
10 that web address.

11 And we do find that many spouses and
12 family members go through this and say that's my
13 husband or that's my wife and get them to get the
14 care that they need.

15 Family support retreats are another
16 example of how we've identified that the family
17 is part of this recuperative process.

18 They are just what you would
19 imagine. They're opportunities for the family
20 to get out and get together and to experience
21 that regenerative experience.

22 I was at a conference very recently

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1 and I walked out during a coffee break. And
2 there were 120 children about this high or
3 smaller running around the lobby of the hotel and
4 about, oh, I don't know, 55 or 60 young women in
5 various states of disarray running after them
6 trying to track them down, and immediately I
7 started shaking.

8 But what I found out though, that
9 they were the spouses of the 2nd Battalion 75th
10 Ranger Regiment doing a spouses weekend and I
11 thought it was great.

12 I mean, my son deployed five times
13 with the 3rd Battalion 75th Ranger. So, the
14 Rangers have a soft spot in my heart.

15 And I met the chaplain who was kind
16 of organizing or trying to herd these cats
17 through the weekend and I told him how great I
18 thought the thing was.

19 And he gave me that look and he said,
20 yes, this is probably our last one. Well, why
21 is it your last one?

22 Well, money is why it's our last one.

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1 We probably can't afford to do this anymore for
2 the next deployment. Needless to say, the
3 warriors had just deployed.

4 So, we exchanged business cards.
5 He has established a foundation. So, there may
6 be a way that we can help them out if indeed the
7 government does not or if he can't find another
8 way to find the financial support for that, but
9 that's another example of how we're happy to help
10 if we possibly can.

11 And as I think Tina implied, the
12 American people have been very, very generous to
13 all of our organizations and we feel especially
14 blessed. And we're happy to have our money do
15 good work.

16 Peer support as I said from the front
17 end, is very, very important to us. It's key to
18 almost all of our programs.

19 One warrior motivates another one.
20 One warrior takes away the stigma for the other.
21 And we have trained peer mentors who are within
22 the organization who work with other warriors

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1 and who, if a warrior requests or if we see the
2 need, we'll actually assign a peer mentor to work
3 directly with a warrior for a long-term
4 relationship and to ensure their head is in the
5 right place and they have a good experience.

6 On the body side, our physical
7 health and wellness, this is a good example of
8 where we saw a gap and we started moving into the
9 sports arena. And then we realized that there
10 are many organizations who are doing this in a
11 world class way.

12 When we see that, we don't want to
13 compete. We'll shift our focus. We'll
14 collaborate with those organizations.

15 And, in fact, in our program
16 partnerships, this is where the majority of our
17 program partnerships are.

18 In the last fiscal year, roughly \$2
19 million we gave to these program partner
20 organizations to facilitate these programs for
21 our warriors.

22 We have now shifted a little bit

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1 away, as I said, from the actual physical
2 event-based activities deferring to others and
3 we're moving now more into the nutrition and
4 physical health arena, the healthy living, the
5 healthy lifestyle, a lifestyle of activity, a
6 fully active life for the rest of their lives.
7 And we're making that more of our focus in our
8 physical health and wellness.

9 We have an agreement working very
10 closely with the CIA. No, not that CIA. the
11 Culinary Institute of America with cooking
12 classes for both the warrior and spouses. And
13 it is enormously popular with the warriors.

14 Soldier Ride. I think Tina
15 mentioned Soldier Ride once before. Soldier
16 Ride is an adaptive cycling event. It's more
17 for the warriors to realize that they can do
18 physical activity and that this is something
19 they can do well into their later years.

20 We saw early on the tremendous
21 potential this has as a fund-raiser. We started
22 going down that trail and the warriors said to

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1 us, we would just assume you not do that.

2 The phrase one warrior used for us
3 is, I really feel like you're pimping me out when
4 you make this a fund-raiser.

5 We walked away from it. So, it's no
6 longer a fund-raiser for us. We don't charge
7 people to participate in Soldier Ride. It's
8 more to get public awareness up and to give
9 warriors the idea around the country that they
10 can reclaim their confidence, reclaim that
11 strength and do, again, part of the healthy
12 living.

13 The final step when the warrior is
14 ready and moved along the process is economic
15 empowerment. Because after all, that's what we
16 want.

17 We don't want to be this patronizing
18 organization. We want you to stay with us for
19 the rest of your life, but we want you to be
20 empowered and to be a taxpayer on your own
21 leading the life you choose to lead.

22 We have education services. We're

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1 collaborating with Student Veterans of America
2 in this regard to ensure that the warriors who
3 are ready and have gone to college, have a
4 successful experience in that regard.

5 TRACK is a program that - it is a
6 unique program. We ask a warrior - and the
7 population we target for this is probably the
8 most at risk wounded warrior population that's
9 out there.

10 Generally speaking, the young men
11 and women who participate in TRACK have failed
12 at least once. They've either had run-ins with
13 the law or they've had drug or alcohol issues.

14 We ask them to give us a year of their
15 life either in Jacksonville or in San Antonio.

16 They come down, we give them
17 initially some life skills trainings. One of
18 the - as I'm sure you're aware, one of the
19 symptoms of posttraumatic stress is you let
20 yourself go physically and hygienically. So,
21 we give them life skills. We get them back on
22 their feet in that regard.

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1 We then put them through two
2 semesters at a junior college in either location
3 depending on where they are.

4 And then we end the program, we end
5 the year with an internship at a local business
6 or establishment ideally key to their career
7 interests, but not necessarily if they haven't
8 decided yet, just to see where they go.

9 We are now looking into - have
10 initiated a vocational phase, because some of
11 the warriors have said I'm not really interested
12 in a four-year degree, but I want to be a plumber,
13 I want to be an electrician. TRACK is perfect
14 for that as well.

15 MEMBER PHILLIPS: Sir, how
16 successful - I'm over here.

17 MR. MOLINO: There you are. I'm
18 sorry.

19 MEMBER PHILLIPS: How successful has
20 that program been? Do you have any metrics?

21 MR. MOLINO: We do.

22 TRACK Has been around in

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1 Jacksonville for about four years. It has been
2 around in San Antonio only for a year. Only for
3 a little over a year.

4 The metrics, the graduation rate is
5 fairly good. It's about 90 percent of the
6 students that get through.

7 The cohort is 15 per semester. So,
8 it's 30 at a location each year. 60 warriors a
9 year can go through.

10 We are now tracking it
11 longitudinally to see what happens three, four
12 and five years out. And because of the newness
13 of the program, we still - we're not there yet.

14 We're not particularly happy with
15 the stay-in-school rate. It does seem to be
16 tapering off. So, we're looking to see what we
17 can do.

18 We're planning to have a TRACK
19 reunion where we bring the warriors back to find
20 out what it is that either turned them - do we
21 need to recharge them to keep them back - keep
22 them in school? Were there economic reasons

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1 that they had to go off and do otherwise?

2 TRACK was a concept we were
3 considering when we first moved to Jacksonville.
4 And the CEO of the railroad company - help me,
5 Ron. I can't think of the name of the - CSX,
6 thank you - came in. Michael Ward was his name.
7 And he said, what are you thinking of?

8 We explained the concept of TRACK.
9 And he said, I'm behind it. My company is behind
10 it. Wrote a check for a million dollars. We've
11 never seen anybody write a personal check for a
12 million dollars before, but he said, here's my
13 commitment.

14 And TRACK when it started, was
15 actually the Training, Rehabilitation and
16 Advocacy Center. That was the acronym, because
17 everything has to have an acronym, as you know.

18 Mr. Ward said, okay, you can have my
19 money and my commitment and my support on one
20 condition. He said, I run a railroad. Track
21 has a K at the end. So, you got to call the
22 program track with a K.

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1 So, when people ask me what the K
2 stands for, it stands for one million dollars.
3 And I'll be happy to put a K at the end of any
4 of our programs for anybody with a checkbook.

5 (Laughter.)

6 MEMBER PHILLIPS: Do things like the
7 GI Bill or anything apply to these programs?

8 MR. MOLINO: Absolutely does.

9 They have to qualify. They have to
10 be veterans, obviously, who are no longer on
11 active duty. They have to have a disability
12 rating that enables them to have voc rehab. And
13 the voc rehab helps pay for the - pays for the
14 tuition.

15 We get them housing. They don't
16 live in a dormitory, but they live in an
17 apartment complex, have a roommate. So,
18 there's two to a room - two to an apartment. We
19 pay for that.

20 We also give them a stipend which
21 amounts to about nine bucks an hour for a 40-hour
22 week for the time they're with us.

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1 We have a forced program - a forced
2 savings program so that some of that money we
3 hold back so that when they do graduated, if they
4 do graduate, they get a slug. They forfeit that
5 if they don't graduate.

6 We have had some withdraw for
7 whatever reason and come back in and complete
8 with another cohort. Totally possible to do.

9 The - and all of this is contractual
10 with the warrior. So, it's not a surprise along
11 the way, any of the terms of the agreement.

12 It's an amazing program. And it's
13 an expensive program, as you can imagine from
14 what I've just described, but, you know, what's
15 his life worth?

16 And this is always a man or a woman
17 who has been down once or twice before. And as
18 we tell them, this is your best last chance in
19 many cases. So, we're very pleased and very
20 privileged to be able to deliver TRACK.

21 The Transition Training Academy,
22 interesting story. Cisco came to the

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1 Department of Labor, I think, if I'm not
2 mistaken, when Mr. Drach was at the Department
3 of Labor, if I'm not mistaken, and tried to come
4 up with a program to introduce IT to
5 transitioning warriors.

6 Together they came to Wounded
7 Warrior Project and said, would you be willing
8 to run this?

9 We said, absolutely. We are now in
10 - on installations. I think it's nine
11 installations right now. Mostly Army, but
12 Marine Corps as well wherever there's a
13 transition battalion or a transition unit where
14 we work with the warriors on IT.

15 We had an introductory course that
16 Cisco developed, but the warriors wanted more.
17 So, we developed a curriculum that facilitates
18 them to either go for the A+, the Network+ or the
19 Security+ certifications. And it gets them the
20 real honest to God certification so that when
21 they do transition out, they are prepared to get
22 a job in the civilian world in the IT arena.

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1 Several of the warriors, and I don't
2 have the number at the tip of my fingers, but
3 several of the warriors have been able to
4 reclassify and stay on active duty and
5 reclassify to another specialty based on their
6 IT certifications and were no longer required to
7 get off active duty.

8 We've expanded this to the extent
9 that we're testing it as basically a storefront
10 operation in our office in San Diego where we're
11 now teaching it on the installation. We were
12 teaching at Balboa, but we're now teaching it in
13 our office space so that we can do it in the
14 evenings, a more flexible schedule. We can do
15 it for caregivers. And we can do it for other
16 family members who might want to take advantage
17 of this.

18 Again, no charge to the warriors.
19 And the certification exams, we pay for those as
20 well.

21 For our A+ which is basically it gets
22 you certified. Most people on a help desk have

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1 A+ certification at least initially.

2 They take the computer apart. They
3 put it together probably ten, 15, 20 times. The
4 difference with our program is when the course
5 is completed, the computer is yours. You don't
6 take it apart and leave it for the next class.
7 You walk away with it.

8 What we found is that when they look
9 down at that box, it's again another
10 reconfirmation I can do this. I can do this. I
11 did it. That's my computer.

12 Okay. Almost finished. Warriors
13 to Work. Much like any other workforce
14 development program that you find out there,
15 with one difference. And that's the high touch
16 that we have found warriors especially those
17 with PTSD or traumatic brain injury need.

18 We stay with them. We work very
19 closely with them all the way through the
20 process.

21 Usually it's the night before
22 calling them to say, I know you can make it on

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1 this interview, I know you're going to do well.

2 We also work at the front end with
3 potential employers to make sure that they
4 understand what it is they're dealing with, who
5 it is they're dealing with, what the conditions
6 are and, more importantly, what the conditions
7 are not to get those stigmas out of the way and
8 to make them realize that you're not hiring this
9 young man who happens to be a Silver Star
10 recipient because you're in a charitable mood.
11 You're hiring him because your workplace is
12 enriched by his presence.

13 And that's the message - we believe
14 it and that's the message we try to get across.
15 And it's matching the right employer with the
16 right employee that leads to a successful
17 future.

18 We've had warriors who have wanted
19 to be - he's an EMT. And we give them that
20 exposure and we find out that's not what they
21 want to be, because it brings back all those bad
22 memories, all the bad mojo. But for some, it

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1 works. It works very well. It works well for
2 him.

3 Let's see. In the last - the only
4 thing I would add to my comments is in the last
5 fiscal year, and our fiscal year aligns with the
6 government, I mentioned that we had \$2 million
7 in program partnerships.

8 We also have a grant program that
9 we've initiated where we granted another \$2
10 million to other organizations, other
11 non-profits.

12 And essentially our rule of thumb
13 there is you do what we do where we aren't so
14 there's no duplication or competition, or you do
15 what we don't do, but it's consistent with our
16 mission. And that broadly spoken, are the two
17 pieces of guideline.

18 And then the other thing is our board
19 has approved four pilot programs for this fiscal
20 year mostly filling in gaps we see with the VA,
21 but it's a counseling program.

22 You know, warriors/veterans have

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1 been getting that initial burst, that initial
2 counseling and then nothing happens for a very
3 long time for that second and follow-up
4 appointment.

5 So, we're initiating a program where
6 it's very similar to an employee assistance
7 program where they'll be able to call and get up
8 to 10 sessions with a mental health professional
9 while they're waiting for the VA system to kick
10 in. And at any point that could break and go
11 back to the VA.

12 We're working on a long-term support
13 program. A long-term support pilot program.

14 The VA is very skilled at geriatric
15 care, but many of our warriors who are the most
16 severely injured warriors have parents who are
17 their caregivers.

18 Well, what happens when they are
19 about 45 years old and mom and dad can't take care
20 of them anymore?

21 So, we're looking at those - a way
22 to keep them in the home using community

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1 government and other private entities so that we
2 can ensure that their life is a quality of life
3 until age and other health issues make them to
4 the point where they have to be
5 institutionalized.

6 But all the data we have seen say
7 that if you institutionalize a 45-year-old man
8 with 80 and 85-year-old people, that their
9 lifespan is about five years. They get
10 depressed and they die. And that's not what we
11 want for these warriors. That's not what they
12 deserve.

13 Wound Warrior Project Talk, we're
14 calling it. We've given this many names. It's
15 based on a model in Israel by a group called
16 Natal.

17 And what this basically is are
18 scheduled phone calls, non-clinical phone
19 calls, but you know it's a scheduled phone call
20 with somebody who knows you. You know them, you
21 get to know them, you have a telephone
22 relationship with them and it's a way to talk out

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1 in the peer kind of mentality.

2 It is not a clinical program. If
3 there's any indication that you need that, it's
4 a break and you go certainly to clinical
5 services.

6 And then the last thing we're doing
7 is a peer-facilitated support program intended
8 to be in communities around the country and it's
9 just what it sounds like. It's
10 peer-facilitated.

11 We'll put the money up front to
12 either rent a facility or get tables or get the
13 refreshments. And then we back away and it's
14 run by peers talking, meeting regularly.

15 And the model it's based on is
16 Alcoholics Anonymous, actually. But we don't
17 tell the warriors that because it might have a
18 bad connotation.

19 But it's an excellent model and it's
20 a neighborhood-based peer-facilitated support
21 group. They just get together periodically to
22 talk.

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1 And those are our four pilot
2 programs that our board has approved. And I
3 think that's probably - that's it. There we are
4 in social media.

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

7 MR. MOLINO: You certainly can.

8 CO-CHAIR CROCKETT-JONES: Do you
9 have any data - and if you have to get back to
10 us, it would be great - on how many hits you get
11 on your website?

12 You know, what is the frequency of
13 use on that and how many calls you're taking at
14 your call center?

15 MR. MOLINO: I can get back to you
16 with those numbers, yes, absolutely.

17 I do know that on Facebook we're over
18 a million friends, over a million likes. Look
19 who's not on Facebook, but, you know, we've
20 broken that million mark. I do know that.

21 But I certainly can get back to you
22 on our call volume as well as our hits on the

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1 website.

2 CO-CHAIR CROCKETT-JONES: Well,
3 you're welcome. I'm one of your likes. So, you
4 know, I help drive your number over. I'm one of
5 your likes on Facebook and you're welcome.

6 (Laughter.)

7 MR. MOLINO: Thank you very much.

8 Well, once again thanks very much
9 for having us appear before you. Thanks for the
10 good work you're doing.

11 MS. DAILEY: So, we're into the break
12 or if you want to ask one last question and wrap
13 up, we'll do that and - or if you want to hold
14 them during your break and chat with them on your
15 own, that's up to you.

16 CO-CHAIR CROCKETT-JONES: I think
17 that we can wrap up and anything we need to do,
18 we can talk to them on our own and we'll be back
19 here at 2:45.

20 (Whereupon, the above-entitled went
21 off the record at 2:34 p.m. and resumed at 2:46
22 p.m.)

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1 CO-CHAIR CROCKETT-JONES: At this
2 time we welcome Dr. William Brim, the deputy
3 director of the Center for Deployment
4 Psychology. The mission of the center is to
5 train behavioral health professions to provide
6 high-quality deployment-related support to
7 military personnel and their families.

8 Dr. Brim will present information on
9 evidence-based treatment for PTSD and the
10 Center's assessment of various best practice
11 techniques.

12 Please find Dr. Brim's information
13 under Tab N. I turn it over to you.

14 DR. BRIM: Okay. Thank you, ma'am,
15 General, Ms. Crockett-Jones and members of the
16 Task Force.

17 First of all, thank you to Ms. Dailey
18 and her team because they've done everything
19 they possibly could do to prevent me from making
20 a fool of myself. So, as they say, it's downhill
21 from here.

22 I'm Dr. Bill Brim. I am the deputy

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1 director at the Center for Deployment
2 Psychology. I am a psychologist by training.
3 I'm an Air Force veteran by the grace of God, I
4 guess, and good luck.

5 And it's an honor to be here to
6 discuss a little bit about evidence-based
7 psychotherapies and our efforts in rolling out
8 evidence-based psychotherapy for psychological
9 health in the DoD and also to introduce a little
10 bit about the Center for Deployment Psychology
11 to you.

12 Dr. David Riggs, our executive
13 director, sends his regrets. He's not able to
14 be here today. He's off roughing it in San Diego
15 actually teaching one of the evidence-based
16 psychotherapy workshops today.

17 He has been involved in helping to
18 develop this presentation, though, and he and I
19 are certainly standing by to answer any
20 questions that come up after this briefing.

21 I always hate going next to last,
22 because everything really smart has already been

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1 said except for the one thing that the person
2 after me is going to say. I'm pretty sure of
3 that.

4 If it's okay with you, I know that
5 probably most of you are familiar with the Center
6 for Deployment Psychology. But what I thought
7 if it was all right, I would take just a couple
8 of minutes and just talk about the mission and
9 the history of the Center to kind of give a
10 context to our discussion.

11 And then, you know, I have a whole
12 stack of notes here to answer the very specific
13 questions that you had and I wanted to make sure
14 I have time to do that and then hopefully be able
15 to have a discussion and more lead a discussion
16 than just talk at you because I think we've had
17 some similar experiences in - sorry. I'm a
18 free-range talker, so, I tend to trip over solid
19 objects that are in the way.

20 And so, we'll lead a little bit of
21 a discussion about what we found in similar in
22 our trips around the Department of Defense.

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1 The Center for Deployment
2 Psychology was first set up in 2006. It was a
3 Congressional mark to the Appropriations Bill.
4 One million dollars.

5 And the mission was to train
6 military behavioral health providers by having
7 them come to a two-week in-residence training
8 where we train them in deployment-related
9 psychological health, TBI, wounded warrior
10 care, treating and assessing family members and
11 working together in a joint environment.

12 So, we started off with that
13 two-week in-residence program for military
14 members and we have a psychologist, what we call
15 a deployment behavioral health psychologist, at
16 each of the 11 MTFs where there is an American
17 psychological Association-accredited
18 psychology internship.

19 So, they're embedded in the units
20 there training the psychology and, where they do
21 exist, social work interns, pre-doctoral
22 interns prior to them going to their first

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1 assignment.

2 So, we have those 11 folks and that's
3 where we started. That first year we conducted
4 five of the two-week in-residence courses. And
5 at the end - roughly about 50 members per
6 training. And at the end of that first year we
7 had almost 400 civilians signed up for the course
8 on a waiting list to take the course.

9 Now, this is DoD civilians, VA
10 civilians and private community providers that
11 were interested in working with service members,
12 veterans and their families.

13 So, I'll talk a little bit more about
14 where we went from there. So, that was our
15 initial mission and you can see where our goals
16 - I won't go into those.

17 So, we have the two-week course for
18 military providers that I mentioned and the
19 DBHPs, the deployment behavioral health
20 psychologists at those locations.

21 I put an asterisk next to each of the
22 projects or programs that we have that includes

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1 evidence-based psychotherapy or treatments, a
2 workshop embedded in the course.

3 So, when the military providers come
4 to the two-week course, one of the things they
5 receive is a two-day workshop as a part of that
6 two weeks in evidence-based therapy.

7 Now, they can choose - for PTSD.
8 They can choose either prolonged exposure
9 therapy or cognitive processing therapy. So,
10 they kind of track to whichever they want of
11 those two.

12 And we also offer evidence-based
13 psychotherapy as part of a two-week course in the
14 assessment and treatment of insomnia. Also,
15 interpersonal therapy for depression. So,
16 those are embedded in the two-week course.

17 So, at the end of the first year, 400
18 civilians wanting to get in the door. So, we
19 partnered with TRICARE, TriWest in particular,
20 to pilot a one-week course for civilian
21 providers.

22 And in many ways, this has become

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1 kind of our masthead or at least our most visible
2 face for civilian providers because we do eight
3 of these and we do them all over the country.

4 So, it's a traveling road show, if
5 you will. The circus comes to town as was said
6 before.

7 And we target around a hundred
8 civilians to attend each one. That seems to be
9 about a manageable number. And that's about
10 what we hit.

11 We've done now - this year we are
12 doing our - we just had our 36th civilian
13 one-week program. So, we've done eight of those
14 a year and we've done some extras here and there.

15 And a big part of that is they spend
16 a day on military culture, the terminology,
17 understanding military culture and what are the
18 stressors involved in the deployment cycle.

19 That's one whole day. That's the
20 first day just kind of getting an introduction
21 to cultural competence, you know, being
22 culturally sensitive to the military members,

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1 veterans and their needs.

2 We talk about the deployment cycle
3 and then we talk about various
4 deployment-related psychological health
5 issues.

6 And then embedded in that five-day
7 course is a two-day evidence-based
8 psychotherapy for PTSD. Some weeks it's PE,
9 prolonged exposure. And some weeks it's CPT or
10 cognitive processing therapy.

11 So, they all walk out of there not
12 only with information from the first three days,
13 but skills, knowledge and skills, at least the
14 beginnings of knowledge and skills from the EBT
15 workshop.

16 The mobile training teams, this is
17 the evidence-based psychotherapy. This is the
18 two and three-day workshops that are exclusively
19 focused on those.

20 And I'll talk some more about those,
21 but we have a range of them and I'll answer - the
22 answer to one of your questions will go in a

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1 little bit more detail of what those are, but
2 those are done all over the country.

3 To date, we have held 106 of the
4 evidence-based psychotherapy workshops. I'll
5 check my number to make sure, but I think 80 of
6 them - just around 80 of them have been for PTSD.
7 And the rest have been for sleep, suicide,
8 chronic pain, depression.

9 And we have 37 of those scheduled for
10 the next nine months coming forward.

11 MEMBER PHILLIPS: Excuse me.

12 DR. BRIM: Yes, sir.

13 MEMBER PHILLIPS: I assume these are
14 just informative type of programs and not
15 certified or pass/fail or anything like that.

16 DR. BRIM: So, the evidence-based
17 psychotherapy workshops are skills-based.
18 They're interactive. There's role plays.

19 The goal is that the person walks out
20 capable of doing the evidence-based
21 psychotherapy the next day. So, they have
22 opportunities to role play.

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1 They're not certifications per se.
2 They do get continuing education credits for
3 them, but there's not - there's no recognized
4 certification at this point in the
5 evidence-based -

6 MEMBER PHILLIPS: So I understand,
7 will you be talking about follow-up to -

8 DR. BRIM: Yes, sir. Absolutely.

9 Just to quickly go through the rest
10 of our programs then, we have a University
11 Counseling Center Core Competency Program.
12 This is one of our, right now, hottest products,
13 if you will. It's a one-day workshop.

14 Half the workshop is open to
15 everybody in the university. So, the students,
16 the president, the financial aid, the dorm life,
17 everybody. And then the second half of the day
18 is just focused on overview of typical
19 psychological health issues that a veteran or
20 service member might bring into the counseling
21 center and kind of bringing them up to speed.

22 Again, an introduction to military

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1 culture so that they understand a little bit of
2 that military vernacular, if you will.

3 We have the STAR behavioral health
4 providers. This is in conjunction with the
5 Military Family Research Institute and the
6 Indiana National Guard.

7 It's essentially our one-week
8 program, but it's broken into tiers where the
9 first tier is the military culture part. And
10 then after the military culture part, they can
11 then go to Tier 2 and some smaller subsection
12 then might do Tier 2. And that's all the other
13 kind of courses they usually get in the two-week
14 - the one-week course on the Tuesday, Wednesday.
15 And then the third tier is the evidence-based
16 psychotherapy workshop. The two-day workshop.

17 So, when they complete that, they do
18 get a Certificate of Completion for that course.
19 They get the continuing education credits.

20 And we've just been funded to expand
21 that STAR program into five additional states.

22 Now that I say it, I can't list them

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1 all, but we're going to be Georgia, Michigan,
2 California and - Arkansas and one other one,
3 which I'll always forget. Iowa maybe, right.

4 And so, we're hopeful that that will
5 be important. Because, you know, one of the
6 things I know you guys know and I go on and on
7 and on about it is if we've deployed 2.2 million
8 service members and you want to conservatively
9 say that 30 percent of them have PTSD, anxiety,
10 depression or TBI, that's three-quarters of a
11 million people, right?

12 That's not even counting the family
13 members and, you know, going out from there.
14 Three-quarters of a million people.

15 That significantly dwarfs the
16 number of providers in DoD, behavioral health
17 providers in DoD. It's interestingly almost
18 exactly the same number of licensed
19 psychologists and social workers in this
20 country.

21 So, talk about give an hour. You
22 got a lot of hours to give. If every therapist

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1 in this country gave one hour, we'd begin to
2 scratch the surface of just the service members,
3 right?

4 And as they age, kind of one of our
5 beliefs is that as they age and move through the
6 life cycle, the problems are going to change that
7 they face, right?

8 So, I mean, the 19-year-old that
9 went to Iraq in 2002 is now 30 years old, married
10 with kids maybe facing divorce, substance abuse
11 problems, you know, going to college, you know.

12 There's a whole life spectrum that,
13 you know, this kind of - I think of it as the pig
14 and the python, right? This bolus of people
15 that for the next - that ten years of people
16 that's going to move through the whole life cycle
17 for the next hundred years. And we need to be
18 able to meet their needs along the way. And
19 we're not going to do it alone.

20 And so, taking advantage of the
21 civilian counterparts and their willingness and
22 eagerness is an important cornerstone of what we

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1 do.

2 And I think it will pay off in spades
3 down the line because, you know, especially with
4 Guard and Reserve when those guys shoot off to
5 the four corners of the state where they may not
6 have access to a VA or to an MTF if they have the
7 benefit, we have to have civilians trained to be
8 - these are my - this is my key phrase I say all
9 the time. They need to be culturally sensitive
10 and clinically competent. So, we're trying to
11 make sure that they have both of that.

12 We offer Speakers Bureau which is
13 just most of our courses that are available and
14 can ad hoc as requested. And that may include
15 an evidence-based psychotherapy workshop.

16 And then we have online courses,
17 because we have to utilize technology to
18 disseminate.

19 We've had over - over 40,000 people
20 have taken the military culture online course or
21 had the military culture live course. It's our
22 most popular one, obviously, as the last panel

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1 kind of mentioned that need to be culturally
2 sensitive.

3 And they're afraid. Some providers
4 are afraid that they don't know how. You know,
5 I say to providers all the time, you know, the
6 therapy that works for the civilian with PTSD
7 will probably work for the military member with
8 PTSD, but they're hesitant to do that.

9 And this comfort in this military
10 culture and terminology realm seems to be part
11 of that hesitance and fear that we get from
12 civilian providers and we're trying to kind of
13 overcome that barrier.

14 Yes, General.

15 MEMBER MUSTION: This may sound like
16 the dumb question of the day, but who does the
17 center that you work for, work for?

18 DR. BRIM: Yes, sir. A fair
19 question. I kind of skipped over that part,
20 yes.

21 So, after that original
22 congressional mark, we were picked up

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1 temporarily funded through DCoE, but then we
2 kind of backed out of that and went back home to
3 the university.

4 So, we are currently funded with -
5 primarily with Health Affairs dollars through
6 USUHS. We are part of the baseline budget of
7 USUHS currently.

8 Our headquarters is at Bethesda and
9 then we have the 11 spokes.

10 GENERAL MUSTION: Thank you.

11 DR. BRIM: Follow-up, ma'am?

12 MEMBER MALEBRANCHE: I have a
13 question, because I was wondering the same
14 thing.

15 How are you related or
16 associated/affiliated with the VA? Do you do
17 something with also the Center for T2 out in
18 Washington state?

19 Are you connected somehow?

20 DR. BRIM: Informally and loosely.

21 MEMBER MALEBRANCHE: Okay.

22 DR. BRIM: We were all along with the

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1 Deployment Health Clinical Center, the Center
2 for the Study of Traumatic Stress, T2, the CDP,
3 we were all component centers under the Defense
4 Center of Excellence for Psychological Health.

5 And as that's been downsized, CSTS
6 reallocated. CSTS, the Center for the Study of
7 Traumatic Stress, the Center for Deployment
8 Psychology and the Defense Health Clinical
9 Center have gone back to where we were
10 originally, which is under USUHS.

11 I can't speak for CSTS and DACC as
12 far as their funding, because a lot of theirs is
13 outside grant and research money.

14 We're 90 percent a grant from Health
15 Affairs through USUHS as a grant.

16 MEMBER MUSTION: Since we're already
17 disrupting your presentation here -

18 DR. BRIM: Not a problem.

19 MEMBER MUSTION: The training
20 courses that you've outlined here, which are all
21 great, is this a Department of Defense-directed
22 requirement, for example, that every military

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1 provider needs to go through this or every
2 clinical provider?

3 I mean, is there a standard with
4 which we measure the execution of the program?

5 DR. BRIM: The measure -

6 MEMBER MUSTION: What I'm trying to
7 get at is you've outlined all the great things
8 that the Center is doing and the courses that
9 they run, but what I'm wondering is, is there a
10 directed requirement across the services that
11 says everybody has to complete this training or
12 everybody in a particular skill set or a
13 particular type healthcare provider.

14 DR. BRIM: Yes, sir. Understand.

15 Unfortunately, I can't answer that
16 as simply and straightforward as I would like by
17 saying yes or no. In varying degrees.

18 So, we have an agreement with each
19 of the 11 psychology internships that in
20 exchange for that deployment behavioral health
21 psychologist all year long to utilize as a
22 training asset embedded within, they will send

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1 all of the psychology and social work interns to
2 the two-week program. So, that's a handshake
3 Memorandum of Agreement.

4 We have a guidance from the
5 assistant secretary of defense for Health
6 Affairs saying that all active duty mental
7 health providers who see patients with PTSD are
8 required to be trained in an evidence-based
9 psychotherapy for PTSD through the Center for
10 Deployment Psychology.

11 So, it's kind of a convoluted
12 mandate, if you will, to apply that training.

13 MEMBER MUSTION: So, maybe that's
14 good that we have some mandate out there.

15 So, are we achieving that mandate?
16 Do we have a way of measuring whether we're
17 achieving that mandate?

18 DR. BRIM: So, of course it's a moving
19 target that we train every active duty mental
20 health provider, just based on throughput.

21 We have - again, we've done 106 of
22 the DoD-focused evidence-based workshops. And

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1 to date, we've trained just under 10,000
2 providers. That's active duty and civilian,
3 you know, like DoD civilian GS-type folks.
4 6,000 of them within the DoD. 10,000 total
5 including the civilians.

6 So, roughly there's about 7500
7 mental health providers if you include
8 psychologists, psychiatrists, social workers,
9 psychiatric nurses in the DoD. We haven't
10 reached all of them.

11 MEMBER PHILLIPS: Another just quick
12 question.

13 Since you're at the school, are you
14 connected at all or work with the National Center
15 for Disaster Information and Public Health?

16 DR. BRIM: No, sir.

17 MEMBER PHILLIPS: No, okay.

18 DR. BRIM: Make sure I'm caught up on
19 my notes here and make sure I covered everything
20 there and answered your questions as well.

21 I do want to, you know, make sure I
22 get to the eight questions that you had for me

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1 and that may answer some of the additional
2 questions that you have.

3 The first question was what is the
4 CDP's assessment of the availability of
5 evidence-based treatments for returning
6 warriors with PTSD?

7 And as I mentioned to date, the CDP
8 has delivered 106 evidence-based psychotherapy
9 workshops. 80 of them in PTSD.

10 The bulk of the rest are in insomnia
11 which is, by the way, the number one complaint
12 of service members returning from deployment.

13 And we've done that at 65 unique DoD
14 locations worldwide. We have 37 more of those
15 scheduled for the next nine months, and we've
16 been funded through FHP&R to continue that, the
17 DoD-focused evidence-based psychotherapy
18 workshops.

19 In addition, I'll mention, you may
20 already know this, that the Army Medical
21 Department Center and School also delivers a
22 limited number of evidence-based psychotherapy

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1 workshops per year. They target big Army bases.

2 So, the AMED Center and school does
3 a handful of PE, a handful of CPT and a handful
4 of stress inoculation therapy courses, but
5 they're relatively small in number.

6 MEMBER MALEBRANCHE: Do you do things
7 together with the VA?

8 DR. BRIM: Yes, ma'am, we do.

9 And, in fact, most of that
10 evidence-based psychotherapy workshop is a part
11 of that overarching integrated mental health
12 strategies of the 26 that you may be familiar
13 with.

14 Number 9 is the collaborated
15 delivery of evidence-based therapy. So, we
16 collaborate with the VA. We make sure our
17 evidence-based workshops mesh with one another,
18 that we're teaching essentially the same
19 principles.

20 And I'll talk a little bit about the
21 follow-up and that's where we differ, the
22 competence piece.

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1 MEMBER MUSTION: You mentioned that
2 the Army Medical Department has its own training
3 program at its major installations.

4 Do they model or emulate and use the
5 same standards that you do?

6 DR. BRIM: Yes, sir. For the, you
7 know, what we certainly call the big two, PE,
8 prolonged exposure, and CPT, cognitive
9 processing therapy, our decks are very similar.

10 And we've both consulted with the
11 same person that developed those two treatments
12 to develop our decks.

13 So, I want to make a quick
14 correction, though. We do a lot of training at
15 Army bases.

16 I was at Fort Bragg last week doing
17 a training there. We do a lot of training at
18 Army bases. So, we are integrated. We do
19 collaborate.

20 What we don't do at CDP is we don't
21 go to the bases where AMED Center and School has
22 been. So, they tend to hit Hood, Carson, Drum,

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1 you know, Campbell. They hit the hot spots,
2 right.

3 And so, we end up covering some of
4 the other Army locations as well. So, it's not
5 like there's a fence there between the two of us.

6 So, one of the things I want to say
7 and kind of already have answered the question
8 that the General asked is that understanding and
9 knowing where all the active duty members are and
10 where all these DoD civilians are that we've
11 trained.

12 Our data suggests that many, but not
13 all, MTFs currently have at least one provider
14 who has been trained in at least one
15 evidence-based psychotherapy for PTSD.

16 In one study, this was a self-report
17 done by WRAIR, I'll reference more in detail
18 shortly, 78 percent of providers surveyed
19 reported that they had been trained in at least
20 one trauma-focused evidence-based
21 psychotherapy. So, about 80 percent. That's
22 EMDR, eye movement desensitization, PE, CPT and

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1 SIT, stress inoculation therapy.

2 So, the potential availability of an
3 EBT for PTSD has improved significantly in the
4 last three years since that ASD Health Affairs
5 memo requiring that service members delivering
6 PTSD treatment be trained.

7 But here's where I kind of want to
8 mention we think of - evidence-based - the
9 delivery of an evidence-based therapy happens
10 within the scope of an evidence-based practice,
11 right?

12 So, what I - and this is relevant to
13 your next question as well. This evidence -
14 this idea of evidence-based practice is kind of
15 more of a holistic or a comprehensive practice
16 of delivering evidence-based therapies.

17 And when we think about - I'll just
18 read a definition of evidence-based practice
19 from Dr. Sackett - David Sackett - "the
20 conscientious explicit and judicious use of
21 current best evidence in making decisions about
22 the care of an individual patient.

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1 It means integrating clinical
2 expertise with the best available external
3 clinical evidence from research."

4 So, the components of that then are
5 not only the evidence-based, right? You have to
6 have the research and the evidence-based. You
7 have to have the provider expertise which they
8 get from attending this two-day - well, at least
9 the knowledge that they get from attending the
10 two-day workshop, the patient preferences and
11 then the environment, right?

12 So, you have to consider the
13 provider, the environment and the patient and
14 what their wants are when you're attempting to
15 deliver the right therapy in the right dose or
16 in the right time or in the right way for each
17 individual patient.

18 So, the reason I go through all that
19 is because to answer your question, I think there
20 is significantly improved awareness that there
21 are evidence-based psychotherapies out there.

22 We have the research component.

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1 We've gone out and delivered the workshop to the
2 majority of the currently active duty providers.
3 So, we've increased - we have begun the process
4 of increasing their clinical expertise, but
5 there remains significant barriers.

6 And this is the same things you guys
7 are seeing, we think, when you go out and do your
8 site visits. Because there's a lot of variation
9 in the clinic use, how the clinic - so, this is
10 that environment piece.

11 You got the research, you got the
12 therapist, but there is the environment piece.
13 And so, the issues are the staff utilizing it and
14 feeling supported in utilizing the
15 evidence-based therapy, ops tempo, the nature of
16 the military lifestyle, deployments, duty and
17 training requirements for the provider and the
18 patient, and then conflicting organizational
19 metrics, that RVU, productivity issue that
20 doesn't - that sometimes conflicts with the
21 delivery of evidence-based therapy.

22 Okay. I'll come back to that. So,

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1 it ties in with the second question about does
2 evidence for EBTs support latitude in their
3 delivery and to what extent does this impact
4 quality of care.

5 This is that question from you guys
6 going out and the Task Force and seeing different
7 ways of implementing these manualized
8 treatments.

9 And so, what we think you're seeing
10 is people that are knowledgeable that here is
11 this evidence-based therapy that I should be
12 using it, but the milieu doesn't support doing
13 it. The environment, the command, whether it's
14 the clinic command, the MTF command who, by the
15 way, in our interviews have been very
16 supportive, but higher than the MTF command.

17 The push-down for productivity
18 numbers is affecting the delivery of
19 evidence-based therapies.

20 So, the milieu is not consistent
21 with the delivery in some ways of evidence-based
22 - manualized therapy.

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1 And so, what I think you guys are
2 seeing where you're seeing this intensive
3 ten-day program or this intensive outpatient
4 program or them seeing a person every day for
5 five days in a row, what you're seeing is people
6 trying to deliver evidence-based components in
7 that constrained environment, right. So,
8 they're being kind of creative.

9 And unfortunately, the state of the
10 evidence today doesn't support that, but - this
11 is the good part - but the delivery of
12 evidence-based therapies is different from the
13 delivery of manualized therapy.

14 And I think this is where some of our
15 clinicians get confused is they're trying to -
16 if you try and - if you try and provide therapy
17 with fidelity to the manual and the model, you've
18 got to have one to two appointments a week, 60
19 to 90 minutes in length for, you know, six to 12
20 weeks.

21 I mean, that's what - that's the way
22 the manuals are set up. And I bet you've never

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1 been to a clinic where they have the opportunity
2 to do that.

3 There are a few exceptions, but you
4 probably have not been to many clinics where that
5 environment exists.

6 So, you've got a conflict between
7 the manualized requirement and having fidelity
8 to that model and the environment, but I think
9 there's a way around that. And we'll talk a
10 little bit about that.

11 MS. DAILEY: Excellent point.
12 Excellent point, Dr. Brim. You've really
13 summed up our experiences out in the field as we
14 spend time with the Departments of Behavioral
15 Health.

16 But to your last question about
17 manualized two appointments a week, 90 minutes
18 per appointment, I think the only place we have
19 seen it delivered exactly like that was at Fort
20 Lewis with the social workers in the battalion.

21 DR. BRIM: Yes, and there are a few
22 other places you might see that.

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1 CO-CHAIR CROCKETT-JONES: Right,
2 that is where we saw it, but they were innovating
3 to do that. They were innovating outside of
4 traditional policy everywhere else -

5 DR. BRIM: Right.

6 CO-CHAIR CROCKETT-JONES: - in
7 order to do that.

8 DR. BRIM: And where you see that
9 successfully happening is places where you've
10 got a strong person who's consistently
11 advocating for the sustainment of that program
12 like at Portsmouth Navy Clinic, at BAMC, at
13 Wilford Hall.

14 And as long as you have those people
15 in place advocating up the chain and protecting
16 the people productivity-wise, that's where you
17 see those programs flourish.

18 Otherwise, I think you're seeing
19 individuals who are adamant in wanting and
20 knowing that an evidence-based therapy would
21 work, but trying to do it in kind of strange ways.

22 Well, if PE says - if the manual says

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1 for PE to be - what we know from the evidence is
2 that PE, the therapy, the research is based on
3 PE delivered in 90-minute sessions twice a week
4 for five to six weeks, there's very, very few
5 places where that's happening or even feasible.

6 So, what you end up doing is well,
7 you know, you have a 75-minute session 15 minutes
8 into your lunch - which is what I used to do -
9 or you do multiple sessions. You do two
10 60-minute sessions and those kinds of things.

11 But what I will mention real quick,
12 and I'm going to end up running way out of time,
13 I bet, is that if you look at the VA/DoD clinical
14 practice guidelines for PTSD, I want to point out
15 that it says on Page 44, some manualized
16 approaches have gained wide popularity, but
17 there is no evidence that they are any more
18 effective than less-accepted protocols that
19 package the core components of trauma-focused
20 therapies in different ways.

21 And so, what that means is that the
22 clinical practice guidelines say, do exposure

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1 therapy. They don't say, do PE. they say, do
2 cognitive therapy. They don't say, do CPT,
3 right?

4 So, what we know is that the
5 components of effective therapy are exposure,
6 cognitive component and anxiety or stress
7 management component.

8 CPT does a lot of cognitive and a
9 little bit of exposure and a little bit of
10 anxiety. PE does a lot of exposure and a little
11 bit of cognitive and a little bit of stress
12 management. And stress inoculation therapy
13 does a lot of anxiety management with a little
14 bit of exposure.

15 So, the ones that are evidence-based
16 therapies that are effective treatments use
17 those components.

18 And so, what we think is maybe - and
19 we don't have the research yet to support this,
20 but that maybe the robustness of these
21 manualized treatments is due to the components
22 and not how they're packaged, right.

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1 So, that's maybe that kind of way,
2 perhaps, around the idea that we have to hold the
3 gold standard of competence in a manualized
4 treatment and maybe instead we need to be focused
5 on a gold standard of delivering the right
6 component to the right patient at the right time,
7 right, given the environment.

8 So, we've worked our way up in 30
9 minutes to question number three of eight, I'll
10 mention, and I kind of put the two together.

11 Which EBTs are DoD clinical staff
12 trained to provide, and how many EBTs are
13 clinical staff trained to provide and do
14 providers get multiple ones?

15 And there's a couple of ways I can
16 cut that up. And the first is that here's the
17 therapies that are currently - the
18 evidence-based psychotherapy workshops that are
19 currently offered by CDP.

20 So, we have cognitive processing,
21 prolonged exposure, cognitive behavior therapy
22 for insomnia, pain, depression and suicide risk

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1 assessment and mitigation, which is basically
2 managing outpatient - suicidal behavior in an
3 outpatient basis.

4 We've got anxiety, substance abuse
5 disorders and therapy for relationships that are
6 coming online.

7 Again, you can kind of see following
8 that pig through the python, if you will, kind
9 of - as issues come up, kind of addressing some
10 of those issues. So, that kind of answers
11 Question 3, if you will.

12 And then for Question 4, this one,
13 providers may be trained in more than one
14 evidence-based therapy. And often they are.
15 And to some extent we encourage that that those
16 who are interested in treating PTSD be trained
17 in several different models.

18 The concern is the provider that
19 does not get adequate opportunity after the
20 training to implement the model that they were
21 trained in so that they feel comfortable and that
22 that model fits their theory.

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1 So, let me just kind of put it this
2 way. I've been trained in PE and CPT. I'm much
3 more behavioral. I tend to be more effective
4 delivering PE.

5 When I do PE, I start PE and I stay
6 with PE, right. I can do CPT. I prefer to refer
7 them to people that have more practice doing it.
8 But if that person doesn't exist, I can do CPT.
9 And when I start CPT, I stick with CPT, but that
10 takes a lot of effort to kind of keep that Chinese
11 wall, if you will, between the two.

12 But I think a lot what ends up
13 happening if you don't provide after the
14 workshop opportunities for the provider to
15 become comfortable and feel competent in that
16 therapy, then they end up cherry picking from
17 different ones, right.

18 That may be okay. Like I just said,
19 that may be okay. If they're cherry picking
20 from exposure, cognitive therapy or anxiety
21 management, that may be fine, but we don't know.
22 We just don't know right now if that is fine.

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1 So, the better thing right now is to
2 train them in a model, have them use that model
3 with as much fidelity as possible and to provide
4 the supports for them to have fidelity to that
5 model with some flexibility, because they need
6 to be able to do - PE has been delivered downrange
7 very effectively. I can show you the data.
8 We've done it.

9 People that we've trained have done
10 it. They've done it by doing three-hour
11 sessions five days in a row while wearing their
12 full battle rattle sometimes being interrupted
13 by mortars coming in and having to go in the
14 bunker to finish doing the exposure therapy in
15 a bunker while - and it still worked, right? So,
16 it's a robust therapy, but we're going to have
17 the flexibility to deliver it in the environment
18 that exists.

19 And we need to support people in
20 doing that. And the way to do that, I think, is
21 by providing them with a consultation
22 post-training. So, I'll talk a little bit about

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1 that.

2 To finish up answering Question
3 Number 3 over the span of March 2007 to March
4 2013, approximately 3300 unique DoD providers
5 were trained in our workshops. About 13 percent
6 of that 3300 had attended both PE and CPT.

7 So, when I checked back with Ms.
8 Dailey and her folks about the nuance between,
9 you know, what are they trained to provide and
10 are they provided in multiple ones, that was the
11 division I made.

12 So, that's the therapies that we
13 train in. And as I mentioned, the AMED Center
14 and school also provides EMDR training and they
15 provide stress inoculation in addition to the PE
16 and CPT that they do for those targeted posts.
17 So, yes, providers do seek to be trained and
18 about ten percent do.

19 MEMBER PHILLIPS: Not to take much of
20 your time, but you mentioned the AMED School and
21 I know they do a lot of sophisticated testing,
22 looking at, you know, paths of the brain and so

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1 forth.

2 How do you feel about that or do you
3 have any programs like that?

4 DR. BRIM: The Center for Deployment
5 Psychology's funding is strictly not research
6 funding. And so, our vice president for finance
7 at the university said don't make me do the
8 research dance.

9 So, no, we're not involved in any
10 research per se like that, unfortunately. We
11 are definitely the recipient of - the
12 beneficiary of the data that they get.

13 MEMBER PHILLIPS: So, that research
14 has validity.

15 DR. BRIM: Oh, yes, yes.

16 And I think then again this may just
17 be information for you to have all the
18 evidence-based psychotherapies for the primary
19 psychological health issues that we see.

20 All right. Question Number 5, how
21 do you assess if providers are using
22 evidence-based therapies?

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1 Gathering data on the use of
2 evidence-based therapies in the real world
3 setting can be somewhat complicated especially
4 doing it on a routine or ongoing basis right now.
5 And this is one of the problems.

6 It's not built into the system, and
7 it should be. The outcome effectiveness
8 measures should be built in, and we'll talk a
9 little bit in a second about how that may happen.

10 There are three kind of ways that
11 this has been done. We have our surveys that
12 we've done. There's an Air Force study that's
13 in press now. And there's an Army study that I
14 had mentioned earlier that was done at WRAIR.
15 And so, I'll talk just kind of a little bit of
16 each one of those.

17 The interesting thing about the Army
18 study, and you'll see the N was fairly large
19 comparatively, 543 behavioral health providers
20 volunteered to self-report their data.

21 They were given an hour - if they
22 volunteered, they were given an hour blocked out

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1 in order to be able to do that.

2 And I highlight that because what
3 we've heard repeatedly especially at the Army
4 and Navy, but not as much currently at the Air
5 Force, but that doesn't necessarily mean
6 anything positive or negative about the Air
7 force, a complaint from providers. The number
8 one reason why providers that are trained in
9 delivering evidence-based therapies don't
10 deliver that therapy is time. They don't have
11 the time. Their therapy milieu, their clinic
12 milieu does not allow them the time.

13 They're expected to see, what we
14 hear consistently, is between 30 and 34 hours of
15 direct patient care per week, leaving six to ten
16 hours per week for their notes, continuing
17 education and training requirements, additional
18 duties, all those other kinds of things.

19 What tends to get squeezed out is if
20 you're rigidly thinking about evidence-based
21 protocol, I can't do that evidence-based
22 protocol because this is 90 minutes twice a week.

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1 I can't do it.

2 So, they don't start, because the
3 milieu doesn't provide it, that kind of
4 environment to do it, or the piece they need to
5 feel comfortable delivering it, that's the
6 competence part, right. The confidence and
7 competence to deliver it.

8 Nothing, I mean, you guys have all
9 experienced this your first day on the new job
10 or if you, you know, when you learn a new
11 technique. You have to build confidence.

12 And what builds confidence over time
13 is role play, rehearsal and having consultation
14 with peers that have gone before you.

15 And what tends to get squeezed out
16 when you've only got six hours to do everything
17 else and there's no incentive to do any - to
18 maintain competence or to get consultation,
19 there's no incentive to do that, then that's what
20 gets squeezed out. It gets done on their
21 personal time or it gets squeezed out. And
22 that's what we tend to see in our surveys in a

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1 nutshell.

2 Have you used an evidence-based
3 protocol to treat PTSD? 68 percent of people
4 that we've trained reported that they have used
5 the evidence-based protocol.

6 Interesting how often did they use
7 the full protocol. Now, this is their
8 self-report. Their full protocol. About 50
9 percent said they never use the full protocol.

10 50 percent say they never use the
11 full protocol they were just trained in, yet 92
12 percent of patients get very or moderately - have
13 a very or moderate reduction in their PTSD
14 symptoms, again, by the therapist self-report,
15 no validated outcome measures necessarily
16 implied in there.

17 But even though 50 percent aren't
18 doing the protocol exactly like it says, 90
19 percent are getting a reduction in symptoms.

20 For the Air Force study, 103
21 providers who completed an EBP that we did, that
22 the Center for Deployment Psychology did, 77

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1 percent of those who had seen PTSD cases had used
2 the EBP that they had been trained in, either 81
3 percent of CPT, 70 percent of PE on an average
4 three to six cases. 20 percent of providers,
5 though, in this Air Force survey never used the
6 EBP they were trained in, because they didn't
7 have the time, was the number one reason.

8 And this is the Army study, Wilk and
9 Hogue. It's under review right now. Again,
10 you see fairly similar numbers. 86 percent of
11 them treating PTSD cases were using an
12 evidence-based therapy. 90 percent of those
13 using the evidence-based therapy had received
14 formal training instead of just buying the book
15 off the shelf to do it.

16 So, the majority are using some
17 components of the evidence-based therapies with
18 some of their cases and they're seeing
19 improvements when they use them.

20 Now, we're obviously surveying
21 people that have been trained. Do not get this
22 confused with the idea that the majority of

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1 providers have been trained.

2 Still today, the most commonly used
3 treatment for PTSD is what we generically call
4 supportive counseling, not an evidence-based
5 therapy.

6 If they had been trained, they're
7 using it. But if they haven't been trained,
8 they're doing supportive counseling, which
9 doesn't work.

10 I call this the random
11 out-of-the-blue question about the DSM-V.

12 (Laughter.)

13 DR. BRIM: So, I guess given - being
14 sensitive to the time and with your - I took the
15 liberty of adding a few slides looking at the
16 difference between the DSM-IV and the DSM-V
17 diagnosis of PTSD. But let me just say the
18 bottom line up front, minimal impact on our
19 current training.

20 We've already integrated discussion
21 on proposed changes to all of our evidence-based
22 therapies. So, not just the PTSD ones, but

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1 sleep and pain where there are differences in the
2 DSM-V. We've already integrated that. And to
3 some degree, already discussed the impact of
4 that.

5 Let me just say really quickly for
6 those of you - well, you're all probably
7 familiar. Right now the DSM-IV definition is -
8 this is the A1 and A2.

9 A1 is that you experienced,
10 witnessed or been confronted with an event of
11 actual or threatened death.

12 I've never actually seen a patient
13 that was exposed to their actual death, but
14 that's not really what that means.

15 Anyway, A2 is - this is the response
16 at the time. This is that A2 criteria.
17 Response involved intense fear, horror or
18 helplessness.

19 If you look at the DSM diagnosis -
20 so, this is using the old DSM-III. This is
21 percent of people in the United States exposed
22 to a potentially traumatic event that end up with

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1 PTSD that are - excuse me - exposed to a traumatic
2 event based on the DSM diagnosis of the
3 definition A1 criteria, right.

4 So, with the DSM-III you see it was
5 fairly low comparatively because what they did
6 in DSM-IV is they expanded the A1 criteria to
7 include childhood sexual abuse and those kinds
8 of - rightfully so.

9 And so, what you see is that when you
10 include A1 and A2 criteria, so not only did they
11 have the exposure to the trauma, but they also
12 reacted to that exposure with fear or horror,
13 then you can see the rough percentages.

14 When you take away the A2 criteria,
15 so all you're saying is you have to be exposed
16 to a trauma, you don't have to react either now,
17 either at the time or later, you don't have to
18 react with fear or horror. You take that away
19 and you see an increase.

20 And that's what they've done in the
21 DSM-V is they're taking away the A2 criteria.

22 What that's going to probably mean

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1 for us especially because what you see is a
2 flip-flop of men and women, is you're going to
3 see an increase especially in men and especially
4 in combatants. Because combatants will tell
5 you that at the time of their exposure to their
6 trauma, they weren't experiencing fear. They
7 weren't experiencing horror. They were doing
8 their job, right.

9 It's later, sometimes years later
10 that that A2 criteria may come into play, right.

11 So, by eliminating that A2 criteria,
12 we're probably going to see an increase in the
13 number of combatant - just in general people, but
14 combatants that meet the criteria for PTSD.

15 And not wrongfully so, necessarily,
16 but that - we're also going to see an increase
17 because if you're familiar, right now the DSM-IV
18 is re-experiencing, one; avoidance, two; and
19 arousal, three. You need one, two three of
20 these criteria.

21 They're lowering the avoidance to
22 one, and they're adding negative alterations in

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1 cognitions and mood. This too is probably going
2 to increase the number of people that meet the
3 criteria for PTSD.

4 This is really nothing new. Talk to
5 clinicians and we've always known that this
6 negative alterations in cognitions and mood were
7 symptoms associated with PTSD. They're just
8 going to kind of state it now.

9 So, the big ones are reduction in the
10 number of avoidance and getting rid of that A2
11 criteria. So, it's just A with different ways
12 you can experience that trauma.

13 So, I don't know if that answers your
14 question related to training. This is what
15 we're talking about. Related to treatment,
16 probably not a significant impact.

17 Then Questions 7 and 8. What are
18 the requirements for providers continuing
19 education/ongoing training in PTSD EBTs?

20 Currently there are no requirements
21 of providers with continuing education/ongoing
22 training for PTSD evidence-based therapies.

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1 They gain knowledge and they gain
2 motivation in a two-day workshop. And then they
3 go back to their clinic and they don't have a PTSD
4 patient.

5 And then six months later a PTSD
6 patient shows up and they just do what they've
7 always done, which is supportive counseling,
8 right? They've lost that motivation a lot of
9 times.

10 And we know that providers require
11 confidence in order to deliver therapy. It
12 takes a lot of confidence to say to a person, I
13 want you to close your eyes and in as vivid detail
14 as possible, tell me everything you see, feel,
15 think, taste, touch, smell in your trauma.

16 It takes a lot of confidence to be
17 able to do that. And it's very difficult for the
18 therapist to do that.

19 It's very, very difficult for the
20 patient to do it, but it's very difficult for a
21 therapist without confidence to do that, but
22 that's what's going to make the patient better

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1 or at least that's a component of what's going
2 to make the patient better. And so, we don't
3 have the system that allows that.

4 I may also say as a sidebar not
5 intended to be stereotypical, but one of the
6 things that we - we may especially see is when
7 we bring in seasoned therapists which sounds
8 like a good idea, but seasoned therapists - like
9 on a contract.

10 So, you get a DoD contract and you
11 fill it with a bunch of contractors. And a lot
12 of seasoned therapists are attracted to doing
13 these contracts and they want to help the service
14 members and veterans, but they have no
15 background in evidence-based therapies.

16 And so, you're asking them to do
17 something completely different from what
18 they've done for the last 20 or 30 years and
19 giving them no support or reinforcement for
20 doing it.

21 It's a recipe for disaster and it's
22 a recipe for clinics full of people being seen

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1 for 40, 50, 60 sessions once a month, supportive
2 counseling or psychoeducation.

3 Providers need opportunities to
4 practice following training, role playing,
5 rehearsal opportunities provided by
6 consultation service or peers. Cheat sheets or
7 session outlines and notes will help, as well as
8 just-in-time boosters.

9 So, one of the things we have on our
10 website is - I won't use the language that I call
11 it, but it's that "oh, crap" moment when you
12 realize you've got a patient with PTSD coming in,
13 in five minutes and you don't remember from your
14 training six months ago what do you do in Session
15 1 of prolonged exposure.

16 Well, we have a ten-minute webinar
17 basically that I recorded of here's what you say
18 in Session 1. And you can listen to it right
19 there. You can even listen to it with the
20 patient sitting with you and to kind of help
21 facilitate that practice of utilizing until that
22 confidence gets built up.

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1 If you want to go back to the gold
2 standard, providers need fidelity checks. And
3 most importantly they need constructive
4 feedback about how they're doing.

5 In conversations with more
6 experienced colleagues or consultants, none of
7 these are required or incentivized in the DoD.

8 The VA model which you may be aware
9 of, is basically providing case supervision over
10 several cases for three to six months following
11 the training. And that may be the gold
12 standard.

13 So, once a week they call into a
14 consultation call. They're assigned a
15 consultant. They call in for a week, every
16 week, for 12, 14, 16 weeks and they receive
17 supervision.

18 They send in tapes or they're
19 actually visualized delivering the
20 evidence-based therapy and graded on a fidelity
21 checklist. And that's probably the gold
22 standard in competence in a particular model.

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1 However, as with everything else, it
2 must be balanced with the intensity of time
3 required to do that at the expense of the
4 supervisor's time and at the expense of access
5 to care, which we've seen in the VA.

6 Alternatively, there are efforts to
7 establish fidelity to treatment protocols could
8 use less direct approaches such as medical
9 record review or be incorporated into the
10 existing peer review process in an effort - if
11 these efforts to rely on medical record, we have
12 to develop standardized session templates in
13 AHLTA, which I'll mention in just a minute.

14 And then finally, Question 8 was a
15 discussion of new best and promising practices.
16 And I should note here that the Center for
17 Deployment Psychology as part of that integrated
18 mental health strategies, Number 9, training in
19 evidence-based therapies, has undertaken a
20 series of site visits ourselves very similar to
21 the ones you guys did in identifying best
22 practices and barriers to adoption and

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1 implementation of EBTs and we're not
2 surprisingly seeing some of the things that you
3 guys saw on your trips.

4 So, I think - there we go. So, some
5 of the recommendations that we have for
6 consideration would be these optional pre-EBP
7 workshops. And this may address some of that
8 disparity in the consultants that maybe are
9 hired and come in and maybe don't have the
10 background or some - as we expand the disciplines
11 that are allowed, and this is not intended a
12 reflection on the disciplines, but if we start
13 to hire marriage and family therapists or
14 licensed clinical providers or LPCs or LMHCs,
15 their training is different.

16 It's not bad. I'm not saying it's
17 bad. It's different and it may not have the
18 intensity of basic cognitive and behavioral
19 skills and assessment skills and diagnostic
20 skills that say a PhD or an MSW may have. May
21 have.

22 Now, there's licensed marriage and

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1 family therapists that are better than
2 psychologists I've seen. So, it's not that.
3 It's just that they don't have that background.

4 So, one of the things is prior to the
5 evidence-based psychotherapy workshop,
6 optional pre-EBP workshop training in these
7 basic skills so that they come to the workshop
8 understanding the underlying theories.

9 And we're doing that in CBP. We're
10 rolling those out as webinars. You can kind of
11 watch them. You don't necessarily attend them
12 live.

13 We need consistent post-training
14 survey of utilization and dedicated time to
15 complete that survey.

16 We can't expect providers to throw
17 out a survey if we're asking them to do it during
18 that six to ten hours, but we have to find a way
19 to protect that time.

20 We need these things, the
21 utilization and the efficacy data, the outcome
22 data built into the system. So, it needs to be

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1 built into AHLTA.

2 There needs to be fidelity
3 checklists and session guides built into AHLTA.

4 So, when I diagnose a patient with
5 PTSD, there's a PE template in AHLTA that I can
6 bring in. And that says in Session 1, here's the
7 checklist. Did you cover this? Did you cover
8 that? Did you do the overall rationale?

9 In Session 2, did you do this? Did
10 you do that? Did you go over the common
11 reactions to trauma? And you kind of can go
12 through each one. You can write their SUDs
13 level in there.

14 They're being developed. We have
15 templates for them. The VA has developed
16 templates for them. We need to have them
17 integrated, but there's no requirement that they
18 be utilized.

19 CO-CHAIR CROCKETT-JONES: Well, I'm
20 just hoping that if everybody is building
21 templates, that the IEHR folks are also aware of
22 those templates.

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1 DR. BRIM: Yes, we have been talking
2 with them.

3 One of the things we've very adamant
4 about is this idea of champions. And I want to
5 talk a little bit about that, but champions to
6 increase the MTF command, the primary care docs
7 and the behavioral health clinic awareness of
8 evidence-based psychotherapies.

9 I'll kind of say as a sidebar, too,
10 we should utilize these non-profits and the
11 returning warrior workshops that Yellow Ribbon
12 like you'll hear about shortly, we need to
13 utilize those to educate what I call - not I call.
14 I didn't invent it, unfortunately, but direct to
15 user marketing, you know.

16 What our friends the
17 pharmacological folks have done is basically
18 what we want to do is have the clinic walk in the
19 door and say I caught that PTSD thing, I want PE,
20 I want CPT, right.

21 The same thing when you go in and you
22 say, I want Viagra, you know, because you saw the

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1 commercial with people happily sitting in a tub
2 on a beach.

3 So, I mean, we want that direct to
4 the user marketing, but not just to the service
5 member user, but also to the primary care doc.

6 So, the primary care doc says, you
7 have, you know, does the four-symptom PTSD
8 checklist and says, I think you got PTSD. You
9 need to go to the mental health clinic and you
10 need to get this PE. And what means is blah,
11 blah, blah, blah, blah. They know, right?

12 We need to educate line commanders,
13 because line commanders need to know. It's
14 their right. It's their job to know what's
15 happening with their service members.

16 So, they - I want to live to see the
17 day where a line commander says, I think you have
18 PTSD. I want you to go to mental health and I
19 want you to get therapy. And I know that it's
20 going to take you six to ten weeks and that you're
21 not going to be a full up round during that six
22 to ten weeks, but my expectation is that you will

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1 be after that, right, because the line commander
2 knows. He or she has been educated to know.

3 And so, we can do that through that
4 direct to marketing kind of public health
5 campaign that needs to be done.

6 Because just like suicide, PTSD is
7 not a mental health problem. It's a community
8 problem, right. People in the community know
9 somebody has PTSD long before I do.

10 And if they don't know how to
11 identify it and where to send them for what, it's
12 not going to make a difference.

13 I have to say because I'm going to
14 run out of time and I have to squeeze this in,
15 this is important, I think, is we have to
16 incentivize not only - so, we have the champions
17 and that's kind of the role of the champions.

18 And one of the things we've put in
19 for the joint incentive funds, the JIF funds, and
20 it's looking promising that we may be able to
21 place evidence-based therapy champions in ten to
22 15 MTFs. And the role of the champion will be

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1 to do exactly what I just said.

2 Train the providers, provide
3 consultation to the providers, help develop the
4 milieu within the mental health facility, but
5 also in the community to refer, you know. Train
6 the primary care docs.

7 If the person has these, do this, say
8 this. And so, we're hoping that that gets
9 funded. Hopefully we'll find out in the next
10 couple of weeks because - so we - because we've
11 got to educate not just providers in-house who
12 want to do it, but also all the way up to the line
13 commander. Because the line commander right
14 now thinks mental health is a black hole.

15 I'm going to send my guy to mental
16 health and I'll never see him again. And he's
17 just going to come back, you know, if he comes
18 back.

19 CO-CHAIR CROCKETT-JONES: Well, as
20 with the - we see the increase of embedded mental
21 health.

22 DR. BRIM: Yes.

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1 CO-CHAIR CROCKETT-JONES: Line
2 commanders might be more savvy on expectations,
3 but it also means that the education can't rest
4 only in MTFs. It will have to expand out to
5 those embedded health folks.

6 DR. BRIM: Right. Absolutely. And
7 embedded mental health providers in primary care
8 as well.

9 MEMBER MALEBRANCHE: You mentioned
10 JIF funding. And since that's a joint thing,
11 what's the VA role in that which you are
12 proposing?

13 DR. BRIM: They helped us write the
14 proposal. At this point it's to mirror as best
15 we can - the VA model, that gold standard model,
16 we have not been able in all of our interviews,
17 found anybody that said that's a workable
18 solution for the DoD where you require a DoD
19 provider to go to the training and then have a
20 dedicated consultant for three to six months
21 once a week send your tapes in.

22 Like, we would do it. CDP, I'd

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1 listen to tapes, but no mental health provider
2 is going to send their tapes, you know, not to
3 mention all the myriad of, you know, problems
4 with giving me a tape to listen to then give them
5 feedback.

6 So, the model won't work. And so,
7 what we think will work is, again, the primary
8 piece that I think will work is championing the
9 use of evidence-based therapies within the
10 environment, and then providing consultation.

11 So, our goal is that there be a
12 consultation, a person identified as a
13 consultant in every MTF, or the MTF mental health
14 clinic has a dedicated consultant elsewhere.

15 It's not realistic for every MTF to
16 have a consultant, because they'll move. As
17 soon as you train them, they PCS, but to have a
18 place, right.

19 So, CDP offers consultation right
20 now. Very few people utilize it. We have a
21 weekly PE call, a weekly CPT call. Anybody can
22 call in and get consultation on cases or, oh, my

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1 God, my first session is in an hour, what do I
2 do. Anything.

3 And we maybe get three, four people
4 on a call. Sometimes none. And so, it goes
5 back to that incentivizing because what we're
6 told is we have to incentivize use of
7 consultation.

8 And it's really not that complicated
9 to - well, it's very complicated. The idea is
10 not that complicated.

11 We have the ability to provide
12 continuing education credits to providers for
13 doing consultation.

14 So, if you join that phone call, I've
15 got a learning objective for that phone call, you
16 can get one CE credit for that hour.

17 So, it's less of a punch if you have
18 to take it outside of your 40 hours, right. So,
19 we can incentivize it by offering them CE
20 credits.

21 The other thing, this is the more
22 kind of radical idea, is that once you've had an

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1 evidence-based psychotherapy workshop, is there
2 a way that you could be protected from that
3 productivity requirement for three to six months
4 while you get consultation?

5 The other piece of that is that if
6 you are trained as an evidence-based therapy
7 consultant, right, so you come to one our
8 train-the-consultant workshops. You're
9 identified as a consultant.

10 Could your clinical - in your
11 competency, you know, in your credentials
12 packet, could one of the clinical specialties be
13 EBP consultant?

14 And if it is, that designator in your
15 path or in your - lost the word now - in your
16 credentials folder, right, could that protect
17 you from some productivity so that you're
18 required to do 30 hours of patient care instead
19 of 31 or 32. Would that be possible?

20 And would that one hour or two hours
21 a week of protected from productivity increase
22 - because what we know is going on is lots of

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1 informal peer support. So, could we formalize
2 that by incentivizing people to become
3 consultants, incentivize people to use the
4 consultation and make that consultation
5 available.

6 So, that's what all the consultation
7 piece has to do with.

8 MEMBER PHILLIPS: Kind of expanding
9 a little bit on that, though it may be a little
10 obtuse, going back to that Question Number 5
11 where you had the pie charts where the therapists
12 are only using components because of time
13 constraints.

14 DR. BRIM: Right.

15 MEMBER PHILLIPS: Is it possible to
16 look at the global components that they're
17 using, develop some commonality and maybe kind
18 of streamline the whole protocol so that it fits
19 in with the time and you find best practices and
20 so forth?

21 DR. BRIM: Right now what we have are
22 case studies, right. So, there's a case study

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1 of three Air Force members that received
2 prolonged exposure therapy downrange.

3 Very effective. And like I said,
4 one of them was delivered in, you know, five
5 two-hour sessions in one week. Very effective.
6 So, right now we have those kinds of data, right.

7 And so, we need two things. We need
8 more research, like formal research in those
9 components.

10 Rather than in PE or in CPT, we need
11 components, you know, in evidence-based
12 therapy, in, I mean, in exposure therapy, in
13 cognitive therapy to know for certain that
14 question.

15 The other component of it is one of
16 the things that would really help is
17 standardized outcome measures again embedded in
18 the note taking.

19 If every time you saw your patient
20 you filled out or they filled, you know, it was
21 automatic, again, this is part of that
22 environment, that milieu, the mental health tech

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1 is on board.

2 Here comes the PTSD. Here's your
3 PCLN, right. You fill it out and it gets put
4 into AHLTA so that we have in AHLTA that mineable
5 data built into the system, but there's no
6 standard across the services for outcome
7 measures - and that would give us a big hint about
8 effectiveness, outcome measures.

9 Pair that up with, you know, AHLTA
10 session notes, you know, and you've got the
11 fidelity checklist, you know, kind of built
12 right in.

13 CO-CHAIR CROCKETT-JONES: On that
14 same topic in your backup slide, this one with
15 the checklist for pre and post-PE.

16 DR. BRIM: Uh-huh.

17 CO-CHAIR CROCKETT-JONES: How far
18 post?

19 DR. BRIM: Okay. So, I kind of
20 didn't - they're in the backups here. This one.

21 So, these are different sites. And
22 this is a variety of sites of people trained by

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1 CDP.

2 This follow-up was three months,
3 right. So, this is three-month follow-up data
4 here for CDP-trained people.

5 This one is in Germany at an Army
6 location in Germany. CDP-trained folks. This
7 one is at Portsmouth at the Navy facility at
8 Portsmouth, the people that we've trained.

9 And this one is kind of ongoing.
10 So, I think the average is about ten months
11 follow-up for this one. And I don't remember
12 this one. It will come to me in a minute.

13 The best study that we have for
14 effectiveness is a very clever study where they
15 use the social security number of the
16 participants to get their financial - a portion
17 of their financial records so they can track
18 them.

19 And so, we have five-year outcome
20 data on PE and CPT. And it's very effective.
21 It maintains the gains that we've seen at six,
22 ten, 12 months, you know, because most of the

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1 research is three, six, nine, 12-month follow-up
2 and this was a good longitudinal grab that they
3 did of data.

4 So, they had three, six, nine, 12
5 months and five years. And there was no change
6 between the person at 12 months and five years
7 out.

8 Some people were still on meds.
9 Some people were off their meds. I mean, there
10 was a variety of issues within that five years.

11 Some people had continued in
12 different therapy and stuff like that, but
13 that's the best study we have longitudinally
14 about the effectiveness of these evidence-based
15 therapies.

16 If I could one last quick plug,
17 because I think you guys might be able to say
18 something about this, and that would be related
19 to that contractor piece.

20 Seriously consider recommending
21 that when statements - to the extent that we have
22 the ability when statements of work are written

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1 to hire contractors, they should include the
2 contractor's willingness - the contractor
3 company allowing their contractor psychologist
4 or therapist time to receive military culture
5 training and evidence-based psychotherapy
6 training, because they won't release them.

7 If they are supposed to be 100
8 percent patient care 100 percent of the time,
9 they won't release them for training.

10 And they're not going to do it if the
11 statement of work doesn't say the only people you
12 can hire to put in these positions either need
13 to have military background or you need to build
14 in time in your contract for them to receive
15 military culture and an evidence-based
16 psychotherapy for PTSD.

17 CO-CHAIR CROCKETT-JONES: Thank you.
18 That's excellent advice.

19 DR. BRIM: I appreciate your time.

20 CO-CHAIR CROCKETT-JONES: We have a
21 brief time for a break. Be back at 4:00 for the
22 last briefing.

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1 (Whereupon, the proceedings went
2 off the record at 3:51 p.m. for a brief recess
3 and went back on the record at 4:05 p.m.)

4 CO-CHAIR CROCKETT-JONES: Okay.
5 We'll settle the cookie mystery later.

6 (Laughter.)

7 CO-CHAIR CROCKETT-JONES: for our
8 last briefing of the day we have Ms. Marie
9 Balocki, acting executive director of the Yellow
10 Ribbon Reintegration Program, and Captain Jami
11 Mason, the Navy liaison officer for the Yellow
12 Ribbon Reintegration Program.

13 The program is a DoD-wide effort to
14 connect National Guard and Reserve members and
15 their families with resources throughout their
16 deployment cycle.

17 Ms. Balocki and Captain Mason will
18 provide us with an overview of the program and
19 the program's impact on recovering warriors.

20 We'll also receive information
21 regarding the Navy's Returning Warrior
22 Workshop.

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1 We have their information under Tab
2 O. I'm going to turn it over to you.

3 MS. BALOCKI: Great. Thank you.
4 And thank you for having us this afternoon.
5 This is exciting for us to come out and speak with
6 you.

7 This is the Yellow Ribbon
8 Reintegration Program. And what we were asked
9 to do was present the top line overview, and then
10 we have some questions that were sent to us that
11 we will attempt to answer those questions for
12 you.

13 And if you have any other questions,
14 we're happy to take those as well. And then
15 Captain Mason will give a little synopsis of the
16 Returning Warrior Workshop for the Navy.

17 So, let's begin. Obviously I'm not
18 Mr. Welling. Mr. Welling has just taken another
19 position after the slides were sent and all that.
20 So, we're in flux, I guess.

21 Okay. So, what is our mission? We
22 are to promote the well-being of National Guard

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1 and Reserve members and their families.

2 We connect them with resources
3 throughout the deployment cycle. Now,
4 obviously I work at OSD. So, we implement a lot
5 of the policy that the services carry out,
6 because these are service programs and they are
7 commander's programs. And we fit under P&R,
8 personnel and readiness, within Reserve Affairs
9 in OSD.

10 We support service members and their
11 families throughout the entire deployment
12 cycle. So, before they deploy, during
13 deployment and when they return.

14 We do it by providing resources. We
15 do it by bringing - because reservists don't have
16 the opportunity to live on installations and
17 they're living in the communities, they don't
18 have the opportunity to necessarily get together
19 with other service members who have deployed.
20 So, we bring them together.

21 The services will bring them
22 together for a weekend event. Normally starts

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1 on a Friday afternoon, Friday evening. Goes all
2 day Saturday with the resource providers coming
3 in to tell them what's available within their
4 communities. And then ends on Sunday with
5 usually the commander coming in and giving some
6 words. And then they return back to their
7 communities.

8 The connections that are made on
9 these weekends are indescribable. To see
10 people connect with each other - if I'm in my
11 local community, and actually I was and my
12 husband deployed, I was all by myself. There
13 wasn't anybody else in the community that was
14 going through it.

15 So, if I had the opportunity to go
16 to a Yellow Ribbon Reintegration Program event
17 to find a service member and their family who was
18 also going through it who perhaps had a
19 16-year-old son who was kicking up in school and
20 perhaps got suspended and expelled and could
21 have shared my misery, it would have really made
22 a difference in my life as opposed to somebody

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1 from my husband's unit calling me. Because I'm
2 not telling them on the phone what's happened,
3 because I don't know what's going to happen to
4 my husband when he, you know, when that person
5 then tells the commander, the rear detachment
6 and all that kind of stuff.

7 I know nothing is supposed to
8 happen, but I don't know that. I just - it's
9 just a scary thought. Plus, I don't know that
10 person.

11 So, that's the real heart of what
12 Yellow Ribbon does for family members and the
13 service members.

14 Now, what we do at OSD is we, as I
15 said, we establish the policy. We have asked
16 for an exception to policy on conferences
17 because, again, reservists don't have that
18 opportunity to get together to see each other and
19 we felt like it was that important to do this.

20 We also provide cadre speakers.
21 What we learned through the years was standing
22 up here doing a PowerPoint presentation, not

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1 really so great. And family members aren't -
2 anywhere do not have the tolerance that service
3 members have who get it day in and day out.

4 So, we implemented a program called
5 Cadre of Speakers where we have hired
6 professional speakers to come and give
7 presentations that are engaging.

8 And we have to see their PowerPoint
9 presentations before they use them. And
10 there's got to be built-in activities. Because
11 if you've done it, then you probably learned it
12 and we probably are changing behaviors as
13 opposed to just being told about something.

14 We're trying to do some branding
15 with our fulfillment so that all of these
16 tablecloths will have Yellow Ribbon.

17 As we move along down the road and
18 money gets tighter and events are less regional
19 and more localized, we want the family member and
20 the service member to know wherever they go where
21 they see that Yellow Ribbon, they're getting the
22 same information that they would have gotten at

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1 another Yellow Ribbon event.

2 So, if they're going - if I'm in
3 Seattle and I'm going to an Army event even
4 though I'm Navy, I'm getting the same
5 information I would have gotten at a Navy event.

6 We are five years old. Our office
7 is five years old and we're pretty proud of that.
8 And we're pretty proud of what we have
9 accomplished in five years and where we are and
10 where we're going.

11 What we do, as I said, is we connect
12 people with local services. We also connect
13 them with the OSD-funded services like
14 Tutor.com, MilitaryOneSource, DCoE, Defense
15 Centers of Excellence, MilitaryOneSource.

16 We work a lot with community
17 covenants because they're out in the community
18 making those agreements with the local community
19 to support service members and their families.

20 So, we reach out to them when they're
21 in a community, to see which partners can come
22 to the local events.

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1 And of course employment. We work
2 a lot with employment with the Employment
3 Initiative Program, to have hiring fairs at the
4 end of Yellow Ribbon events so that we can get
5 service members employed.

6 Our Center for Excellence, that's
7 really our mainstay of what we do. As we are
8 drawing down, that will be the place where the
9 services can go if - a lot of Yellow Ribbon events
10 are put on by somebody who's on orders to execute
11 the event. So, they may be on orders for 60 days
12 just to put on a Yellow Ribbon event.

13 Well, where do they start and what
14 is required by the DoDI and how do they find the
15 information and how do they find the local
16 providers?

17 All of that can be located on our
18 Center for Excellence. They just pull it down,
19 fill in the blanks for their event and off and
20 running they're going. So, that's sort of the
21 mainstay.

22 Yes, ma'am.

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1 MEMBER MALEBRANCHE: Marie, I know
2 because we've talked a bit before about this, but
3 as far as events, you know, because the VA often
4 tries to support those and -

5 MS. BALOCKI: Right.

6 MEMBER MALEBRANCHE: - connects
7 with you on that, but what have you been able to
8 do to eliminate, let's say, the Marine Corps in
9 one end of town and 25 miles away the Army doing
10 an event the same time, but meeting different
11 people.

12 Have you been able to do something
13 with that now that you've got some kind of
14 visibility?

15 MS. BALOCKI: We've done a couple of
16 things. We haven't been able to eliminate it
17 completely, but we have done a couple of things.

18 The first one is we have program
19 specialists out in the field. And as they're
20 working with event planners, they go onto Event
21 Plus which is the portal for all events and they
22 say, hey, you know that there's another one on

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1 that same weekend? Let's combine efforts.

2 We're seeing a lot of that now
3 happening. And with money getting as tight as
4 it's getting, we're seeing a lot of services
5 reaching out to each other because they can't all
6 afford to keep doing these events time after
7 time. So, they're combining events.

8 We have seen now events where they
9 would - the policy for the Army Reserves was
10 reintegration events shall not mix with
11 pre-deployment because, you know, we don't want
12 those families who are getting ready to deploy
13 with the families who are coming back. Because
14 they're so excited and these people are getting
15 ready and we don't - well, times have changed and
16 now we see one venue with different tracks for
17 pre-deployment, during deployment and
18 post-deployment to help, because there's not the
19 community resources to support all these events.
20 And there's not the hotel, you know, money for
21 hotels and all that kind of stuff.

22 So, we're going towards that.

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1 We're not a hundred percent, but we're much, much
2 better. Yeah, it took quite a toll on our
3 service providers.

4 These were the event totals we had
5 for 2012. We had 2,028 events. That's almost
6 50 events a weekend. That's not a holiday
7 weekend. That's a lot to sustain. Our event -
8 our resource providers, we're killing them.

9 We had 248 - 49,000 service members
10 and families that we serviced. That's pretty
11 impressive.

12 And for FY13, we're projecting
13 1,691. Although, I think that number will go
14 lower with the budget. People not getting their
15 budgets. We'll see.

16 As I talked about the EIP
17 Initiative, that is a huge part of what we're
18 looking at now is employment and underemployment
19 and making sure that our service members have a
20 job.

21 It's very hard to integrate back
22 into your family if you don't have a job and back

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1 into community.

2 Our Hero2Hired Program is - it's a
3 website. It's a web application. And it's
4 just been very effective at taking resumes and
5 converting the military into civilian language.
6 So, it converts the MOS's into civilian to help
7 people find jobs.

8 And here are their statistics for
9 FY12. They had 45,000 people registered.
10 6,000, almost 7,000 employers. I think now it's
11 10,000 employers, but as of the end of FY12.
12 20,000 jobs posted.

13 So, it's really making a difference
14 and we're excited about it. Because the more
15 people that - oh, yes.

16 MEMBER DRACH: Excuse me. Do you
17 have any outcome data? I mean, you have 45,000
18 job seekers. How many got jobs?

19 MS. BALOCKI: I can tell you as of
20 October 2012 to March, the end of March, we're
21 in April, the end of March, we had 54 what we call
22 ETCs, employment transition coordinators.

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1 Each one of them has - rough numbers
2 - has placed 24 people a month. So, I forget
3 what the - what 24 times 54 is, but that's how
4 many from October til the end of March.

5 MEMBER DRACH: So, you had roughly
6 more than twice as many job seekers as jobs
7 posted.

8 MS. BALOCKI: Correct.

9 MEMBER DRACH: Are you seeing a
10 problem of skills gaps so that the job seeker may
11 not have the skills that the jobs that are being
12 posted match up, or are you seeing any trends at
13 all one way or another?

14 MS. BALOCKI: No, we don't seem to
15 think it's a skill set. Some of it is a resume
16 writing issue.

17 And so, we've taken on additional -
18 some of our employment transition coordinators
19 are resume writers to help improve the resume.
20 I mean, that was a big one was resume writing.

21 The other part is we've only just
22 started really tracking how many. Because once

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1 you are a job seeker and I go on there and I
2 register and I maybe found a job through here or
3 maybe I found it somewhere else, I don't come
4 back to tell you because I'm fat, dumb and happy
5 now. I have a job.

6 Now, we're tracking the actual
7 numbers, because we have actual people to check
8 back with you and say, did you find a job? So,
9 that's part of it too.

10 MEMBER DRACH: Thank you.

11 MS. BALOCKI: We just don't have the
12 greatest data off the website.

13 Okay. And this is where the EIP
14 staff, and there's one in every state and
15 territory and where the Mobile Job Store has
16 visited.

17 The Mobile Job Store is really just
18 a trailer that has mobile kiosks on it, but, boy,
19 is it eye-catching and we get service members.
20 And it's one actually that we get a lot from
21 wounded warriors.

22 When we go to a Fort Belvoir or

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1 someplace and we're in front of a Wounded Warrior
2 Transition Center or something like that where
3 the wounded warriors come out and have said,
4 thanks so much for not forgetting us, and they
5 come out and they'll come onto the website and
6 put their resume and we help them and stuff.

7 So, it's really - we've gotten a lot
8 of feedback on that. Good feedback. Positive
9 feedback.

10 So, that is all that I have that I
11 was asked to present to you all. Any questions
12 that you have on that?

13 MEMBER MALEBRANCHE: What have you
14 found out as far as like best practices and
15 having done all these things or things to
16 promulgate or changes that might be needed?

17 Have you gathered that kind of
18 information?

19 MS. BALOCKI: We have gathered best
20 practices from events. So, we know that if we
21 don't see them for ten hours a day, we have better
22 attrition, things like that.

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1 We have not tracked a lot of best
2 practices on if we offer a stress management
3 class, it changes somebody's behavior three or
4 four months down the road. We're working on
5 those kind of studies right now.

6 So, I'm not exactly sure what kind
7 of events practice you are -

8 MEMBER MALEBRANCHE: Well, I know
9 because I attended a couple of these -

10 MS. BALOCKI: Sure.

11 MEMBER MALEBRANCHE: - and it seemed
12 to me that there were certain planners that were
13 better than others. Some might have financial
14 planning that was a key thing or having childcare
15 there so that their families can do things
16 together. Some were separate events, weekends.

17 You had so many different kinds.
18 I'm wondering if you know like what has worked
19 the best to draw, keep them in or feedback that
20 you've gotten, that sort of thing.

21 MS. BALOCKI: That, we do track. But
22 what we found, Karen, truly is this is a

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1 commander's program. And the commander knows
2 his unit.

3 And so, those commanders that are
4 truly involved are the ones that have the best
5 events because they know - for example, I was an
6 event planner a couple of years ago. Now, about
7 four years ago and I had a unit.

8 We were doing a during deployment
9 event. So, the service members were gone and it
10 was just for the spouses.

11 Two days before the event, we had a
12 couple service members killed overseas. And
13 what I didn't know because my husband was active
14 duty, was these reservists' spouses did not know
15 how they would be notified if it was their
16 service member that was killed.

17 My phone rang as a family program
18 director, kept ringing, was it my husband? How
19 will I know? How will I know?

20 So, what we - what the General said
21 to me was, I don't care what you think you're
22 doing at this event. We're changing it and it

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1 is going to be casualty assistance.

2 The Red Cross came in, casualty
3 assistance officer, things like that. And that
4 was such a great, I mean, the turnout was huge
5 when people knew what we were going to offer.

6 Everybody was interested and it was
7 huge because the commander knew his unit and knew
8 what was going on, and we were able to offer what
9 we needed for that unit.

10 Those are the ones that have
11 phenomenal turnouts and people stay and it seems
12 like the feedback is much better than those that
13 just do it by rote, you know, I'm going to do a
14 financial planning because they're leaving and
15 so everybody is going to learn that they're
16 getting extra money and what their taxes are.

17 Well, these people have been
18 deployed seven times. They know. But if you
19 knew that unit, you'd know that and you'd be able
20 to change.

21 So, that's some of what we are seeing
22 now is people who are very involved in the unit

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1 know what to offer and know how to do it and get
2 that attrition.

3 We know if we offer childcare, we'll
4 get a better turnout. That the units will get
5 a better turnout because people don't have to
6 worry about their children. Their children are
7 not coming to events and they're not screaming
8 over them to get people's attention, things like
9 that.

10 So, we do have -

11 MEMBER MALEBRANCHE: And then what do
12 you do for IRRs, because I know there was one or
13 two. What do you do for them in this program or
14 what's your plan?

15 MS. BALOCKI: Well, one of the
16 questions on here is wounded warriors. So, I'm
17 going to take both of those.

18 The IRRs are very difficult. If the
19 service, because again this is
20 service-specific, the services are tracking
21 them and can get hold of them and bring them to
22 a unit or bring them to an event.

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1 The Marines have done two - I think
2 two Yellow Ribbon events only for IRRs, but they
3 are hard to reach. I mean, everybody knows
4 that. That's not unique to Yellow Ribbon.
5 They're very, very difficult to reach.

6 If the commander has done - well, if
7 they come back with the unit, then, you know,
8 they would be part of the unit.

9 But if they're just going over as an
10 augmentee and coming back by themselves, it's
11 very, very - all we can do is give them the
12 information and hope that they will come.

13 It's one of the questions on here is
14 how do we ensure that they attend YRRP events.
15 They're not mandatory. I mean, we take
16 attendance and we have seats, but they're not
17 mandatory. So, there's no consequence if you
18 don't go.

19 CO-CHAIR CROCKETT-JONES: What's the
20 rate of your - what's your success rate of
21 getting families? What percentage of those
22 service members, you know, actually come with

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1 families?

2 MS. BALOCKI: With family members, I
3 don't have that number, but that is definitely
4 service - the Marines are very good because they
5 - well, I didn't want to say they order their
6 family members to come, but they highly
7 encourage their family members to come, and they
8 do. So, we see a great turnout.

9 The Navy has a great turnout, but
10 that's because they do it with only the sailor
11 and their spouse. And so, it's nice. It's a
12 nice weekend. They have a nice dinner.

13 So, they have a great family - I'm
14 sorry. Okay. So, they have a great family
15 turnout.

16 So, it's really a service-specific
17 - I think the Air Force too does very - but I don't
18 have overall numbers of, you know, 50 percent or
19 whatever. I don't have those because, again,
20 it's not mandatory.

21 And then the topic - the wounded
22 warriors. Wounded warriors in the Reserves are

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1 still on active duty. And so, they are part of
2 the active duty community until they are
3 released.

4 When they are released, they are
5 definitely eligible to come to Yellow Ribbon
6 events and their unit would pay for it. But
7 until they're released from active duty, they
8 wouldn't come to a Yellow Ribbon event because
9 it's for active - because it's for Reservists.

10 So, any other questions? I'm going
11 to turn it over to Captain Mason.

12 CAPT MASON: Thank you. Okay. Can
13 you hear me?

14 All right. Well, I'm going to start
15 off with saying that - since you mentioned best
16 practices, that the Navy's best practice is the
17 Returning Warrior Workshop.

18 And it's basically a
19 post-deployment event that we conduct anywhere
20 from 60 days on out after our reservists have
21 come back from deployment.

22 And it's an offsite weekend retreat,

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1 we call it, because basically we take these folks
2 to, you know, hotels and they bring their spouse.

3 And as Marie said, we do not have
4 children at the event. So, we do have a success
5 rate because couples can come without their
6 children and experience all the different
7 sessions that we offer and the resources that we
8 offer. And it's sort of a reconnecting for the
9 couples at our event.

10 We facilitate the reintegration
11 process for the Reservists and their families.
12 And we do talk about children. And we have
13 breakout sessions for how children might be
14 reacting to, you know, their parents going to war
15 and what have you.

16 And so, it's really important for
17 them to get the information that they need and
18 the resources that they need, and they get it at
19 this weekend retreat.

20 It's also to identify psychological
21 health issues. And of course that's big with
22 the medical community.

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1 So, we make sure that we have
2 chaplains and medical folks on board to help,
3 because we could identify during the course of
4 the weekend, during a breakout session like
5 we'll have women warrior breakout sessions and
6 we have, you know, operational stress breakouts
7 and all these different sessions. And folks
8 will then begin to open up and reveal that they
9 have some issues and problems.

10 And we want people on site during our
11 event that can help them and at least start the
12 process of, you know, the reintegration of
13 coming home and dealing with the issues that
14 they've had.

15 Attendees, like I said, are given
16 information and resources. And that assists
17 with the transition of coming back to their home
18 because, you know, we call it the new normal, you
19 know. It's not what it was when they left.

20 And so, the spouse is different.
21 They're dealing with their - the member that's
22 gone on to war and has a lot of issues. And so,

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1 this is a reintegration transition process to
2 help them and we provide every resource we can.

3 Some of the resources, you know, are
4 Veterans Affairs, the Vet Center, employer
5 support of the Guard and Reserve,
6 MilitaryOneSource, as Marie mentioned, and
7 they're there to answer questions.

8 And then an array of other resources
9 that we held - just outside the event we'll have
10 a table sort of like this where we've got
11 different folks at each table.

12 And you mentioned like a financial
13 person, you know. We have financial help. We
14 even have a session where we can talk about how
15 to build a budget, what they're dealt with, you
16 know, while they were away.

17 You know, you have the USERRA laws
18 that help the folks with the ESGR on, you know,
19 if they had problem with their mortgage payments
20 and that kind of thing.

21 And the session that I just went to,
22 I even got help. It was great because, you know,

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1 I'm headed toward retirement and there was
2 somebody sitting at a table. And, you know, we
3 got to talking and next thing you know he was
4 telling me how much I was going to make and what
5 I needed to do.

6 And, you know, it was really great
7 just to be able to go out and talk to these
8 different people.

9 So, it's an opportunity for all
10 these couples at our Returning Warrior Workshop
11 to be able to get help in the areas that they need
12 help on.

13 And then they can go on site as well
14 on our website and be able to pull down
15 information as well.

16 Again, the RWW is described as a best
17 practice within the DoD Yellow Ribbon
18 Reintegration Program. So, we've been very
19 successful at getting people to go.

20 And as Marie said, it is volunteer.
21 But, again, usually couples want to go because
22 it's a way, you know, it's an opportunity to get

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1 away, go to a nice hotel.

2 And of course one of the things that
3 we do at the end of our Returning Warrior
4 Workshop is we present - you've seen the quilts
5 of valor, these beautiful quilts that this
6 organization makes by hand.

7 We actually wrap our member in it,
8 you know, put it around the warrior at the end.
9 It's a culminating event, you know, effect at the
10 very end of the workshop. So, it is really
11 fantastic.

12 We've held over a hundred Returning
13 Warrior Workshops since the inception of the
14 program with over 12,000 attendees.

15 The major goals for the Returning
16 Warrior Workshop are honoring the warrior and
17 the warrior's guests for their service for our
18 country.

19 So, we really put on a good event to
20 let them know how much we appreciate what they've
21 done for our country.

22 And again, you know, provide

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1 information about the many resources available
2 to them and their families to assist with the
3 reintegration into civilian life.

4 Because as Marie said, these are
5 Reservists that are coming back and they have to
6 go back into the community, as you mentioned, try
7 to get a job.

8 So, we're there to help them with the
9 Hero2Hire, the employment initiatives program
10 that we have within the Yellow Ribbon Program to
11 be able to help them to get a job.

12 And my children are using Tutor.com
13 which, you know, I heard about it and, you know,
14 it's under our program. And I'm like I got to
15 see what this is all about.

16 And of course my kids were bucking
17 it and my daughter gets on Tutor.com practically
18 every night and she's on it and then I said, what
19 are you doing?

20 She goes, oh, I'm on - she's got her
21 iPhone and she's on Tutor.com getting help with
22 her math. And she is just getting so much better

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1 at math now. So, I'm like, oh, my God, this
2 really does work. I love it.

3 So, we have lots of good programs
4 that are helping our service members and they're
5 giving us feedback. And we are tracking the
6 metrics now through our Center of Excellence so
7 that we can begin to see what's happening with
8 these folks.

9 We've had a lot of suicides. We've
10 had a lot of problems with service members today.

11 So, we want to be able to get the
12 metrics and be able to prove that this is really
13 helping.

14 Our program - Marie handed out our
15 report to Congress. And we had to report back
16 to Congress everything that we do in the Yellow
17 Ribbon Reintegration Program.

18 So, if you take a few minutes to look
19 at that, it really describes what we do well.

20 And, you know, it's a mandated
21 program by Congress and we want to be able to
22 continue it so that we can help our service

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1 members and their families.

2 Because even though we talk about
3 downsizing because of the war, you know, there's
4 going to be another - well, we hope there's not
5 going to be another contingency, but, you know,
6 we see what's happening in the world today,
7 right?

8 And if it's not, you know, a
9 contingency, it might be a humanitarian effort.
10 And we know that people get posttraumatic stress
11 syndrome from even humanitarian issues, you
12 know.

13 So, we want to be able to help our
14 members in one way or another. And the Yellow
15 Ribbon Reintegration Program does that for those
16 members.

17 MEMBER EUDY: Ma'am, I've got a quick
18 question for you right here.

19 CAPT MASON: Yes.

20 MEMBER EUDY: The question being
21 regarding those Navy reserve members that are in
22 either the MedHold West or East or at their NOSC

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1 that are eventually going to get into the IDES
2 process.

3 Do you feel that you're able to reach
4 out and address those needs for them as, you
5 know, we've learned that this process where they
6 go there it may be a short-term fix, but they end
7 up staying there for a long period of time at both
8 east and west locations. It could last as long
9 as six months, if not up to a year or more
10 especially as they get into the IDES system while
11 their brothers and sisters may return from their
12 unit and they're, you know, now going through the
13 reintegration process.

14 And at 60 days, you said,
15 post-deployment either that's a family
16 gathering or a unit gathering.

17 CAPT MASON: So, ongoing from the
18 point that they go to the Returning Warrior
19 Workshop throughout the life cycle, in other
20 words, to help them -

21 MEMBER EUDY: Correct, yes.

22 Are those members that are at

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1 either, you know, the onesies and twosies that
2 may be floating around at a NOSC or those at
3 MedHold East and West receiving the same exact
4 programming and support that's available?

5 CAPT MASON: Well, that's why we have
6 the resources out there, because we want to
7 continue to support the member.

8 And, you know, an Air Force person
9 that knew about the NOSC, I'm impressed. NOSC,
10 Navy Operational Support Center. They're very
11 impressive.

12 I haven't met an Air Force guy that
13 knew what NOSC was. When Admiral Cotton changed
14 it from Navy Reserve Center to NOSC, nobody said,
15 what is a NOSC? Navy Operational Support
16 Center, because we wanted the word "operational"
17 in there.

18 But, yes, we support our members
19 throughout the entire military life cycle. And
20 that's really, you know, we're calling it the
21 military life cycle because, you know, we want
22 to take them throughout their entire service,

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1 but then beyond that because a lot of people, you
2 know, retire, they get a job, they move on, they
3 do other things, but they can always reach back
4 to the NOSC, to the Navy Center wherever that
5 happens to be. And throughout the nation we
6 have people that are out there to help.

7 So, yes, that's why, you know, we're
8 putting these resources - Marie talked about the
9 Center of Excellence and these, you know, these
10 - this website that you can go to, to pull
11 information whenever you need it.

12 So, even if we do downsize and we
13 don't do it the way we were doing it and have
14 these great hotel venues or what have you, we're
15 going to still be able to give them the
16 information that they need to help them
17 reintegrate into the civilian community.

18 So, yes, I hope we continue to do
19 that and -

20 MEMBER EVANS: They capture the ones
21 that are attached to MedHold. So, that's the
22 MedHold unit that we have, East and West.

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1 CAPT MASON: That's true.

2 MEMBER EVANS: Right. And so, they
3 do capture -

4 CAPT MASON: Oh, that's what you were
5 talking about with the IDES.

6 MEMBER EVANS: Right.

7 MEMBER EUDY: Yes, ma'am.

8 MEMBER EVANS: MedHold.

9 CAPT MASON: MedHold, okay.

10 MEMBER EUDY: Just because as we
11 visited MedHold identifying that those
12 recovering warriors were staying there for
13 extended periods of time, I just want to make
14 sure that they are not missing out on the
15 benefits that this program provides.

16 CAPT MASON: Well, if they're in
17 MedHold, they're usually having to - they have
18 to have contact with this within every 30 to 60
19 days. And they have to actually keep - our
20 medical corpsman at the Reserve Center has to
21 keep up on their documentation.

22 So, they're checking in. They have

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1 to check in with us and they have to continue and
2 we have to keep track of it. So, yes.

3 CO-CHAIR CROCKETT-JONES: So, I'm
4 trying to understand. The Returning Warrior
5 Workshops, how many who are eligible
6 participate?

7 CAPT MASON: Anybody who has been
8 augmented, you know, they've gone on an
9 individual augmentee, they've gone to war.
10 Anybody that's come back from whatever location
11 is eligible to attend a Returning Warrior
12 Workshop.

13 CO-CHAIR CROCKETT-JONES: And how
14 many of those who are eligible take advantage of
15 the workshop?

16 CAPT MASON: 26 percent.

17 CO-CHAIR CROCKETT-JONES: And how
18 many of those who take the workshop bring a
19 family member, specifically I'm really asking
20 about spouse, along?

21 CAPT MASON: Well, I've been to
22 several of them now and normally I'd see a large

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1 percentage that bring their spouse. But now
2 since we opened it up to any significant other
3 or family member, I notice there was a mother
4 with her, you know, a daughter with her mother
5 service member, there were other folks that
6 brought their friend because they didn't have a
7 spouse.

8 So, I can't give you an exact
9 percentage on who brings their spouse and who
10 brings a significant other, but I can tell you
11 the largest percentage that I saw were spouses
12 together.

13 CO-CHAIR CROCKETT-JONES: And how
14 many of the attendees bring somebody?

15 CAPT MASON: All the attendees that
16 were there.

17 CO-CHAIR CROCKETT-JONES: They're
18 always bringing a second person with them.

19 CAPT MASON: Correct. Because they
20 can and we pay for it. So, why wouldn't you want
21 to, right? It's a nice trip away from home.

22 CO-CHAIR CROCKETT-JONES: Thank you.

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1 CAPT MASON: Any other questions?

2 Well, thank you so much for giving
3 me the opportunity.

4 CO-CHAIR CROCKETT-JONES: All right.
5 Thank you very much.

6 Denise, do we have any housekeeping?
7 What would you like us to -

8 MS. DAILEY: Do we want to discuss
9 Elmendorf? We did not get a chance to. We've
10 got about 30 minutes here.

11 CO-CHAIR CROCKETT-JONES: I think we
12 should discuss Elmendorf.

13 MS. DAILEY: Want to discuss
14 Elmendorf, okay.

15 CO-CHAIR CROCKETT-JONES: Go ahead
16 Alex. You have the notes.

17 MEMBER EUDY: It's a very unique
18 environment up in Elmendorf especially with Fort
19 Wainwright and those that are dislocated, both
20 the Army and the Air Force in partnership with
21 each other using providers and with the joint VA
22 venture that we see there.

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1 The limit on providers, we saw
2 difficulties especially amongst behavioral
3 health providers that they were experiencing.

4 We all know about getting
5 contractors in those areas. And Alaska is a
6 very unique environment.

7 So, we talked about the resourcing
8 of that, but the number one thing that was
9 brought up by families was childcare as a
10 concern. Not being able then to take their
11 spouses to appointments, because a large
12 population of the WT up there is behavioral
13 health-related.

14 I cannot remember the exact figures.
15 I want to say it was 70 or 80 percent had a
16 behavioral health either diagnosis or condition
17 that was identified during their stay there, but
18 the members heard many families express about
19 childcare being that number one concern.

20 CO-CHAIR CROCKETT-JONES: Let me
21 jump in a second on that.

22 One of the things that kind of raised

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1 red flags for me is at least they had made a sort
2 of independent decision at one of their SFACs to
3 open up - the SFAC provided childcare to anyone
4 on the post up at Fort Wainwright, which had
5 pretty much maxed it out capacity making it
6 almost impossible for family members to get in
7 at their, you know, appointment time, you know.

8 They could maybe plan - if they could
9 plan things out way ahead, but sometimes the
10 appointment schedule was totally in conflict
11 with childcare availability.

12 I also felt that there was a little
13 - there was an issue related to that which was,
14 you know, you've got pretty extreme weather
15 conditions, medicated service members, lots of
16 behavioral health polypharmacy service members
17 requiring spouses to drive, spouses doing lots
18 of driving and trying to juggle childcare, their
19 own children's supervision and care, I think
20 that we saw some seriously overextended family
21 members.

22 They were frustrated and they were

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1 tired. And, you know, whatever the reality of
2 available services was, their perception was
3 that they just - they could not - they could
4 barely, you know, hang on.

5 And so, childcare was one of the sort
6 of hallmarks of this sort of over encompassing
7 extension, but the childcare, I think, was sort
8 of a symptom, you know, one symptom in a list of
9 a stressed out - and driven by location,
10 geography.

11 Go ahead.

12 MEMBER EUDY: We continue to see
13 similar things that we've seen across several
14 war transition units regardless of service.

15 The perception amongst both the
16 service members and families regarding
17 medications for behavioral health issues, again
18 we're running into availability there of
19 holistic medicine practices.

20 Obviously, again, remote location
21 especially as you get into Wainwright and the
22 area that they cover you have a small contingent

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1 of whether it be behavioral health or primary
2 care that is available to meet an ever evolving
3 population.

4 So, we have discussed at length the
5 ability to treat service members in certain
6 locations before moving them down, you know, to
7 Elmendorf or if they were to go back to another
8 WTU back in the states.

9 And the most reference was Fort
10 Lewis. Obviously that is the closest
11 behavioral health provider available especially
12 when it comes to longer duration and treatments.
13 But then again they are so remotely located from
14 all of those that it makes it quite difficult.

15 And something else that was
16 identified, and we've seen this before, is the
17 perception of service members attending our
18 groups, but being unable to attend appointments
19 due to command-related duties.

20 So, that's constant. We see the
21 struggle between both command to meet the needs
22 of the Force, and the service members, the need

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1 to making sure their medical care is priority
2 number one.

3 MEMBER MALEBRANCHE: The one good
4 thing that we saw there that was commented on,
5 I think, that's also commonplace was the legal
6 support.

7 Everybody was calm. Very, very
8 supportive. And the attorney that spoke to us
9 there liked her job. She was commented on as
10 professional is extremely supportive up there.
11 So, I think the legal aspect of that was very
12 good.

13 CO-CHAIR CROCKETT-JONES: The
14 remoteness of the location was driving some
15 innovations.

16 The legal - as well as NARSUM writing
17 which the Army, you know, has NARSUM writers.
18 And to handle overflow they had basically
19 telephone, you know, access to a NARSUM writer
20 who, you know, was remote so that they could, you
21 know, farm it out to folks down in the lower 48
22 when they needed the overflow.

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1 MEMBER MALEBRANCHE: The unique
2 thing about the NARSUM writing though is that
3 they had the NARSUM writers displaced from, I
4 mean, different - from Alaska had been there
5 before, but had access to records.

6 I mean, so that was a little
7 different piece, because that was kind of like
8 is it good, is it bad to have someone that doesn't
9 necessarily know the patient?

10 But they did have access to records,
11 which was something that obviously can be done.

12 CO-CHAIR CROCKETT-JONES: They had
13 to work -

14 MEMBER MALEBRANCHE: They worked
15 there.

16 CO-CHAIR CROCKETT-JONES: They had
17 to do a workaround to get those folks a
18 designated laptop and, you know, access to be
19 able to do it the way they have other people
20 onsite doing that work.

21 MEMBER MALEBRANCHE: And the
22 attorney and the legal folks also had access.

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1 So, that was something, I mean, here remote,
2 thank goodness they have access, but that was a
3 very - not all places have that. So, I thought
4 that was pretty good.

5 MEMBER EVANS: What was the feedback
6 from leadership on the childcare issue?

7 MS. DAILEY: They had tried to solve
8 it. And the battalion commander had been
9 unsuccessful in changing the - Fort Wainwright's
10 garrison commander who made that decision had
11 been unsuccessful in changing his mind or
12 arguing effectively to not make that decision.

13 CO-CHAIR CROCKETT-JONES: But it
14 could be that because it came up in the out-brief
15 that at least they were going to readdress the
16 particular issue at Fort Wainwright. At least
17 they had a new reason to talk about it again.
18 We'll see.

19 MEMBER EUDY: One of the other -
20 before I forget, one of the positives that we
21 have not heard in quite some time was unanimous
22 amongst the service members regarding the squad

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1 leaders, the cadre, their availability and their
2 knowledge.

3 We had seen one of the lowest ratios,
4 though, of cadre to service members. I believe
5 that some had a one to three ratio. So, being
6 able to provide that one-on-one level of care.

7 One concern though that we did bring
8 up and that we had seen elsewhere was the
9 relationship between the PEBLOs and DRAS and not
10 being able to get updated information.

11 They had difficulties with that
12 relationship.

13 CO-CHAIR CROCKETT-JONES:
14 Everywhere we've gone that - everywhere I've
15 gone there's been sort of a different tack on
16 this. There seems to be no standard protocol
17 for contacting DRAS or some folks have someone
18 designated to call them, some folks seem to have
19 someone at DRAS who's willing to take the calls,
20 other places they are told don't call, don't call
21 us.

22 This seems to be something that is

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1 totally seat-of-the-pants manufactured at each
2 site, or unachieved. And this is the point at
3 which we hear service members say that is - this
4 is the black hole.

5 When we hear service members say it
6 gets to a certain point and then I just don't
7 know. And I have to just sit around and wait and
8 I have no information. And the PEBLOs say we
9 don't have any more information.

10 And I think we've finally gotten a
11 good understanding that what - what the control
12 of that packet is when we lose sight of its
13 progress.

14 And what's the timeline that DRAS -
15 how many days does DRAS have it at that point?
16 I forget what their projected days are.

17 MS. DAILEY: Yes, they don't want to
18 call until about 60 days across the board. It
19 had to be out of their hands 60 days before they
20 start calling DRAS.

21 CO-CHAIR CROCKETT-JONES: Right.
22 So, this is - if it goes longer than - they're

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1 not going to be called before then. But if
2 you're talking - you're talking about two months
3 of sight unseen minimum.

4 Yeah, I think that this is not
5 necessarily something we have the power to
6 influence, but I think at least we now understand
7 who has it when the black hole feeling starts.

8 MS. DAILEY: I would like to put
9 something in that I think Admiral Nathan would
10 advocate for, at least kind of get it in our
11 public record.

12 He understood the manning situation
13 pretty well. He realized that the environment
14 does not support an education or a university
15 feed into the mental health community. There's
16 very few mental health assets out there. Zero
17 to none.

18 So, and there's no university that's
19 producing mental health providers in the
20 community. And you can't contract to get them
21 up there. And you can't grow them. You can't
22 contract them.

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1 So, he was very acutely aware of the
2 fact that, you know, a lot of these fills need
3 to be uniform. And that where you have rich
4 locations for universities and opportunities to
5 do internships, you want to pull your slots out
6 of those locations and put your uniforms up there
7 so that there's more robust providers in the
8 lower and specialty care areas.

9 CO-CHAIR CROCKETT-JONES: Yes, he -
10 mental health was definitely the highlight of
11 that, but he really was basically saying if a
12 place is so remote that offering all these
13 incentives hasn't gotten a contractor up there,
14 it should maybe be a uniform billet because for,
15 you know, it's going to save money. You don't
16 have to incentivize contracts in other places
17 which have them more available.

18 So, it's kind of he was definitely
19 advocating for the services to relook at how the
20 remote locations are manned.

21 MEMBER EUDY: They were sourcing
22 active - well, not active. Excuse me. Reserve

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1 behavioral health physicians through the
2 Reserves, but they were not able to stay there
3 a long duration.

4 So, it was just band aids for what
5 we know is a continuous problem regardless of the
6 deployment turnover factor. Because they had
7 mentioned, well, we see the spike every year or
8 every couple years from the return of the units.
9 But due to the climate, they always had a
10 continuous behavioral health population.

11 MEMBER MALEBRANCHE: And I think the
12 other thing was we didn't really have time for,
13 but we didn't have good visibility, they are a
14 joint venture site up there. And about the VA
15 social workers in that clinic, I don't think they
16 had the shortage that the military site did, but
17 we didn't have a good picture of that.

18 CO-CHAIR CROCKETT-JONES: I think
19 we're all - I think we've covered it all.
20 Everything I remember.

21 MS. DAILEY: I think I'm going to
22 cycle the childcare at Fort Wainwright back

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1 through the WTC, back through General Bishop as
2 the possibility he may want to be involved or
3 that we experienced it and he ought to know.

4 CO-CHAIR CROCKETT-JONES: Yes,
5 because I think that that SFAC childcare policy
6 might have guidelines. I mean, someone needs to
7 at least relook at how those decisions can be
8 made if that's within the power of those people
9 who made the decision.

10 MEMBER EVANS: So, no CDC.

11 MS. DAILEY: Yes, CDC, I mean, the
12 SFAC was rolled back into the CDC, it appears.

13 MEMBER EVANS: Okay.

14 MS. DAILEY: It was rolled back into
15 the CDC rules. And from what I understand from
16 your feedback from the focus groups, the wounded
17 warrior families were not able to get
18 appointments in there for drop-in -

19 MEMBER EVANS: Because of -

20 MS. DAILEY: - because the Fort
21 Wainwright total population now had access.

22 MEMBER EVANS: Okay.

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1 MS. DAILEY: And they had basically
2 been squeezed out.

3 CO-CHAIR CROCKETT-JONES: And there
4 may have been a limited CDC at all up at Fort
5 Wainwright. So, basically they were using the
6 SFAC as the bump up for what limited CDC they had.

7 MEMBER MALEBRANCHE: If they could
8 get in, it was 30 days in advance to do an
9 appointment.

10 MEMBER EUDY: And if it was
11 unavailable, it was expressed by many family
12 members using off-post services. And those
13 were at a substantial cost on the economy.

14 Which at the same time, the majority
15 of the spouses especially in that location are
16 the primary caregivers for those under the most
17 severe behavioral health and TBI cases.

18 CO-CHAIR CROCKETT-JONES: And given
19 weather and car accident rates just in the
20 general population, they need drivers
21 considering the polypharmacy situation.

22 It's not an easy place.

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1 MEMBER PHILLIPS: Did they even try
2 to prioritize the needs? I mean, a medical
3 appointment versus I want to go into town and get
4 drunk and take care of my kids?

5 CO-CHAIR CROCKETT-JONES: No, not so
6 far as I know.

7 You had to make your schedule things
8 in advance and you just got in the line.

9 We are done, folks. Thank you all
10 very much for attending our meeting. See you
11 next time.

12 MS. DAILEY: We'll be back in June.
13 You're going to be getting a number of products
14 from us over the next few months.

15 (Whereupon, at 4:52 p.m. the meeting
16 in the above-entitled matter was concluded.)

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