UNITED STATES OF AMERICA

DEPARTMENT OF DEFENSE

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RECOVERING WARRIORS TASK FORCE

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OCTOBER BUSINESS MEETING

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MONDAY

OCTOBER 28, 2013

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

PRESENT

VADM MATTHEW L. NATHAN, MD, USN, Co-Chair

SUZANNE CROCKETT-JONES, Co-Chair

RONALD DRACH

TSGT ALEX J. EUDY, USAF, USSOCOM

LTCOL SEAN P.K. KEANE, USMC

COL KAREN T. MALEBRANCHE (Ret.), RN, MSN

MG RICHARD P. MUSTION, USA

DAVID K. REHBEIN, MS

ALSO PRESENT

COL DENISE DAILEY (Ret.), Executive Director, Designated Federal Officer

RICK BECKER, Air Force Representative, IDES Lawyer Panel

LAKIA BROCKENBERRY, RWTF Staff

MAJ WILLIAM COLLINS, Marine Corps Representative, IDES Lawyer Panel

LAKANDULA DUKE DOROTHEO, Army Representative, IDES Lawyer Panel

RACHEL GADDES, RWTF Staff

CROSBY HIPES, RWTF Staff

KRISTAN HOFFMAN, VA Insurance Center

JOHN KUNZ, RWTF Staff

SUZANNE LEDERER, RWTF Staff

STEPHEN LU, RWTF Staff

CDR KIRSTEN MARTIN, USCG

KEVIN McDONNELL, Director, SOCOM Care Coalition

MATTHEW McDONOUGH, RWTF Staff

DAVID McKELVIN, RWTF Staff

KAREN MORRISROE, Navy Representative, IDES Lawyer Panel

ELIZABETH MOORES, Navy Representative, IDES Lawyer Panel

JOSEPH NAGORKA, RWTF Staff

ASHLEY SCHAAD, RWTF Staff

STEPHEN WURTZ, Acting Deputy Director, VA Insurance Center

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

2 (9:01 a.m.)

3 EXECUTIVE DIRECTOR DAILEY: Good

4 morning, ladies and gentlemen. I would like

5 to bring the Task Force to order. We have all

6 the members that we are going to have here

7 this morning except Admiral Nathan and he is

8 due to be here at about ten o'clock.

9 So, welcome back and ma'am, I am

10 going to turn it over to you.

11 CO-CHAIR CROCKETT-JONES: Thank

12 you, Denise.

13 I would like to welcome everyone

14 to the first business meeting of our fourth

15 year of effort. Over the last three fiscal

16 years, the Task Force has assessed policies

17 and programs relating to the care of wounded,

18 ill, and injured Servicemembers and their

19 families. Currently, we have gathered input

20 through the execution of 39 installation

21 visits, 16 business meetings, and we have made

22 a total of 77 recommendations. These were

1 submitted to the Secretary of Defense through
2 our three annual reports. During this fourth
3 fiscal year, we will continue our work through
4 installation visits and business meetings. We
5 will, once again, make substantial
6 recommendations to address the level of care
7 and quality of support provided to our
8 Servicemembers and their family members.
9 Before we begin, I would ask that
10 the members introduce themselves once again.
11 And I am going to start with you, Mr. Drach.
12 MR. DRACH: Ron Drach, non-DoD
13 member.
14 T SGT EUDY: Technical Sergeant
15 Alex Eudy, representing the Air Force and
16 Special Operations Command.
17 MS. MALEBRANCHE: Karen
18 Malebranche, representing Veterans Health
19 Administration.
20 MG MUSTION: Rick Mustion,
21 representing the United States Army.
22 LT COL KEANE: Lieutenant Colonel

1 Keane, representing the Reserve Component.
2 MR. REHBEIN: Dave Rehbein, non-
3 DoD member.
4 CO-CHAIR CROCKETT-JONES: And I'm
5 Suzanne Crockett-Jones, the civilian co-chair.
6 I would also like to note that
7 Command Sergeant Major DeJong will not be
8 joining us during this business meeting. Dr.
9 Phillips will be here tomorrow, possibly later
10 today. Dr. Turner will be phoning in this
11 afternoon. And as Denise just said, Admiral
12 Nathan will be with us later this morning.
13 So, now I get to read the blue
14 portion. Normally during this time, we would
15 discuss our recent site visits but because of
16 the absence of funding earlier this month, our
17 visit to installations in Hawaii was canceled
18 but will be rescheduled.
19 On the 21st, Admiral Nathan and
20 Denise and I had the pleasure of meeting with
21 the House Armed Services Committee and Senate
22 Armed Services Committee staffers to discuss

1 our 2013 recommendations. It was informative.
2 We walked the staffers through the
3 recommendations that we had made and
4 especially highlighting those which were of
5 interest to the Congressional staff. They
6 were particularly interested in our
7 recommendation, the very first one on the
8 Centers of Excellence. They have been -- had
9 much internal discussion about the Centers of
10 Excellence. And they are looking for greater
11 empowerment and outcomes from the Centers of
12 Excellence, which I know had been also an
13 interest that we all share.
14 Recommendations three and four
15 were also of interest as they, too, were
16 looking for DoD and VA to move to the next
17 level in PTSD and TBI care.
18 Recommendation 10 about
19 information resources generated a lot of
20 discussion. And we directed them to the
21 findings in our report because they were
22 looking for some forward movement in that area

1 as well.

2 The last recommendation we

3 discussed was 20 on family members. They did

4 bring up an "opt out" requirement for

5 caregiver or family members as an option. It

6 was a robust discussion.

7 The one and a half hours went very

8 quickly. We did not get to all the

9 recommendations. We did not get much in the

10 way of direction from them for this year's

11 effort. We did talk to them about our

12 thoughts about IDES and about a holistic

13 change. They were informed about the

14 services, each services process improvements

15 for IDES and they did not seem receptive to a

16 holistic change. They didn't believe that

17 there was much support. They did not think

18 major changes to overall benefits and

19 compensation system was feasible. I believe

20 that they said basically unless a

21 recommendation for a holistic change

22 maintained the overall benefit structure that

1 we currently have, that they were not
2 supportive of that effort. So, I thought that
3 was a little disappointing to me.
4 During this business meeting, we
5 are going to cover various topics. At our
6 June 2012 meeting we discussed Traumatic
7 Servicemembers' Group Life Insurance as a
8 topic of interest for this fiscal year. We
9 will receive a briefing from OSD and Veterans
10 Affairs on this topic today. We will receive
11 updates regarding SOCOM Care Coalition and
12 speak with a panel of IDES lawyers for each
13 Service about their thoughts on the process.
14 Tomorrow, we will be receiving a
15 briefing regarding Veterans Affairs polytrauma
16 rehab services, as well as updates from the
17 Physical Disability Board of Review and the
18 Army National Guard Management Processing
19 System and Reserve Component Managed Care. We
20 will end our day tomorrow with a presentation
21 from the Army IDES Transition Office.
22 And I believe we have gotten a

1 response from the Secretary of Defense's
2 Office on implementation of this year's
3 recommendations. So we will be discussing
4 that.
5 So, at this point, we are going to
6 discuss that Implementation Plan. We are
7 going to go through it, right, recommendation
8 by recommendation. So, we have that
9 information in Tab B.
10 MR. REHBEIN: Suzanne, may I ask
11 one question about your meeting with the
12 staffers? Because I am trying to wrap my head
13 around what they said about IDES. Their
14 reaction was that if it was going to mean a
15 change in benefits to the Servicemember, there
16 was no support for that but as long as it was
17 something of a zero sum, there may be support.
18 Am I simplifying it too much?
19 CO-CHAIR CROCKETT-JONES: No.
20 MR. REHBEIN: Am I going in the
21 wrong direction? I am just trying to get a
22 little bit better understanding.

1 CO-CHAIR CROCKETT-JONES: I think
2 the tone was part of the reception. My
3 hearing was that it was a non-starter.
4 EXECUTIVE DIRECTOR DAILEY: Good
5 morning, ladies and gentlemen. I am Denise
6 Dailey. I am the Executive Director for the
7 Task Force. I am going to be briefing the DoD
8 Implementation Plan for the Task Force's 2012
9 recommendations. And I am going to take one
10 minute here before I jump into that, I am
11 going to take one minute here to do some
12 administrative information for the Task Force.
13 So, last time we met was July,
14 late July, where you voted on your
15 recommendations and where we had the
16 opportunity to move forward into this year's
17 publication. A busy summer, I think, as you
18 all remember, and a busy fall. We did one
19 administrative task. I had to re-compete our
20 research contract and we were lucky enough to
21 bring in a company called InSight
22 Incorporated. I would like to have Rachel

1 Gaddes stand up. She is the project lead for
2 Insight Incorporated and they were kind enough
3 to partner with our current sub, which was ICF
4 International. So, we do have this pretty
5 much a similar team here from the last three
6 years to do our last year of effort. So,
7 thank you, Insight.
8 And I think you all know our
9 research team with Mr. John Kunz as our lead.
10 And we have a new person. I would like him to
11 stand up. Your name is?
12 MR. HIPES: Crosby Hipes.
13 EXECUTIVE DIRECTOR DAILEY: Crosby
14 Hipes will be joining us as a new research.
15 So, good news. We were able to bring in some
16 new talent and maintain some of our continuity
17 for our research effort.
18 Okay, I would like to talk about
19 the DoD's response to the FY2012 report. Now,
20 as the legislation lays out, when we turn in
21 a report traditionally and consistently the
22 third of September every year, the legislation

1 states DoD does an Implementation Plan that
2 they submit to the appropriate committees,
3 Senate and Armed Forces Committees. And then,
4 at 180 days, DoD does an Implementation Plan.
5 We have in our hand the
6 Implementation Plan. I do want to go over it.
7 We have got an hour here. We should be able
8 to get through it in an hour. Please feel
9 free to ask questions. It is in Tab B of your
10 books.
11 Now, I want you all to kind of put
12 your head back where it was in June of 2012,
13 what you were thinking about, what your
14 emphasis was that year. You had just
15 published your '11 report, where you had 21
16 broader, more encompassing recommendations.
17 And in 2012, you had kind of settled into a
18 plan to do more recommendations. So, your
19 2012 report had 35 recommendations and your
20 2012 report was a little more tactical. It
21 was a little more detailed and pointed where
22 you recommended the DoD go with their various

1 programs. And I think that their responses
2 have been somewhat similar to their evaluation
3 plan.
4 All right. So, we are going to
5 move -- let me have you guys -- can you go to
6 the next written page, please? So that is
7 just the cover letter and the top part is our
8 introduction.
9 Let's talk about Recommendation 1,
10 where you kind of started getting your arms
11 around publications that needed to be printed
12 and needed to be published. You have in 2012
13 and then even more in 2013, really narrowed
14 down what publications you think need to get
15 published. There has been a lot of lag time
16 in some of these recommendations, in some of
17 these publications. So, your Recommendation
18 1 kind of focus in on three of them. It was
19 the Air Force's publication for its Wounded
20 Warriors Programs. You felt strongly that
21 needed to get pushed out. The recommendation
22 also here was for the E21 and the Wounded

1 Warrior Operation Warfighter Programs
2 publications to get published. And the big
3 success here also is the medical case
4 management DoDI.
5 And their response indicated that
6 these three documents have been successfully
7 published.
8 All right, Recommendation 2. And
9 you will find throughout the Implementation
10 Plan that DoD submitted to the Congressional
11 Committees, they are relying a lot on their
12 initiatives, the DoD's initiatives to stand up
13 the Interagency Coordination Committee. So,
14 several of these recommendations talk about
15 the Interagency Coordination Committee's
16 efforts to streamline, to simplify, and to
17 create an overarching document.
18 So in your Recommendation 2, where
19 you are talking about clarifying roles for the
20 RCCs, the FRCs, you are getting in this
21 recommendation the efforts that they are
22 utilizing to streamline this process, identify

1 these roles in the Interagency IC3, the
2 Interagency Coordination Committee. They have
3 several references here to the efforts of the
4 IC3.
5 Okay, on Recommendation 3 we have,
6 in the last two years, in FY11 and in FY12, we
7 are talking about a Bill of Rights for issues
8 within both the line units and in the warrior
9 transition units, both Army and Marine Corps.
10 They have pledged here in their
11 response to provide this type of guidance for
12 the services and for these commanders in their
13 units. So, they have a concur here and gave
14 us an approximate publication date of 30
15 October or submission of the guidance to the
16 services of 30 October.
17 Recommendation 4. Again part of
18 your vision over these last few years has been
19 that both DoD and VA are collaborating on the
20 expertise that has been developed over the
21 last ten years and that is, as we develop this
22 expertise in both agencies, that it not be

1 lost. That there be locations and that there
2 be plans for ensuring this type of skill set,
3 whether it be psychological help, whether it
4 be amputation and extremities, injuries,
5 hearing, vision, that these types of skill
6 sets will remain in either one of the
7 agencies. And so in this recommendation, you
8 capture that thought. You capture that intent
9 in this recommendation.
10 And the DoD pledges that this is
11 their intent, that they are and do have this
12 type of collaboration going on and that they
13 are maintaining their skill set across the two
14 agencies.
15 You will notice on this one, they
16 also consider this one closed. I do believe
17 this is they think that there is sufficient
18 interaction and sufficient integration of
19 their activities through the JEC, through
20 their memorandums of agreement that this is
21 captured in the intent of both agencies.
22 I see someone's finger on the red

1 button there. Go right ahead, Mr. Rehbein.
2 MR. REHBEIN: My brain isn't quite
3 as totally in gear. Can we drop back to
4 number 3 for a second?
5 EXECUTIVE DIRECTOR DAILEY: Yes.
6 MR. REHBEIN: When they say they
7 are distributing suggested content for a
8 letter, are they suggesting that there be a
9 letter or are they saying there should be a
10 letter and this is suggested content?
11 EXECUTIVE DIRECTOR DAILEY: Option
12 two.
13 MR. REHBEIN: Good, thank you.
14 EXECUTIVE DIRECTOR DAILEY: Okay,
15 Recommendation 5. We get a nonconcur on this.
16 Your intent and your thought process at this
17 time was there was some reorganization going
18 on within the OSD P and R of Warrior Care
19 Policy. It was realigned under Health
20 Affairs, which they note in here.
21 I think your concern at the time
22 also was that with changing political

1 environments, with changing leadership, there
2 was no real anchor for the Warrior Care Policy
3 Office, not in legislation in particular. And
4 your intent on this regulation was to anchor
5 this Warrior Care Policy Office permanently in
6 the P and R. You were indifferent to where in
7 the P and R, which you made clear in your
8 findings, but to anchor it permanently via a
9 legislative initiative.
10 They assure you in this and they
11 assure Congress in this recommendation that
12 Warrior Car Policy is an integral part of the
13 P and R and that legislation to secure it and
14 to ensure its mission continuance within the
15 P and R is not necessary. And they also
16 consider this one closed.
17 Recommendation 6, you all went to
18 Twentynine Palms in 2011 and 2012. And your
19 intent in this one and where you were going
20 with this one was to ensure that these small
21 remote locations, and Twentynine Palms being
22 the example, receives the attention and the

1 resources that is required if, indeed, it is
2 a decision of the Service to put people in
3 these smaller more remote locations, keeping
4 them close to family, keeping them close to
5 their units.
6 In this recommendation you are
7 assured that there is sufficient medical care
8 out there, that it is monitored, that it
9 fluctuates with the number of cases. They
10 have got some good figures here on who is in
11 the Warrior Transition debt at Twentynine
12 Palms and who is still out in their units --
13 with their units, they have not been put in
14 the Wounded Warrior Regiment debt at
15 Twentynine Palms. And the caseload for the
16 medical care of these individuals both in and
17 out of the Wounded Warrior debt.
18 The other piece of information
19 they provide here is that they say they have
20 hired a VR&E representative from the VA to
21 look after some of the nonmedical care issues,
22 in particular the employment issues in a

1 remote location, which has a nationwide reach,
2 the VR&E program. So they have identified
3 that they hired someone in June of 2013.
4 So, your intent in Recommendation
5 7 was an extension of the Transitional
6 Assistance Management Program, TAMP, which is
7 the acronym for TAMP to one year.
8 There was a nonconcur on this.
9 They feel there are sufficient medical options
10 for individual to exercise without extending
11 the TAMP one year.
12 And they identify a program; I
13 have to tell you I think we are all pretty
14 aware it is a program I have never heard of
15 before, the Transitional Care for Service-
16 Related Conditions. It was also embedded in
17 the 2008 NDAA. And they reviewed that. They
18 feel that provides the services that the TAMP
19 would provide after six months, in the case of
20 identifying late arising conditions. And they
21 have stated here that they have also updated
22 the TRICARE website to identify this option on

1 the TRICARE website.
2 They have also indicated that they
3 consider this one closed also.
4 All right, Recommendation 8,
5 ladies and gentlemen. In this one, at this
6 time you focused on training. We had been out
7 to, by that time, approximately 20 sites. You
8 were identifying through your site visits the
9 level of training of the psychological health
10 providers in the field. So your emphasis here
11 was a drive to ensure that the maximum amount,
12 in fact you put 100 percent of your behavioral
13 health providers had training in evidence-
14 based practices, in evidence-based treatments
15 for psychological health.
16 DoD concurred with this
17 recommendation and identified throughout their
18 response who has been trained, who is
19 responsible for training, and how they are
20 incorporating it into the new patient-centered
21 home care program. They also identified some
22 memorandums that they have published in order

1 to ensure training in the evidence-based
2 treatments and given analysis 15 to 18 months
3 ago when you made this recommendation. And
4 you have seen a lot of changes since then.
5 And so this year's recommendations
6 progress from this training recommendation to
7 another level. But they have identified their
8 efforts in psychological health in this
9 recommendation in their upcoming Department of
10 Defense instructions.
11 You also identified at that time
12 the need to review psychological health
13 records -- this is Recommendation 9 -- and to
14 identify non-completion rates within these,
15 which have been documented to be very
16 successful evidence-based treatment programs
17 when conducted consistently and when conducted
18 with fidelity.
19 You also had an interest at that
20 time of who was making it through a full
21 session, a full cohort for psychological
22 evidence-based treatments. So in your

1 Recommendation 9, you urged the Department of
2 Defense to review records, look at non-
3 completion rates, and increase efforts to
4 bring individuals who have not been able to
5 complete, which is really kind of a rigorous
6 program in treatment of PTSD to try and bring
7 them back in to the programs to complete these
8 efforts.
9 In this response, they identified
10 their current efforts in how they are set up
11 to review records. And they identified
12 practices that they already have in place for
13 assessing completion rates and keeping these
14 programs aligned with the clinical practice
15 guidelines.
16 Now, they did not close this
17 recommendation and consider it ongoing.
18 Next recommendations. This was
19 your single comprehensive recovery plan
20 recommendation. And this is another
21 recommendation where they are depending
22 heavily on the results of the Interagency Care

1 Coordination Committee. They refer to its
2 activities and give you a relatively detailed
3 description of where this intent is, the
4 intent for one plan, the intent for a lead
5 coordinator to synchronize efforts across both
6 services, across both agencies. And so in
7 this, they do anticipate that there will an
8 outcome that is similar to this
9 recommendation. We really don't know what it
10 is going to look like at this time.
11 So, they have given us some time
12 lines here. They think that an implementation
13 will be and a comprehensive plan that will
14 cross both agencies will be available by June
15 of 2015.
16 Recommendation 11 talked about the
17 current CRP. Now, the Army's program is a
18 CTP, a Comprehensive Transition Plan. The DoD
19 policy talks about a Comprehensive Recovery
20 Plan. And DoD developed an online
21 Comprehensive Recovery Plan that the Marines,
22 the Air Force, and the Navy use. And your

1 concern at the time was because Servicemembers
2 could not go into that Comprehensive Recovery
3 Plan and family members could not access that
4 Comprehensive Recovery Plan, that their input
5 was minimized to a degree. Their real ability
6 to feedback from that plan and to input to the
7 CRP was filtered a little bit by the RCCs.
8 The Army's plan is online. You
9 can get into it through a KO but they are
10 different documents. So, in this
11 recommendation, you highlighted the Navy,
12 Marine Corps and Air Force in their RCCs and
13 your urged them to ensure family input to
14 that, to the Comprehensive Recovery Plan.
15 This was also where, in response
16 to this recommendation, they drew on the
17 efforts of the Interagency Coordination
18 Committee, the IC3. And they also said they
19 are making changes here to the Comprehensive
20 Recovery Plan. And they drew on the same time
21 line they identified in the Recommendation 10,
22 which is procurement development

1 implementation of an interagency comprehensive
2 plan is estimated by June 2015.
3 Okay, in 2012 this was a big
4 recommendation, number 12. You really wanted
5 an expansion of the Category 2. And in
6 particular, the biggest piece of this
7 recommendation had to do with trying to draw
8 more people in who were identified as PTSD or
9 identified or being process for PTSD in the
10 IDES system. You want to draw them into
11 Category 2. You felt at the time that
12 Category 2s in the IDES system identified for
13 PTSD needed RCC services. They needed
14 nonmedical care case management and ought to
15 be treated as Category 2.
16 You also wanted to identify a
17 population in the Reserve Component that was
18 being drawn back on active duty or had been
19 retained on active duty for six months or
20 more. You also identified that population as
21 needing RCC or Category 2 services.
22 There was a nonconcur on this one.

1 And they identified that RCCs are provided to
2 all Category 2s. They have some numbers in
3 here that identify the population and they
4 also are confident that this population of
5 Servicemembers is covered with these
6 categories, with these types of services that
7 go with these categories.
8 CO-CHAIR CROCKETT-JONES: Denise?
9 EXECUTIVE DIRECTOR DAILEY: Yes?
10 CO-CHAIR CROCKETT-JONES: They
11 seemed to miss the point on this one. Their
12 implementation plan in their response doesn't
13 seem to address some of the issues that
14 brought us this concern in the first place.
15 So, I am a little frustrated. And I guess
16 will we have an opportunity this year to look
17 again at the very specific populations, the
18 reservists were the big concern, to make sure
19 that they are -- that the real void there in
20 needing some help when they are retained for
21 long periods of time in a care situation, are
22 we going to get a chance to look at that

1 population again this year so that we can make
2 sure that we understand the situation
3 ourselves and see if this is something that
4 needs to be revisited?
5 EXECUTIVE DIRECTOR DAILEY: We
6 will go back to -- I think one of the things
7 that sparked this recommendation was the
8 Norfolk debt, the Navy MEDHOLD in Norfolk
9 where the Task Force came to the conclusion
10 that they felt that the individuals in the
11 Navy HOLD debt in Norfolk needed Category 2
12 services. So, we will be going back there.
13 We have scheduled a Reserve
14 Component look in Hawaii with an Air Reserve
15 unit. So, we will be touching some of this
16 population. When we have Colonel Faris up
17 here and Mr. Holderman for Guard, the Army
18 National Guard medical processing and their
19 management of ambulatory, and they do kind of
20 consider them Category 1s, and we can talk
21 with them about what is available for people
22 who might be Category 2s.

1 So, I have some touch points, yes,
2 for touching this population.
3 CO-CHAIR CROCKETT-JONES: Yes, I
4 think we need to get a handle on how many
5 Category 1s wind up being held in care for
6 long periods of time. Since that seems to be
7 where we were looking and where we saw a
8 problem but I don't really see that addressed
9 in the response from DoD. So, if we can try
10 and get numbers, even, of Category 1s were
11 kept for over six months and how long their
12 average stay is.
13 EXECUTIVE DIRECTOR DAILEY: Okay.
14 Number 13, ladies and gentlemen, talks about
15 training everybody, everyone who is touching
16 the wounded warrior population in the DoD's
17 RCC program.
18 In this recommendation in their
19 Implementation Plan, they state they are and
20 have reviewed their RCC program with the
21 Army's training program for their squad
22 leaders and platoon sergeants, and they have

1 identified where these two training programs
2 differ and identified what is not being
3 covered. They have also identified that they
4 are converting the RCC program to an e-online
5 learning courses, so that the DoD's RCC
6 training can be available and can be
7 distributed economically.
8 So, they have identified a number
9 of ways here that they have sought to work
10 with the services, to identify where the
11 training gaps between the training programs
12 the services have, and the DoD's RCC program
13 and they have also have initiatives and
14 identified initiatives to train individuals in
15 the RCC programs via an e-Commerce -- via an
16 e-learning, distance learning concept.
17 Okay, in the next recommendation,
18 this was your recommendation that addresses
19 family members. And you sought in this one to
20 de-couple it to provide services to family
21 members and de-couple it from the
22 Servicemember's HIPAA information. You sought

1 to identify an opportunity for Servicemembers
2 to get counseling, to get therapies, to get
3 information, and to not have a permission
4 sequence for Servicemembers to receive this
5 type of -- for family members to receive this
6 type of information.
7 Each one of the services here
8 documents their process for taking care of
9 family members. This was a family member
10 recommendation. And they have four checks
11 here. And the services have identified for
12 you how they keep family members in the loop.
13 And they do consider this sufficient and they
14 have laid out what they do. And they
15 recommended that this be closed, as they move
16 this forward to Congress.
17 Again, I think the Task Force
18 would like to see a change in the dialogue.
19 In your 2013 recommendations you have made
20 another family member recommendation, not
21 convinced yet that the family member outreach
22 is sufficient. And as a Task Force you would

1 like to see some change in the dialogue when
2 you are out there talking with family members.
3 Okay, Recommendation 15. Our
4 Recommendation 15 also refers to the IC3 work
5 and the IC3 Committee's work. This is a good
6 example. I think this intended and started
7 out as an opportunity to provide one point of
8 contact for the family members. And that is
9 a lot of what the findings talk about in this
10 recommendation. This recommendation was a
11 little broader and it talks about one point of
12 contact for the Servicemembers also.
13 So, it is the findings address
14 both the response, the Implementation Plan
15 from the Department of Defense, again, talks
16 a little bit -- talks a lot and basically
17 brings this into the IC3, the Interagency
18 Coordination Committee's camp to work to
19 present their products for identifying the one
20 point of contact, the lead coordinator, and
21 the checklist that they are using to ensure
22 information has been transmitted to both

1 Servicemembers and family members and to
2 ensure that both agency's activities are
3 coordinated.
4 You did a lot of recommendations
5 on family members in 2012. Recommendation 16
6 is another one. This one is very directive in
7 nature and talks about family members getting
8 information they need to understand their new
9 or the change or what is available to them as
10 they transition from DoD to VA. And you
11 pegged this to a point in time in which
12 families and family members move in --
13 services and Servicemembers move into the
14 IDES.
15 I think in this one the
16 Implementation Plan centers quite soundly,
17 quite uniformly out of all the services around
18 the briefings that the Servicemembers get.
19 And in de facto, if the family members were
20 participating in those IDES briefings, they
21 would be getting a lot of information. But we
22 know from our visits that delivery of a

1 briefing to a Servicemember who is going into
2 the IDES and the standardization of those
3 processes, which they identify in this report,
4 is they are working very hard on, it still
5 doesn't reach the family member.
6 Again, this Recommendation 16
7 talks a lot about the services delivery of
8 information to the Servicemember as they
9 participate in IDES. And I am not sure it
10 really gets at this family members' ability to
11 get that information if they aren't there at
12 these briefings.
13 So, again, they are revamping
14 their -- and you will see this in several
15 other recommendations, DoD is revamping their
16 standard briefing for Servicemembers as they
17 enter IDES. They are doing a lot of work to
18 train PEBLOS on what information is
19 distributed consistently across all the
20 services, whether it is an Army PEBLO or a
21 Navy PEBLO. They are investing a lot in each
22 one of those pieces.

1 This recommendation talked a lot
2 about -- the response and the Implementation
3 Plan talked a lot about delivery of this
4 information to the Servicemember and not
5 necessarily the family member.
6 Okay, Recommendation 17. Now this
7 one was very specific. This was about the
8 Exceptional Family Member Program and again,
9 you kind of pegged it to the entry to IDES.
10 And they talked about in this their current
11 efforts for the Exceptional Family Member
12 Program and the case managers for Exceptional
13 Family Member Programs and the case managers'
14 responsibility to deliver this information to
15 families who have exceptional family members.
16 They did talk about how they are
17 changing the training for PEBLOS and
18 reemphasized in this their intent to increase
19 training, increase standardization for the
20 PEBLOS. But in this recommendation, they
21 basically said this is a TRICARE
22 responsibility. It is a responsibility of the

1 Service and the Exceptional Family Member,
2 case members who have exceptional family
3 members and who are managing their cases to
4 keep Servicemembers informed on how these
5 benefits change when they move forward.
6 So now we have got different
7 responses. I know, for example, the Navy said
8 no. We have included the specific EFMP in our
9 checklist for our PEBLOS. So, we had some
10 different responses from the services in the
11 evaluation answer to the Task Force. DoD kind
12 of coalesced around keeping this as a
13 responsibility of the TRICARE and the EFMP
14 program.
15 So, Recommendation 18, keeping
16 families together. I mean this is kind of a
17 mom and apple pie recommendation and I think
18 it is a good lesson for us. I know the intent
19 of this recommendation was the Reserve
20 Component. And I think you have got to put
21 that language in the rec. You have got to put
22 that in the rec, not in the findings. And so

1 we need to be aware of that.
2 This was to address separation
3 that we saw at the Navy MEDHOLDs. It was also
4 to address separation we saw at the WTUs with
5 family members being assigned -- excuse me --
6 with Servicemembers being assigned to a WTU
7 and their family members are in another state
8 or in another location.
9 You know the WTUs have outreached
10 to those family members. It is tough for them
11 to outreach to those family members in a WTU.
12 And as we have seen as we visit the National
13 Guard Joint Forces Headquarters, it is also
14 difficult for the Joint Forces Headquarters to
15 outreach to family members in the WTUs that
16 might be residing in their state.
17 Many of the things they mention in
18 this recommendation as being available to
19 family members aren't available to the Reserve
20 Component Servicemember families. Yes, if
21 their Servicemember comes into Walter Reed,
22 they will receive the ITOs and they can

1 receive nonmedical attendant orders. Once
2 they are in a WTU and settled in a WTU, it is
3 difficult to get family members there at
4 anything other than the family member and the
5 Servicemember's expense.
6 So, your recommendation here had a
7 lot to do with try and keep them in their own
8 communities, if necessary, and to find ways to
9 bring Reserve Component families in the door.
10 Recommendation 19 was very pointed
11 and very directed to the NRD. They have
12 listed a number of responses here and they
13 were very similar to the responses in the
14 Evaluation Plan for the Department of Defense
15 and the efforts that they are taking on the
16 NRD. They talk about their current marketing
17 efforts. And they do not concur with the
18 naming, the renaming of the NRD. However,
19 they do have and outlined for you their
20 current marketing efforts. And they consider
21 this one closed also -- no. I think this one
22 is ongoing. They did not close this one.

1 Recommendation 20. How are we
2 doing on time here?
3 All right, installation-level
4 recommendation, installation-level
5 relationships with the Wounded Warrior
6 Programs. So, you have known and you have
7 determined over the years that probably the
8 most investment and the most time for, and the
9 most committed resources for family services
10 being delivered through the installation
11 family centers if the Army's SFAC, the Army's
12 Soldier and Family Activity Centers. They
13 consolidated a lot of resources in the Army in
14 these SFACs. However, this is not the norm
15 across all the services.
16 The next best Service that aligns,
17 according to your assessment, that aligns
18 Wounded Warrior Programs with the Community
19 Family Services is the Air Force. And all
20 those briefings that talk about financial
21 counseling and all those briefings that talk
22 about childcare and job placement and job

1 preparation for family members, the Air Force
2 takes a wounded warrior down to the Air Force
3 and Family Member Community Centers and they
4 sit down with an individual in the Air Force
5 and Family Member Community Center and they
6 get a briefing on all of those.
7 Your recommendation here was aimed
8 at getting the Navy and the Marine Corps to
9 emulate at least a better alignment with their
10 Community and Family Services Programs in this
11 recommendation so that those services could be
12 delivered to the Servicemember on let's say
13 front of the line function when the
14 Servicemember and family walks into the Family
15 Center, the Marine Family Center or the Navy
16 Fleet and Family Centers, so that wounded
17 warriors had front of the line privileges when
18 they went in these organizations.
19 So, you aimed this at trying to
20 align the Wounded Warrior Programs more
21 closely with the Community Family Programs.
22 Now, again, Air Force and Army are

1 very well aligned. I have information from
2 the Marine Corps that they were including
3 information in their Community and Family
4 Service policy to give Marines front of the
5 line services in the community centers, in
6 their Family Community Centers.
7 The Navy here outlines all the
8 things they do for family members and they
9 believe that now that they fall under their
10 Fleet and Family Service Centers as their
11 chain of command that they have got successful
12 alignment. The Navy is the only one who
13 hasn't put anything in policy.
14 But this recommendation documents
15 a lot of the Response Evaluation Plan from DoD
16 evaluates -- not evaluates -- provides their
17 current business practices.
18 Okay, Recommendation 21,
19 centralized case management for the Reserve
20 Component. This was an opportunity, as you
21 saw in 2012, to address those Servicemembers
22 who are remaining in their communities, those

1 Reserve Component Servicemembers who are
2 staying in their communities and to get them
3 the same services, particularly if they are
4 Category 2, staying in their communities, for
5 them to receive the same services a Category
6 2 will receive on active duty orders. And
7 your recommendation here was a centralized
8 case management. It was modeled after what
9 the Army Guard was doing in trying to manage
10 their ambulatory wounded, ill, and injured in
11 their communities and after the Air Force's
12 centralized case management for their Reserve
13 Component.
14 So, this response was a discussion
15 from DoD about what they are currently doing
16 to address the needs in the community for the
17 recovering warriors that are remaining in
18 their communities. And they talk about some
19 of their initiatives in here and how each
20 Service is managing it.
21 Recommendation 22, Reserve
22 Component recommendation. The Task Force

1 really wants to see a more speedy process of
2 getting Title 10 orders out to Servicemembers
3 who have identified medical needs that might
4 have stemmed from their service needs that
5 weren't identified during their opportunity to
6 access TAMP or needs that came up after some
7 of these benefits had run out. It was mostly
8 about just moving the process along a little
9 faster.
10 And the response here talks about
11 the consolidation and the rewriting and a new
12 DoDI that addresses incapacitation pay and
13 addresses the opportunities to get and who is
14 eligible for incapacitation pay and the line
15 of duty process.
16 Recommendation 23 was very, very
17 pinpoint. Again, it had to do with the Army
18 requirements to out-process their National
19 Guardsmen and Reserve Component back through
20 their home unit. Your recommendation here
21 sought to ensure that state Guard and Reserve
22 centers knew when an individual was being

1 either released back to their unit and ready
2 for duty or then they were being processed out
3 completely, had been retired through the DES
4 process.
5 The outline, and this is center-
6 focused on the Army, so this outlines what
7 they are doing, how the Army has changed their
8 practices, how the Army has changed their
9 checklist in order to ensure that this link,
10 this final link between the WTU and it was so
11 focused a lot on the WTU's feedback into the
12 state or the Reserve Center.
13 We are going to have to go back to
14 DoD on Recommendation 24. Recommendation 24
15 talks about the response to the Task Force's
16 Recommendation 24 talks about TAP, Transition
17 Assistance Program. Section 551 is Congress'
18 message to DoD to allow internships and to
19 allow training programs. So, this is really,
20 we had a briefing from Mr. Diogianni about the
21 publication he is trying to put out for
22 internships, training programs, preparing

1 individuals for their transition into the
2 civilian sector. They did not answer this one
3 correctly. They thought this was
4 implementation of the VOW Act and the
5 Mandatory Transition Assistance Program. So,
6 we will need to go back to them on that.
7 Okay, Recommendation 25 -- ten
8 more. All right, a lot of good information on
9 Recommendation 25 in their Implementation
10 Plan. This recommendation encapsulated your
11 believe in the VR&E program and its
12 integration into the day to day activities and
13 culture of the Department of Defense.
14 So, in this recommendation, you
15 recommended the expansion of the VR&E program,
16 the expansion of the Memorandums of Agreement
17 that were already out there. And even as you
18 were making this recommendation, there were
19 changes in the law that made it mandatory that
20 anyone going to IDES would also get a VR&E
21 briefing. And this recommendation is an
22 Implementation Plan. It talks about the

1 numbers who have been hired. It talks about
2 where they plan to go with these installation
3 visits and it has a pretty clear course for
4 who they are trying to bring onboard for VR&E.
5 The last thing here they talk
6 about is a DoDI that captures VA and DoD
7 participation in it in what you have been
8 advocating for, which is basically a permanent
9 document. The DoDI is an implementing set of
10 instructions. And the last bullet here talks
11 about when they want to finish that DoDI,
12 February 2014.
13 Okay, Recommendation 26 talks
14 about the VOW Act. It talks about the
15 Transition Assistance Program. Your
16 recommendation here was to create a new set of
17 documents a DoDI or update the DoDIs that had
18 not been updated since early 1990s and to
19 capture the new law that was included in
20 legislation.
21 And so they talk about the work
22 they are doing on that new DoDI and when its

1 estimated publication date is. They said the
2 new instructions should be published by
3 October 2013. We will gather statuses on the
4 dates that they have guidelines, milestones,
5 they have gathered. We didn't have time but
6 we will know by next year's report what they
7 met and what they didn't in these milestones
8 and implementation plans.
9 Okay, 27. Your intent in 27 was
10 to bring in the DoD higher level emphasis to
11 the very important initiatives that are going
12 on. At the time, these initiatives included
13 the new and start from scratch electronic
14 health record. And, at the time, you were
15 looking to bring a higher level of emphasis
16 from DoD to the IDES program across both
17 agencies. This requires, and you debated it
18 pretty heavily, you decided to go forward with
19 a legislative change.
20 DoD nonconcurs with this. They
21 think that the Under Secretary of Defense for
22 Personnel and Readiness is sufficient level to

1 link in the JEC, within the Joint Executive
2 Council with the Deputy VA Director, the
3 Deputy of the VA, to bring about, to
4 supervise, to ensure consistent sustained
5 attention on the very important cross-agency
6 issues.
7 So, bring the Deputy Secretary of
8 Defense into the JEC as the co-chair was
9 nonconcurred with. The DoD feels that the
10 Under Secretary of Defense for Personnel and
11 Readiness is the appropriate level to co-chair
12 with the Deputy Director of the VA.
13 So, Recommendation 28 was an IDES
14 recommendation. Each one of the services
15 right now has a process for ensuring that the
16 individuals who go into the IDES are truly
17 going to leave the military, that their
18 conditions are severe enough that they will
19 not be able to medically retain them and that
20 they will not be able to meet medical
21 retention standards.
22 So, in this recommendation, you

1 have urged them to continue these processes
2 that only individuals who are not going to be
3 able to meet retention standards are going
4 into the IDES. And each Service has a
5 different process for doing that. And as we
6 have gone out on the site visits, we have
7 looked at those processes.
8 All right, Recommendation 29. So,
9 this one is almost at fruition. This
10 recommendation was to create a case management
11 system in IDES and a single way to manage the
12 records that are being included in an IDES
13 packet.
14 And they reference in this
15 recommendation their current initiative, which
16 is the Healthcare Artifacts Information
17 Management Solution and they indicate that it
18 is and has been fielded. And we saw it at
19 several locations. We saw it in particular
20 when we were out in San Antonio last fall.
21 And they are expecting that it will be widely
22 available and widely used in the fall of 2013.

1 Next recommendation again is an
2 IDES recommendation and it talks to the survey
3 program that the Warrior Care Policy Office
4 has implemented. In particular, I mean you
5 all know and you have seen many of their
6 survey systems, your concern here was that it
7 would be reincorporated back into the survey
8 system and that it is used to improve the
9 process.
10 So, they concur with this one and
11 they talk about what efforts they are doing to
12 ensure that this very important survey, which
13 is a touch point is its results are taken and
14 its results are incorporated back into
15 improving the process.
16 All right, Recommendation 31, IDES
17 recommendation. We had input from the
18 services that including the Terminal Leave in
19 the total time and total goals for the
20 Department of Defense's IDES program was not
21 reflecting of how long it really is taking an
22 individual to go through the process.

1 Now, they decided to keep that
2 Terminal Leave time frame in there. However,
3 when you look at these goals and you look at
4 the time frames that are being accomplished in
5 moving towards these goals, they basically
6 said we can take those 30 or 60 days out of
7 the time line. We can evaluate it by just
8 pulling those numbers out or we can leave them
9 in and you have a comprehensive picture, or we
10 can pull them out and you can look at them
11 that way.
12 But their response was we don't
13 want to pull those leave dates out from the
14 total goal because we think we lose a real
15 honest look at how long it takes for someone
16 to walk out the door.
17 Recommendation 32. About the same
18 time we were making this recommendation, which
19 was to consolidate the PEB, a formal PEB at a
20 joint level, and we didn't make the
21 recommendation they do it, we made the
22 recommendation that they consider it, Congress

1 was also giving them guidance on looking at
2 the IDES system. So in their response to
3 this, they talk about their response to
4 Congress and the options that they have
5 presented to Congress for changing the IDES
6 process, not changing benefits, not changing
7 the disability, but in changing and
8 consolidating certain locations. And so they
9 also identify in their response that they are
10 considering and have options for consolidating
11 certain parts of the IDES.
12 All right, Recommendation 33, an
13 IDES recommendation also. You were not
14 satisfied with the various formulas that were
15 being executed to determine PEBLO rates out
16 there. And in Recommendation 33, you talked
17 about a different and better ratio. Along
18 with Recommendation 32, when they are looking
19 at the various ways to redesign IDES, they
20 also included in that report to Congress their
21 study of the PEBLO workload. They included in
22 this recommendation in response to us and a

1 report to Congress the new ways in which they
2 can provide ratios in the PEBLO process. And
3 so they are looking at it and they think like
4 February 2014 they will have finalized the
5 PEBLO piece of the report to Congress.
6 All right, Recommendation 34. In
7 this recommendation, this is your lawyer
8 outreach to Servicemembers in the IDES
9 process. And you have made a recommendation
10 here that the lawyers have 100 percent
11 outreach to Servicemembers. Their response in
12 the Implementation Plan kind of leaves this,
13 again, it kinds of leaves the responsibility
14 on the PEBLO and the Service to inform the
15 Servicemember that PEBLOs -- excuse me -- to
16 inform the Servicemember that a lawyer is
17 available, that an independent medical review
18 is available. Your intent here was that the
19 lawyers be given tools and outreach and lists
20 so that they could independently of that
21 information being passed to the Servicemember
22 reach out to IDES participants. They outline

1 here for you each Service's efforts to ensure
2 the training of the PEBLO, to ensure that they
3 have the information for the PEBLO to refer
4 the individual to the IDES lawyers.
5 And the last one, Recommendation
6 35. Recommendation 35 addressed interagency
7 collaboration, interagency cross-education.
8 And you also had here in the same
9 recommendation was everyone should be signed
10 up for eBenefits. Their response was centered
11 mostly on and the Implementation Plan is
12 centered mostly on the eBenefits piece, the
13 early integration of individuals into the
14 eBenefits program. A number of people who
15 have signed up for eBenefits. And based on
16 that, what they consider a very high level of
17 participation, they have currently 2.4 million
18 individual users who have registered in
19 eBenefits and that is about 31 percent of the
20 DoD population. They feel that this is the
21 portal and the best way to keep individuals
22 informed about DoD and VA benefits. And

1 because they have gone down this route with
2 the eBenefits portal, that they don't need to
3 incorporate it into the noncommissioned and
4 the officer's education programs as you also
5 included as part of the recommendation.
6 CO-CHAIR CROCKETT-JONES: I think
7 that we might want to note that they basically
8 said that they rely on the NRD, NRCC training
9 as their vehicle for getting information out.
10 And I have to say, we found those to be two
11 areas that were a bit lacking. So, this might
12 be something that we have to keep assessing,
13 since they are relying on programs that are
14 not performing well. So, I think we should --
15 you know, that is something to note that they
16 felt that these are sufficient because of
17 these actions but they are relying on programs
18 that are not really performing sufficiently.
19 MS. MALEBRANCHE: And I have to
20 agree with Suzanne. The other thing that it
21 is noting is it all on the benefit side, not
22 on the health side. It is not My Healthy Vet,

1 it is all eBenefits. So, there are some
2 differences there that they might not get from
3 the other. So, the intent was the whole of
4 VA, not just the benefits positions.
5 So, I think this year as we talk
6 to folks, perhaps we could look at that.
7 EXECUTIVE DIRECTOR DAILEY: Okay.
8 MS. MALEBRANCHE: And then as a
9 side note, just for consistency sake
10 throughout the recommendations and comments,
11 the Interagency Care Coordination Committee is
12 sometimes referred to as Integrated but it is
13 Interagency Care Coordination Committee.
14 EXECUTIVE DIRECTOR DAILEY: Okay.
15 MR. REHBEIN: If I may make one
16 more comment to follow up with that.
17 EXECUTIVE DIRECTOR DAILEY: Yes.
18 MR. REHBEIN: I think what we see
19 here reflects a basic lack of understanding in
20 the DoD of the VA because, in our
21 conversations with some of the military folks,
22 I get the impression that the DoD thinks that

1 there is one VA and there is not one VA, any
2 more than there is one DoD. So that sort of
3 cross-understanding is really what needs to be
4 developed here. I think that was part of the
5 professional development part of it.
6 EXECUTIVE DIRECTOR DAILEY:
7 Exactly, yes. Yes, there will be more
8 opportunities in more depth to understand what
9 each agency, in particular the VA's mission
10 was.
11 Okay, I am going to release you
12 for a break. I'm not sure -- I don't have my
13 agenda in front of me. We either 15 minutes
14 on time or 15 minutes behind.
15 CO-CHAIR CROCKETT-JONES: We are
16 15 minutes behind but we should still take a
17 break.
18 EXECUTIVE DIRECTOR DAILEY: Okay,
19 break time. Thank you, ladies and gentlemen.
20 CO-CHAIR CROCKETT-JONES: Thank
21 you, Denise.
22 (Whereupon, the foregoing

1 proceeding went off the record at
2 10:15 a.m. and went back on the
3 record at 10:30 a.m.)
4 EXECUTIVE DIRECTOR DAILEY: Ladies
5 and gentlemen, can I get the Task Force
6 members to return to their seats, please?
7 CO-CHAIR CROCKETT-JONES: Before
8 we begin briefings, we will receive a
9 presentation from Mr. Kunz and Dr. Lederer,
10 members of our Task Force Research Team on our
11 focus group protocols for the upcoming fiscal
12 year. The focus group protocols provide us
13 with guidance on specific questions and topics
14 to discuss during all of our installation
15 visit focus groups. It delivers a standard
16 template for the members to follow to ensure
17 each experience has the same objective goal.
18 We have information under Tab C
19 and those of us who have conducted focus
20 groups know it is essential to being able to
21 get through a lot of information in the focus
22 groups. So, we are happy to hear from you.

1 DR. LEDERER: Good morning,
2 everyone. It is kind of interesting going
3 from the last hour to this one. We were
4 looking big picture at results,
5 recommendations from last year and now we are
6 zooming in with a focus on the coming year at
7 a very granular level. And it is just me.
8 John has turfed this to me this morning.
9 So over the past three years, you
10 all have conducted about 83 focus groups, by
11 my count. And you have talked with about 630
12 plus individuals.
13 In the most recent report, it was
14 interesting for me to discover that of your 21
15 recommendations, over half of them cited focus
16 group results. So, clearly, the focus group
17 results are strongly influencing your
18 impressions and your recommendations. By the
19 same token, you are also balancing those
20 results with information from other sources.
21 When I looked at the total number of end notes
22 in the FY13 report, there were 403. Only 75

1 of those were focus group or focus group mini-
2 survey results. So you are balancing the
3 focus group results, which are sort of the
4 centerpiece of your data collection efforts
5 with information from other sources.
6 So, the purpose of this half hour
7 or so is to refresh your considerable
8 knowledge of the RWTF's focus group
9 methodology, mostly touching on the high
10 points. It has been eight months since your
11 last focus groups, so hopefully, this will
12 help you dust off those cobwebs and set you up
13 for another successful year of focus groups.
14 These are the topics that we will
15 touch on. These three principles, respect,
16 beneficence, and justice are basically the
17 ethical framework for research with human
18 subjects. And they are outgrowths of the 1974
19 National Research Act and a subsequent report
20 in 1979 known as the Belmont Report. So, I
21 would like to talk with you about how we, as
22 a Task Force, operationalize these principles

1 during the focus groups.

2 Respect for persons and for their

3 individual autonomy is mostly about informed

4 consent. And there is a lot of informed

5 consent material built into your kickoff

6 script. We talk about the purpose of the

7 focus groups, how they are going to work, and

8 provide them enough information so that they

9 can make a decision about whether or not they

10 want to participate. But we all know that

11 many of the Servicemembers, at least, have

12 been voluntold, as opposed to truly

13 volunteering to attend. So the way we deal

14 with this, is by telling them that they may

15 have been voluntold but now that they are here

16 in the focus group, their level of

17 participation is entirely up to them. And

18 there will be no consequences attached to a

19 lot of activity from them or silence from

20 them. We also have an informed consent form

21 for them to read and sign.

22 Beneficence basically is do no

1 harm, take steps to avoid causing unnecessary
2 stress. And we do this, we consider this when
3 we are writing the discussion questions. We
4 also consider this when we are moderating and
5 we are encouraging people to participate. We
6 don't push too hard or put them in an awkward
7 position. We consider this also as we are
8 monitoring interactions among focus group
9 participants. If we see badgering, for
10 example, we intervene.
11 The third, justice, is basically
12 assuring that we are impartial moderators, who
13 provide an equal opportunity to participate to
14 all of the people in the focus groups. We
15 don't play favorites. We don't reveal our
16 agreement or disagreement with what they have
17 to say.
18 Another very important area that
19 plays into both respect, autonomy, and
20 beneficence is safeguarding privacy and the
21 confidentiality of the participants' data.
22 And we spent a lot of time on this, as you

1 will remember, in that kickoff, to ensure they
2 know how much privacy and confidentiality they
3 can count on and to choose to regulate their
4 level of participation accordingly.
5 The IRB, Institutional Review
6 Board, that 1974 National Research Act, also
7 provides guidelines for the establishment of
8 IRBs, which are required of all agencies
9 conducting human subjects research and
10 receiving federal funds. And the IRB,
11 essentially, is required to review research
12 plans and instruments, in order to assure that
13 all steps appropriate are being taken to
14 protect the well-being and the rights of the
15 human subjects participants. As we have done
16 now for the past three years at the start of
17 this fourth year also, the ICF IRB reviewed
18 all of our research plans for this current
19 year and approved them.
20 Two final points related to human
21 subjects research, the first being adverse
22 events. It hasn't happened often, but

1 occasionally something comes up within the
2 focus group that make you, as a moderator,
3 concerned for the well-being or the privacy of
4 the participants, one in particular,
5 typically. It is a rare occurrence but we
6 want to remind you that we do have a form and
7 a process when and if that occurs. And we
8 won't spend any time on it now because it is
9 so rare but please know that your scribe and
10 Ms. Dailey are available to assist if this
11 comes up.
12 The last thing with respect to
13 federal policy on human subject research is
14 that IRB requires that you sign a
15 confidentiality agreement each year. And you
16 have one in the inside pocket of your binder.
17 So, at your convenience, if you would read it
18 and sign it and get it back to me or any
19 member of the research team, we would
20 appreciate that.
21 Your role in the research process
22 -- in all honesty, I don't feel all that

1 comfortable talking to you Task Force members
2 about your role, but I am supposed to. You
3 wear many hats. Obviously, you are here
4 because of your expertise. But within the
5 confines of the focus group, which is a data
6 collection event, you are not here to share
7 your expertise, rather you are here to receive
8 information.
9 The right time to share that
10 expertise and to transmit information that you
11 may have for the participants would be
12 afterwards.
13 The active guardian of participant
14 privacy, I can't highlight that enough.
15 Throughout your stay on-site and even beyond
16 the site visit, you need to be very vigilant
17 about safeguarding the identities of those who
18 have participated, as well as what they have
19 said. Because we pledge to them never to link
20 what they have said to their names. And we
21 need to be careful, especially during the out-
22 brief, when you are talking with Command about

1 local issues. I know you wouldn't reveal
2 names but in your effort to communicate you
3 may inadvertently reveal too much identifiable
4 information that would allow Command to piece
5 together who you are talking about; the guy
6 with triplets.
7 Even outside of the out-brief, we
8 need to be vigilant. In the dining facility,
9 if you are having a conversation about the
10 focus group you just conducted, or in the
11 hotel lobby, or even in the focus group room
12 between sessions, the site POC may be coming
13 in and out. You just have to be very vigilant
14 about this.
15 We move now to the focus group
16 parameters. You all know very well, at this
17 point, what a focus group is. And you know
18 that carefully planned discussion in a
19 targeted area of interest is accomplished
20 through those discussion questions in the
21 protocol. But how do we achieve that
22 permissive and nonthreatening environment?

1 Nobody wants to speak up? Okay.
2 How do we? Well, we talk in the kickoff, if
3 you recall, and it has been eight months, we
4 talk about how there are no right or wrong
5 answers. We want to hear the good and we want
6 to hear the bad as well. And even if you have
7 a thought that is different from what other
8 people are saying, we welcome that also. So,
9 what we say helps to facilitate that
10 permissive environment but it is also a body
11 language. We lean in. We provide eye
12 contact. We don't appear impartial.
13 Three focus groups per site. We
14 were counting up last week. And that might be
15 more the exception than the rule this year.
16 We have some anomalous sites and we will have
17 two in one place and five in another. So,
18 that will keep us all on our toes. And do
19 recall that there are no extraneous observers
20 allowed in these focus groups, only Task Force
21 staff and members and the participants, of
22 course.

1 CO-CHAIR CROCKETT-JONES: Suzanne,
2 can I ask you something?
3 DR. LEDERER: Yes, please.
4 CO-CHAIR CROCKETT-JONES: We
5 sometimes have, we have had more than once,
6 where a Servicemember wants to be in with a
7 family member in a family member focus group
8 or a family member wants to be in with the
9 Servicemember. And I know it has been
10 difficult. I find it difficult to handle
11 this.
12 It is hard to combine that sense
13 of this is a permissive and nonthreatening
14 environment with a clear hard and fast rule
15 about having someone with you. I think that
16 if someone is a designated caregiver, I think
17 that that is clear, I think that they should
18 be then in, if that Servicemember wants them
19 in. I think that is sort of they might
20 actually physically need that person there.
21 But do you have any
22 recommendations on language to enforce the

1 rules? And also, in collating the data, does
2 it taint it to have those other people there?
3 And if so, should we just have no
4 participation rather than sort of tainted
5 participation?
6 DR. LEDERER: Great question. And
7 from what I have observed, I think you all
8 have handled it appropriately. Some people
9 need that person there. And what I would be
10 inclined to say, and I think I have heard you
11 all do this, is something like well, this
12 really is a focus group intended only for
13 recovering warriors. We have another focus
14 group for family members and we would love for
15 you to come. That is in two hours from now.
16 If they still seem reluctant to leave, say
17 that is fine, we understand. We ask that you
18 listen to our expectations in terms of
19 privacy. We need you to follow the same
20 rules. We need to sign an informed consent.
21 And by and large, we are looking to hear from
22 the recovering warrior more than the family

1 member.

2 And then our scribes, in terms of

3 tainting the data, our scribes will flag the

4 family member and will not use those data.

5 So you are real familiar with the

6 instruments at this point. We have the two

7 focus group protocols and we have the two

8 mini-surveys. As you will recall, the focus

9 group protocol has basically four parts.

10 There is that kickoff, which is lengthy; the

11 warm-up questions, where they get to introduce

12 themselves; the body of the protocol, which is

13 those discussion questions; and then there is

14 a you will conclude the group, rather than

15 just splitting. You will wind it down.

16 And I would like to impress upon

17 you that the protocols provide consistent

18 questioning, which is really very, very

19 helpful. It allows from moderator to

20 moderator, session to session, and location to

21 location the same questions, basically, to be

22 asked, which are then eliciting the same types

1 of responses that can be grouped and compared.
2 And it is these types of comparable responses
3 from which we can identify things, i.e.,
4 results that then inform your impressions and
5 your recommendations and support them in the
6 report. So, very important to the extent
7 possible to use those scripted questions.
8 The purpose of the mini-survey is
9 two-fold. We use it to capture demographic
10 information about the participants. And in
11 your report, this information is summarized in
12 the appendix. We also use the mini-survey to
13 capture some quantitative data that
14 compliments the qualitative data that we get
15 through the discussion, such as ratings of the
16 helpfulness of various case managers or
17 various information resources.
18 We change the instruments
19 minimally from year to year, in order to allow
20 the opportunity to compare results across. We
21 do, however, change them somewhat and this
22 year is no different. We did do some

1 tweaking. Rather than spend time on that now,
2 let me tell you that it is minimal tweaking
3 but enough that you will want to read your
4 protocols thoroughly and become familiar with
5 the new flow. They are improved. They are
6 streamlined. But you need to read it and
7 hopefully, there will be time the night before
8 the first site visit to review in greater
9 detail what the changes are.
10 The family member protocol changed
11 somewhat as well. And the mini-survey,
12 really, was more of a formatting change than
13 anything else.
14 So in addition to these protocols
15 and these mini-surveys, there are other
16 materials that I am sure you may remember. I
17 just want to refresh your memory about them.
18 We have the consent form that will be
19 distributed, the mini-survey that will be
20 distributed, those warm-up questions, the form
21 that lists local counseling resources, a name
22 tent. Your scribe will assist you with

1 distributing these materials to the various
2 places at the table. And we just ask that you
3 do not start the discussion until the scribe
4 is back at the keyboard and ready to scribe,
5 which is what they are there for, primarily.
6 In terms of the disposition of
7 these materials, this year we are going to
8 collect the consent form and the mini-survey
9 as soon as they are done with it, not at the
10 end of the session. And then as far as the
11 other materials are concerned, what is most
12 important is that you destroy the name tent.
13 And they can take the counseling resources and
14 the RWTF brochure with them, if they would
15 like. We would like them to do that, in fact.
16 So when the group is over, you
17 will not only encourage them to take along
18 those two remaining documents but you can also
19 seize the opportunity to remind them to
20 safeguard what they have heard during the
21 discussion and not to talk with other people
22 about what they have heard inside the room.

1 The richness of the focus group
2 discussion, the productivity of a session is
3 not just a function of the questions you ask
4 but it is also a function of how you interact
5 with the participants, the atmosphere that you
6 foster. So, I would like to talk with you
7 briefly about engagement. Mostly simply to
8 remind you that you need to actively engage
9 them when they walk in the room and manage
10 their expectations. Oftentimes, we find that
11 they think they are coming to a class or they
12 think they are coming to fill out a survey.
13 They don't know that this is going to be a
14 structured discussion with some give and take.
15 They are not prepared for that. Sometimes
16 they sit idly waiting for the session to
17 begin, use that time constructively, let them
18 fill out the survey, first the consent form,
19 talk with them.
20 When you start the kickoff, ask
21 them to put the surveys down. They really
22 can't do both at the same time. They are not

1 listening to you and that important
2 information in the kickoff, if they are
3 working on the survey. And neither are they
4 filling out the survey accurately. So, it is
5 a lose-lose situation.
6 Be prepared for the late arrivals,
7 the stragglers. Have a plan. Basically, I am
8 inclined to say thank you for coming. This is
9 a structured discussion. I need you to read
10 and sign this consent form and do the mini-
11 survey when we are all done in 90 minutes. Do
12 not restart your kickoff. You don't have time
13 for that.
14 The key to engagement is, and you
15 have probably already discovered this, knowing
16 that protocol, being super familiar with the
17 content and the flow. And that will allow you
18 to interact with them in a spontaneous natural
19 way and sustain their attention.
20 So, these are the roles. How are
21 we doing on time? Okay. There is a lot more
22 to moderating than just asking questions. You

1 have a lot of balls in the air, if you are
2 doing this conscientiously or as
3 conscientiously as possible. You are managing
4 the atmosphere as well as the content.
5 Anything you would like to talk
6 about with respect to these various roles that
7 you are juggling as a focus group moderator?
8 If I have to single out one, I
9 think it would be this one right here,
10 evaluating the response and following up as
11 necessary. It is easy to get into the routine
12 of simply asking the questions and knowing
13 that the scribe is recording the answers and
14 then moving on to the next question. But you
15 really need to listen to what they are telling
16 you, evaluate how they responded. Do you
17 understand it? Have you heard from enough of
18 them before moving on to the next question?
19 That is how we elicit useful focus group data.
20 Sir?
21 MR. REHBEIN: That is a real
22 juggling act. Because if you get into a focus

1 group of ten, twelve people, 90 minutes is
2 pretty tight.
3 DR. LEDERER: Absolutely.
4 MR. REHBEIN: And if there is much
5 follow-up that needs to go on, you come to the
6 end of the protocol and you find that you are
7 rushing through that last bit.
8 So that follow-up, in some ways is
9 a --
10 DR. LEDERER: Double-edged sword.
11 MR. REHBEIN: Yes.
12 DR. LEDERER: I agree, it is a
13 juggling act. And it is a bit of an art as
14 opposed to a science figuring out how far to
15 probe, how much time to spend on a given
16 question, realizing that you may end up
17 sacrificing other questions. It is not easy.
18 On the other hand, one-word
19 answers from one out of ten people present
20 really are not useful. I wish I had a
21 solution. More time, I suppose, or a shorter
22 kickoff but IRB required all of that

1 information in that kickoff.
2 Effective moderator behaviors are
3 those that work well and that you want to
4 cultivate and be attuned to. And less
5 effective are obviously habits, bad habits
6 that we all have that we also want to be
7 attuned to and try to curb.
8 And it has been eight months since
9 your last focus groups. It is a good
10 opportunity to think about what did, you do
11 well, and what did you do less well, and what
12 do you want to do differently in the coming
13 year.
14 Any thoughts on which of these
15 various behaviors are particularly useful to
16 you or techniques that work for you?
17 CO-CHAIR CROCKETT-JONES: I really
18 like checking for congruent opinions when we
19 are kind of stuck in a one-word answer mode,
20 to see, monitoring and just asking people to
21 do something like raise your hand if that is
22 your experience, too. It kind of gives you an

1 idea if this is a solo or people aren't
2 talking because somebody just summed it for
3 them.
4 DR. LEDERER: Yes. Actually,
5 thank you. You could have been a student.
6 That is the one that -- a stage person as
7 opposed to a student, perhaps. That is the
8 one of all of them that I was going to
9 highlight for you that is so important.
10 Matt McDonough back there -- raise
11 your hand -- is our focus group analyst. And
12 it is really not helpful to have one-off
13 comments. We need to know what the prevailing
14 sentiment and the common experiences are
15 within the group. Time doesn't permit to go
16 one by one and have everyone answer,
17 admittedly. But if you can check for whether
18 or not what is being said here resonates for
19 the other participants, that is very, very
20 helpful from a data analysis and results
21 generating purpose.
22 So we would say things like we are

1 interested in all points of view. What about
2 the rest of you? Has your experience been
3 similar? Raise your hand if it has been the
4 same for you. And these hand counts, these
5 tallies are very useful to us.
6 This is about striving to be self-
7 aware and we are happy to talk with you about
8 these behaviors offline. We have some
9 additional materials, also, if you are
10 interested.
11 You are a team, your scribe and
12 you, the moderator. And this year, we are
13 very happy to be able to tell you that you
14 will have the same veteran RWTF scribes as
15 last year. You have Ashley Schaad, who
16 actually only went on one trip, one or two,
17 one really -- two trips last year. And we
18 also have Mike Inman, Ashleigh Davis and Sam
19 Golenbock. So, they are seasoned. They are
20 experienced. They are there to assist you.
21 At the same time, they would
22 appreciate it if you would assist them. Those

1 ground rules are very important that you let
2 the participants know that they should talk
3 one at a time and loudly enough and no sidebar
4 conversations. And if you would please
5 reiterate that during the course of the
6 discussion, if necessary, the scribes will
7 appreciate it.
8 The scribes find it very helpful
9 if you are pretty true to the protocol. If
10 you check for congruence and contrasting
11 views, if you count those hands and if you
12 repeat the more obscure acronyms and slang,
13 they may or may not be familiar with. At this
14 point, they are pretty savvy military
15 vernacular-wise. But if you would just repeat
16 it so that even if they don't understand it,
17 if they can get it down semi-accurately, that
18 would be helpful.
19 The example we had last year was
20 somebody referred to getting their rocker and
21 that was easy enough to type but we didn't
22 know what it referred to and it was the bar of

1 the NCO stripes.
2 Exactly 11:00. Any questions,
3 comments? Thank you very much for your
4 attention. I wish you the best of luck this
5 year with your focus groups.
6 We do have some ancillary
7 materials, if any of you are interested.
8 CO-CHAIR NATHAN: Thank you very
9 much. We appreciate that. And I apologize
10 for being late but I came in, obviously, for
11 the most important part.
12 (Laughter.)
13 CO-CHAIR NATHAN: So, at this time
14 if we are ready to go with the next session,
15 I am getting the nod that we are, we are going
16 to welcome Mr. Stephen Wurtz, who is the
17 Acting Deputy Director of the VA Insurance
18 Center, with Ms. Kristan Hoffman, who is an
19 Insurance Specialist at the VA Insurance
20 Center and Commander Kirsten Martin, who is
21 the Assistant Director of Military
22 Compensation with OSD. And they will be

1 discussing the Traumatic Servicemembers' Group
2 Life Insurance, otherwise known as TSGLI.
3 Mr. Wurtz and Ms. Hoffman will
4 provide an in-depth overview of the TSGLI,
5 including the process of how recovering
6 warriors can learn about and access the TSGLI
7 information.
8 So, if you would please reference
9 Tab D for their information. And do we have
10 somebody on the phone as well?
11 EXECUTIVE DIRECTOR DAILEY: Yes,
12 sir. On this particular briefing, the VA will
13 be briefing and they will be providing a
14 telephonic briefing.
15 Commander Martin is sitting up
16 here at the table. It is really a VA program
17 and it is interfaced through OSD through
18 Commander Martin's Office and the Services
19 actually execute the program.
20 So, we will have VA online in just
21 a minute here.
22 (Pause.)

1 MS. HOFFMAN: Yes, Stephen Wurtz
2 and myself are both here.
3 MR. WURTZ: Yes, it is coming
4 through on our end. We hear you well, kind of
5 foggy. So, if we have to ask you to repeat,
6 you will understand.
7 EXECUTIVE DIRECTOR DAILEY: We can
8 hear you fine.
9 CO-CHAIR NATHAN: Please start
10 your presentation.
11 MR. WURTZ: Thank you. So, I am
12 Stephen Wurtz. I am the Deputy Director of
13 the VA Insurance Center in Philadelphia. We
14 have nationwide responsibilities for managing
15 all of the government's life insurance
16 programs designed to protect Veterans,
17 Servicemembers, family members. We started
18 World War I, different programs for World War
19 II, Korea. We have several programs still
20 open to new issues. Here at the VA insurance
21 center for mortgage assistance to especially
22 adapted housing recipients and service-

1 connected disabled Veterans to buy insurance.
2 Today's program, however, is going
3 to concentrate on what we call our supervised
4 programs. In 1965, the Secretary of Veterans
5 Affairs, by statute, bought a group insurance
6 policy from Prudential Insurance Company to
7 provide insurance coverage at the beginning of
8 the Vietnam War. That program has since grown
9 in both size and scope; $10,000 of life
10 insurance is now $400,000. And at first it
11 was only Servicemembers' active duty, then it
12 was reservists were added over the years and
13 family coverage was added. And the most
14 recent major benefit was the Traumatic Injury
15 Protection Provision, which is the subject of
16 today's meeting.
17 So, feel free to interrupt with
18 questions as we move along but I am going to
19 start. We have, I think, just about eight
20 slides. And Kristan Hoffman is going to go
21 over the basics of what the program provides,
22 the rules, and then I will touch base on the

1 history and more about how the program is
2 operated.
3 Kristan?
4 MS. HOFFMAN: Okay, thank you,
5 Steve.
6 Again, if you have any questions,
7 feel free to interrupt. And if you can't hear
8 me or there is something with the audio,
9 please let us know.
10 Let me start with we are on slide
11 1 in the slide deck that you were provided
12 which is titled "What is TSGLI?" I am going
13 to use the acronym TSGLI. That stands for the
14 SGLI, Servicemembers' Group Life Insurance
15 Traumatic Injury Protection Program.
16 The purpose of the program, and
17 Steve will talk a little bit later about how
18 the program came about, but our key purpose is
19 what I have noted on the slide, which is
20 short-term financial assistance to severely
21 injured Servicemembers and Veterans to assist
22 them in their recovery from traumatic

1 injuries.
2 So I want to make clear of the
3 term "short-term." It is designed to focus on
4 their financial needs immediately after their
5 injury, so that they, themselves and their
6 families do not incur any financial cost
7 during their time of recovery. It is, in no
8 way, designed to provide for the long-term
9 benefits that are already provided by other VA
10 and military programs.
11 Also to note that it is
12 Servicemembers and Veterans. I just want to
13 clarify that in a couple of minutes to
14 understand what we mean by Veterans in that
15 group.
16 Number two, it is a rider or a
17 program provision of Servicemembers' Group
18 Life Insurance. Steve just noted to you that
19 in 1965, the program began called
20 Servicemembers' Group Life Insurance, which
21 provides $10,000 of life insurance. So
22 insurance when a Servicemember, Reservist,

1 Veteran passes away and if their benefit is
2 provided to their named beneficiary.
3 That program now offers $400,000
4 of life insurance. Any member who has SGLI,
5 and that coverage is automatic upon entry into
6 service, or any change of duty status moving
7 from active to Reserve or Guard, or vice-
8 versa, or if the member say decided at some
9 point they didn't want the SGLI coverage and
10 came back and applied to have it restored.
11 Anytime that SGLI is in force, the TSGLI is in
12 force. What that means, in short, is someone
13 can't say I just want TSGLI. They have to
14 have SGLI to have TSGLI.
15 MR. WURTZ: They have to have
16 TSGLI.
17 MS. HOFFMAN: They have to have
18 TSGLI. They cannot be separated from each
19 other.
20 The cost of the TSGLI is $1 per
21 month and that is added to the existing SGLI
22 premium that a member is charged. That shows

1 up on their LES. Some branches include it all
2 as one. So for instance, most members have
3 $400,000 of SGLI coverage. That will be $26
4 a month.
5 Would somebody have a question
6 there? I'm sorry. I just heard something.
7 Okay, $26 a month would be the
8 cost for $400,000 of coverage today. A dollar
9 would be added to that for a total of $27 a
10 month, if they had $400,000 of coverage. That
11 is what most members are going to see on their
12 LES.
13 CO-CHAIR NATHAN: This is Admiral
14 Nathan. Can I ask a quick question?
15 MS. HOFFMAN: Sure.
16 CO-CHAIR NATHAN: Do you have to
17 opt in or opt out for this or is it automatic?
18 MS. HOFFMAN: No, you have to opt
19 out. It is automatic once you receive the
20 SGLI. So you can't opt out of TSGLI
21 individually at all or opt in. You get SGLI
22 automatically. If you don't want SGLI, you

1 have to opt out of it. If you opt out of it,
2 you automatically don't have TSGLI either.
3 Does that make sense?
4 MR. WURTZ: TSGLI and SGLI, you
5 can't have TSGLI without SGLI. And you can't
6 have SGLI without TSGLI.
7 MS. HOFFMAN: They are
8 inextricably linked, if that makes it any
9 clearer.
10 CO-CHAIR NATHAN: Got it. Thank
11 you.
12 MS. HOFFMAN: Okay. The cost is
13 $1 per month and that dollar is designed to
14 cover only the civilian incidence rate of the
15 injuries that are occurring. That truly is
16 not charging members for what we are calling
17 extra hazards or the military risk they take
18 for those injuries. Those additional costs
19 are paid for by the branches of Service based
20 on actual claims each year.
21 The benefit that can be provided
22 through this program, meaning if you have the

1 coverage which we just talked about and you
2 are injured, which I will go into, you can
3 receive a maximum per event, and we will talk
4 about in a moment what a traumatic event is,
5 is $25,000 to $100,000. And those are based
6 on the types of injuries or losses that you
7 suffer. And I will talk about them.
8 And basically they can receive,
9 depending on the nature of the injury, a
10 $25,000 payment, a $50,000 payment, $75,000
11 payment and $100,000. There is nothing like
12 we are going to provide you $35,000. That is
13 not a loss that is provided but the range is
14 that.
15 The other really important thing
16 that we like to emphasize to anybody we speak
17 to is it is a combat and noncombat benefit.
18 Many people initially in the program thought
19 there was a combat benefit. We did an
20 extensive amount of outreach, public service
21 announcements, a range of things to try to
22 dispel that rumor.

1 So, just to give you two examples,
2 if somebody is injured in Afghanistan by an
3 RPG and loses their arm due to it, they are
4 covered by this program if they have the SGLI
5 coverage. That same person, instead, is
6 injured driving their car in a motor vehicle
7 accident Applebee's with their family. And
8 they are a Reservist and they were driving and
9 they lose their arm. They are going to be
10 paid the same exact benefits as someone who
11 was injured in combat.
12 Last but not least on the first
13 slide is this program began on December 1,
14 2005. However, it has a retroactive provision
15 that was in effect from the beginning. And
16 that is from 10/7/01, the startup Operation
17 Enduring Freedom through 11/30/05. Was there
18 a question?
19 CO-CHAIR NATHAN: No.
20 MS. HOFFMAN: Okay. Sorry, there
21 is some noise and I don't want to avoid a
22 question.

1 What I do want to say on this
2 briefly is for anybody that knows about the
3 program, the initial retroactive period when
4 the law went into effect in December 2005
5 limited that retroactive period only to those
6 who were injured in support of OEF OIF. That
7 has since changed by a subsequent law change
8 and now in that retroactive period, anyone who
9 was injured, whether in support of OEF or OIF
10 or not during that retroactive period can be
11 paid a benefit.
12 Okay, I am going to move on to
13 slide 2, which is kind of the meat and
14 potatoes of the program, which qualifying for
15 a TSGLI benefit and that is slide number 2.
16 To be eligible for payment and let
17 me just separate it. We talked about when you
18 are covered on the last slide if you SGLI.
19 Just because you are covered, just like life
20 insurance, does not mean you are going to
21 receive a benefit. You would receive a
22 benefit if you meet these qualifications. And

1 these qualifications are what we just stated.
2 Number one, you must insured by SGLI when you
3 experience a traumatic injury. What that
4 means is, if you have a traumatic injury and
5 that happens when you don't have SGLI
6 coverage, you are not covered by this program.
7 If you have SGLI coverage and you are injured
8 at that same time, you are covered by this
9 program.
10 Second, you must incur a schedule
11 loss and that loss must be a direct result of
12 a traumatic injury. Let me break that down
13 for you. What is a scheduled loss? That is
14 kind of our lingo and that is on our website,
15 which is provided at the end of these slides,
16 which Steve is going to refer to, things like
17 paralysis, different types of paralysis,
18 hospitalization, 15 days inpatient
19 hospitalization, limb salvage, losses of arms
20 or legs, fingers, toes, burns.
21 MR. WURTZ: And just letting you
22 know, the word scheduled is actually that is

1 on a schedule of losses, rules that were
2 published through regulations that tell the
3 individuals in the world what losses are
4 covered and how much they are covered for and
5 the rules about them.
6 MS. HOFFMAN: And those again, the
7 website that we provided in our presentation
8 can take you right to that scheduled loss.
9 But let me give you a specific
10 example. If you are a quadriplegic, you are
11 paralyzed in four limbs, you are going to
12 receive $400,000 if that quadriplegia is due
13 to a traumatic event.
14 MR. WURTZ: You said $400,000.
15 MS. HOFFMAN: I'm sorry, $100,000.
16 I'm sorry about that. Or if you lose one leg,
17 you are going to be paid $50,000. That loss,
18 second part, must be the direct result of a
19 traumatic injury. And let me give that
20 vehicle to you. If you lose a leg, that loss
21 must be due directly to the event. So if you
22 were in a car accident and you lose a leg, the

1 leg must be directly related to that motor
2 vehicle accident and no other cause.
3 Okay, you must have suffered the
4 traumatic injury prior to midnight of the day
5 that you separate from the uniformed services.
6 This gets back to what I was saying before,
7 that we can't pay Veterans through this
8 program. This TSGLI coverage ends the day
9 you separate from service. There is no other
10 coverage. It ends at that date.
11 If you are injured on that last
12 day and you suffer a loss of leg three days'
13 later, even though you are now a Veteran, we
14 are still going to pay you.
15 You must suffer the scheduled loss
16 within two years or 730 days of the traumatic
17 injury. We realize that many individuals
18 don't necessarily after their injury
19 automatically have one of the losses. It can
20 happen after a period of time due to surgical
21 interventions, what your physician said was
22 the right course but it has to happen within

1 two years. If it doesn't happen within two
2 years, it is not payable through this program.
3 Last but not least, you must
4 survive for a period of not less than seven
5 full days from the date of the traumatic
6 injury. So, even if you suffer you are in an
7 RPG blast, you lose your leg but you don't
8 live seven days, you will not be paid this
9 benefit. Your beneficiaries would still be
10 paid the SGLI Life Insurance benefit at that
11 time.
12 Any questions on that side before
13 we move to exclusions?
14 Okay, slide number 3, then,
15 exclusions. This program does not cover for
16 payment injuries caused by a mental disorder,
17 including post-traumatic stress disorder,
18 depression, et cetera. Not covered by this
19 program.
20 Injuries caused by a mental or
21 physical illness or disease. Easy example,
22 diabetes. You have diabetes. Because your

1 diabetes your surgeons have to amputate your
2 leg, not covered. Not covered through the
3 program. However, just a quick one, if you
4 look in the brackets there, that does not
5 include illnesses or disease caused by a
6 pyogenic infection -- I know many of you are
7 probably medical but pyogenic infection is a
8 puss-generating wound -- biological, chemical,
9 or radiological weapon, or accidental
10 ingestion of a contaminated substance.
11 Giving you a quick example. If
12 you have someone who was exposed to chemical
13 weapons develops cancer due to that and
14 because of that cancer has to have their leg
15 amputated because of cancer in their leg or
16 they are hospitalized for 15 days, that will
17 be covered because the illness or disease was
18 due to a chemical weapon.
19 Injuries caused by one of the
20 following:
21 Attempted suicide. I think this is
22 pretty clear that we are not going to pay for

1 someone who is taking action to potentially
2 harm themselves and they would get a benefit
3 from that.
4 Self-inflicted wounds.
5 CO-CHAIR NATHAN: Question.
6 MS. HOFFMAN: If you have one of
7 the losses in the program but you cut your own
8 leg off or you did some harm to yourself, that
9 is not covered through the program.
10 Number five, diagnostic --
11 CO-CHAIR NATHAN: Could I ask a
12 question?
13 MS. HOFFMAN: Sure. Sure, go
14 ahead.
15 CO-CHAIR NATHAN: Thank you. You
16 are saying that you will cover somebody with
17 a pyogenic infection?
18 MS. HOFFMAN: Yes, we will cover
19 someone with a --
20 MR. WURTZ: The parenthetic
21 remarks are exceptions to the exclusions. In
22 other words, they are not excluded.

1 MS. HOFFMAN: They are not
2 excluded. So yes, if somebody suffered, had
3 an illness or disease that was related to a
4 pyogenic infection, then we would cover them.
5 They have to have the loss, though. So just
6 because you have a pyogenic infection or you
7 were exposed to biological or chemical or
8 radiological weapons doesn't mean we are going
9 to pay a benefit unless you suffer a loss.
10 CO-CHAIR NATHAN: Okay.
11 MS. HOFFMAN: Did that clarify it
12 for you, sir?
13 CO-CHAIR NATHAN: I think so.
14 Thank you. I can just see medical/legal
15 people getting involved in pyogenic infections
16 and what causes the loss or not.
17 On the attempted suicide, does
18 that mean successfully completed suicide as
19 well?
20 MS. HOFFMAN: Well, if they
21 successfully complete suicide, they probably
22 are not going to survive seven days from the

1 date of the injury, in many cases. But even
2 if they do, they would not be covered by this,
3 they would be covered by SGLI, which does
4 indeed pay if someone commits suicide. Their
5 family would get the death benefit.
6 MR. WURTZ: So that is the life
7 insurance benefit that does not have a suicide
8 exclusion. We pay for everything except the
9 big things like treason and mutiny and things
10 like that.
11 CO-CHAIR NATHAN: Sure. On
12 attempted suicide, somebody attempts to kill
13 themselves and it is found in the line of duty
14 and they suffer a scheduled loss, still not
15 covered?
16 MS. HOFFMAN: Still not covered.
17 CO-CHAIR NATHAN: Okay.
18 MR. WURTZ: Line of duty is not
19 one of the considerations, although --
20 MS. HOFFMAN: Although sometimes
21 it is needed to obtain the evidentiary picture
22 for other things that we are going to talk

1 about at the very bottom of this slide, which
2 is use of an illegal or controlled substance
3 or a felony charge. The evidence through the
4 process is needed but the actual line of duty
5 means nothing.
6 CO-CHAIR NATHAN: Right. The only
7 reason I bring it up is because I think line
8 of duty is required to pay off the SGLI, is it
9 not?
10 MS. HOFFMAN: No, it's not.
11 CO-CHAIR NATHAN: No, it's not?
12 Okay.
13 MR. WURTZ: No.
14 MS. HOFFMAN: No. And Steve, if I
15 may say so, that was actually considered in
16 the beginning of the program and the branches
17 of Service strongly, strongly opposed line of
18 duty, mainly because we wanted this to provide
19 rapid financial assistance and their concern
20 was that that would really slow it down.
21 MR. WURTZ: And to the SGLI, the
22 life insurance benefit itself, suicide is a

1 suicide. A death gets paid, period.
2 CO-CHAIR NATHAN: Okay, thank you.
3 MS. HOFFMAN: Okay, great. Again,
4 I am on the fifth sub-bullet there.
5 Diagnostic procedures, preventive medical
6 procedures such as inoculations, or medical or
7 surgical treatment for an illness or disease,
8 or any complications are excluded. So again,
9 somebody goes under surgery at a military
10 facility. Something goes wrong in the
11 surgery. They are paralyzed. Not covered by
12 this program.
13 The last --
14 MR. WURTZ: And let me just
15 interject one other situation that has come up
16 on occasion is an individual receives a
17 military-required inoculation like for anthrax
18 and has a bad reaction and goes into a coma
19 for a certain period. While a coma due to a
20 traumatic injury, a military explosion or
21 something would be covered. Because this was
22 an inoculation, the outcome coma is not

1 covered.
2 MS. HOFFMAN: Okay, the next one
3 is the members' willful use of an illegal or
4 controlled substance, unless -- go ahead.
5 Does someone have a question? Okay, sorry.
6 The last sub-bullet, the members'
7 willful use of an illegal or controlled
8 substance, unless administered or consumed on
9 the advice of a medical professional. Again,
10 the example that we have a lot, you probably
11 think about is somebody driving a motorcycle,
12 driving a car. They are under the influence
13 of illegal substances. They are not covered
14 by this program. However, illegal or
15 controlled substances do not cover alcohol
16 use. That would not exclude you from this
17 benefit, unless, we will go to the last bullet
18 in a second. If somebody was on medication
19 that was prescribed by their doctors and they
20 were taking the correct dosage and it simply
21 had an inordinate effect on them, they would
22 be covered. However, if you are taking triple

1 the dosage that your doctor took and you were
2 injured, not covered.
3 Injuries sustained while
4 committing or attempting to commit a felony.
5 This is somebody how is convicted. Convicted,
6 not charged, convicted of either attempting to
7 commit a felony or committing a felony.
8 So back to what I just told you
9 about the alcoholic beverages not being under
10 the willful use of an illegal or controlled
11 substance, the only time that can be an
12 exclusion is if they are charged and convicted
13 of a felony in their state for say DUI. But
14 any other felony, if they are charged with
15 that or an attempt to commit, not covered.
16 Any questions before I move to my
17 last slide and we move on to Steve?
18 Okay, let's move to slide 4, which
19 is the TSGLI application process, just to
20 quickly explain how it works. The application
21 which, again, is on the website that was
22 provided in this presentation has two parts:

1 Part A and Part B. Part A, the member needs
2 to complete themselves or, if they are
3 incapacitated, their power of attorney,
4 guardian, or military trustee, somebody who
5 has been named by the military under a
6 military trustee process can act on their
7 behalf.
8 Part A, they provide very basic
9 information: who I am, what is my name, where
10 I served. They explain what happened to them.
11 They also indicate if any of the exclusions we
12 just talked about applied. They sign a HIPAA
13 release for us and they sign a statement that
14 they are providing truthful information to us.
15 And they also provide us either banking
16 information or how they would like the payment
17 to be received, electronic funds transfer, a
18 special account that Prudential sets up, one
19 of those methods for us, so that if they are
20 approved for the benefit, we know who and how
21 to pay. So they have that part.
22 Part B is completed by a medical

1 professional. And I want you to look at your
2 slide closely under the right-hand side at
3 Part B medical professional statement. This
4 is the medical professional stating what they
5 see and have observed. It does not have to be
6 the medical professional who initially treated
7 them. It can be another medical professional,
8 licensed practitioner, acting within the scope
9 of their practice. A licensed practitioner
10 acting in the scope of the practice includes
11 nurses, nurse practitioners, physical
12 therapists, a range of podiatrists, but they
13 have to be acting within the scope of their
14 practice. A podiatrist cannot sign off on a
15 traumatic brain injury. Clearly, they are not
16 acting within the scope of their practice.
17 Also, someone can complete this
18 section of the form if they were not
19 originally the treating medical professional
20 but now they are because it is a year later.
21 They are the primary care doctor and they have
22 the medical documentation in front of them to

1 use it to base the decision on.
2 The key is the member submits A,
3 the medical professional fills out, checks out
4 on the form everything that applies related to
5 Part B and provides supporting medical
6 documentation. That is very critical. The
7 branches of Service, as Steve will talk about
8 later who adjudicate these claims, want to see
9 the form completed on Part B as well as Part
10 A, but they want to see the medical
11 documentation provided from the member or the
12 member's medical professional to support what
13 is stated by him or her and the medical
14 professional.
15 Any questions there, before I turn
16 it back over to Steve?
17 MR. WURTZ: Okay, thank you, Kris.
18 So, I am going to step back in
19 time to when the program started. And two
20 events, I think, were at the beginning. I
21 have been with the VA for close to 40 years so
22 I was certainly here for this and every much

1 involved, working with the Congress' technical
2 specifications and so forth. But it started
3 with a phone call I don't know if it was
4 General Pete.
5 MS. HOFFMAN: No, it was Admiral
6 Cooper and Principi.
7 MR. WURTZ: Okay, Secretary
8 Principi and Admiral Cooper, he was the Under
9 Secretary for Benefits flying back from a
10 visit to Afghanistan and Iraq, identified a
11 need for some short-term or immediate -- I
12 don't want to say immediate because it doesn't
13 happen immediately, but the concept and the
14 Wounded Warrior Project was in its beginnings
15 and they also were interested in this. And
16 conceptually, the idea was members who were
17 wounded overseas spent some time the first few
18 days usually Landstuhl or someplace and then
19 were sent to mostly a handful of medical
20 facilities here, Brook Army Medical, Walter
21 Reed, Bethesda. And then their families were
22 uprooting themselves to travel and be with

1 them.

2 So, the member and the families

3 were incurring expenses. And that was the

4 broad paradigm. There were no rules built in

5 then or now that have shown any actual

6 expenses. But the idea was to make sure that

7 the expenses did not -- lack of funds did not

8 interfere with the recovery of the

9 Servicemember or Veteran.

10 It was broadly modeled after AD&D

11 coverage, Accidental Death and Dismemberment,

12 which is a rider added to a lot of insurance

13 policies, and specifically the dismemberment

14 portion. However, in building the product, it

15 was expanded. The things that were covered

16 was expanded to account for the nature of war,

17 the types of injuries. The program was put

18 together very quickly and the data at the time

19 was very limited. So, it was a joint team of

20 VA Insurance represented from the primary

21 insurer, which was Prudential Insurance

22 Company of America and still is, OSD's Office

1 of Compensation Policy, which is the VA's
2 principle liaison office for the entire SGLI
3 program and all its related features, as well
4 as medical staff from each branch of the
5 Service.
6 And together, we took what the law
7 required, the law enumerated certain things
8 that would be covered, but also gave the
9 Secretary the right by regulation to add
10 covered losses, which we went through and we
11 did burns, for example, is not covered by AD&D
12 policies but it has been covered from the
13 beginning under the TSGLI program.
14 So if there are no questions, I am
15 going to move to slide 6.
16 CO-CHAIR NATHAN: I have a
17 question.
18 MR. WURTZ: Yes, sir.
19 CO-CHAIR NATHAN: Is the TSGLI
20 paid for out of a different funding line than
21 SGLI?
22 MR. WURTZ: The primary part of it

1 comes from premiums, just like SGLI comes from
2 members' premiums and the investment earnings
3 held as reserves in the program that also are
4 available. If, as Kristan mentioned, the only
5 difference both for SGLI and TSGLI, it is the
6 government's responsibility to pay for the
7 cost of war, not the members. So, both their
8 life insurance premiums and their TSGLI
9 premiums are essentially set at standard
10 healthy rates or what the civilian population
11 would expect. By law, any excess above that,
12 generally speaking, come as paid for by the
13 appropriations for the branches, the
14 individual military branches for their pay
15 appropriations. These include extra hazard
16 payments. The first they were at the
17 beginning at the Vietnam War. The last one
18 was made in 1974. Between 1974 and 2002 or
19 2003, no extra hazards were needed. The cost
20 of the program was fully funded by the
21 members' premiums.
22 But as Enduring Freedom and in

1 Iraqi Freedom began resulting in injuries and
2 deaths, the premiums were not sufficient, so
3 the appropriations kicked in from the branches
4 of service. They have fortunately and happily
5 subsided a lot, decreased a lot in the last
6 couple of years.
7 CO-CHAIR NATHAN: So, I guess my
8 question is since they both come out of the
9 same pot of money, why was it decided to stand
10 up a second bureaucratic organization or
11 channel to do this, as opposed to just making
12 it a -- amending the SGLI and making it a
13 rider for people who suffer a traumatic loss,
14 combat or noncombat loss?
15 MR. WURTZ: That is what it is.
16 The payment, Prudential is still the body cuts
17 the checks. VA is still the body that
18 oversees it as part of the general SGLI laws.
19 The only distinction needed is that the
20 adjudication of a death claim involves whether
21 coverage was in place, who the beneficiary
22 was, legal guardianship, things like that, the

1 adjudication of a TSGLI is a medical
2 determination, largely.
3 So, additional adjudicative. So,
4 the law required that the branch is
5 responsible for determining who is eligible.
6 And it makes sense because the Army should be
7 responsible for looking at injuries for
8 Soldiers. They have access to their medical
9 records. They have access to getting them
10 counseling and so forth. So each of the four
11 branches set up an adjudicative function
12 following the Part 1, Part 2, Part A, Part B
13 that Kristan had mentioned. It goes into the
14 branch of service. Some of them are very
15 small, it is just a person or two. The Army
16 is a little bit larger, they have eight or ten
17 and the Marines have three of four members who
18 basically adjudicate the claims. They do the
19 administrative. They accept the claims,
20 record them, adjudicate them, discuss with
21 their medical professionals, if needed,
22 review, and then they certify the payment to

1 SGLI, to Prudential, who pays it just like
2 they would pay a death claim.
3 So, there was not really a big
4 overlay of bureaucracy. It is fully
5 incorporated into the program, except a
6 different kind of discipline is needed to look
7 at in the medical, instead of just legal.
8 MS. HOFFMAN: And Steve, might I
9 add that in an number of the branches of
10 Service, it is exact same office that is
11 adjudicated the actual SGLI death claims that
12 is also adjudicating the --
13 MR. WURTZ: The casualty.
14 MS. HOFFMAN: -- casualty that is
15 adjudicating the TSGLI claims. It is not in
16 every branch but Air Force and Navy,
17 definitely.
18 MR. WURTZ: Okay?
19 MS. HOFFMAN: Does that answer
20 your question, sir?
21 CO-CHAIR NATHAN: Yes, thank you.
22 MR. WURTZ: Good, you're welcome.

1 So, I think that basically
2 completes slide 5 and that is how the program
3 came up and running.
4 Slide 6 shows if you want to do
5 any kind of detailed review, Title 38 of the
6 United States Code 1980A is the statutory
7 underpinnings of the program and they are
8 expanded in the Code of Federal Regulations
9 Title 38 9.20. And that also includes the
10 schedule of benefits.
11 As I mentioned earlier, the
12 program got up and running in a very short
13 time frame. We had promised -- I think the
14 legislation was passed in June. Nothing
15 existed. There was nothing like it. So, we
16 committed to having it ready and the
17 regulations published before Christmas of that
18 year. And I am proud to say that a lot of
19 hard work by everybody in VA and DoD, we did
20 that.
21 But because of the short time line
22 and the unavailability of a lot of detailed

1 morbidity, accident rates, injuries, we knew
2 that we might have missed something. So, we
3 waited for a year and we conducted what we
4 nicknamed the Year One Review. We stepped
5 back and we looked at the type of injuries
6 emerging from the battlefields, losses,
7 definitions, and so forth, the adjudication
8 and administration of the program. And we did
9 a very extensive paper with an eye towards
10 finding those things we had missed because of
11 the short time line and we did.
12 We visited military sites, I
13 mentioned, VA hospitals. We did a lot of
14 research and data analysis. We met with
15 medical experts in every field,
16 rehabilitation, my staff spread around the
17 country and just rehab and the finest rehab
18 and medical facilities. And we came up with
19 some very good enlargements to the program
20 that lined up with our findings.
21 For example, you would be paid for
22 loss of a limb under the original one. But

1 more and more doctors and members were
2 deciding to try to salvage a limb. This could
3 go on for months or more. There weren't
4 always very long. A lot of times you were in
5 and out of the hospital. They would work on
6 the bone and then you would recover, and then
7 come back and they would work on nerve or
8 muscle groups, and come back and they would
9 work on skin grafts and things. But it really
10 wasn't covered under TSGLI because they didn't
11 lose the limb.
12 So, we worked with the medical
13 professionals and came up with definitions of
14 limb salvage. So once it is certified by a
15 surgeon that the member is undergoing limb
16 salvage, he gets paid as the equivalent of had
17 that been a loss of limb or limbs.
18 Along the same lines, people,
19 because of the nature of the conflict and the
20 IEDs, burns were bad. We went from requiring
21 that an individual have second degree burns
22 over 30 percent of their body -- third degree

1 burns and we "liberalized" that, that they
2 only needed second degree burns over 20
3 percent of their body or 20 percent of their
4 face. So, more people became covered by that.
5 We also included facial
6 reconstruction, where the member had to go
7 through a series. And we struggled with a
8 definition but we used the surgical world's
9 definitions. And if they need certain bone
10 replacements, and I don't want to get into
11 details but they are in the regulations on the
12 website, that member got paid money based on
13 the scale, the schedule of losses that we
14 updated.
15 Also, one more important one. The
16 law, since the beginning, has allowed for all
17 the basic injuries are kind of specific
18 injuries like blindness, loss of hearing, loss
19 of limb, and so forth. But there were
20 certainly instances where members were badly
21 wounded and injured, torso wounds and others
22 that did not fall under the schedule. So, we

1 created a measure working with that original
2 group to consider the loss of Activities of
3 Daily Living as an indicator of the
4 seriousness of the injuries and, more
5 importantly, the amount of time the patient
6 would be needing assistance, which ties into
7 the original purpose of the program.
8 So, there are Six Activities of
9 Daily Living, we call them ADLs, such as the
10 ability to by yourself eating, transferring,
11 toileting, bathing, things like that. And the
12 law required if an individual loses two or the
13 Activities of Daily Living for various periods
14 of time directly caused by traumatic injury,
15 they are entitled to milestone payments.
16 So, for these kinds of injuries I
17 have mentioned, if you are 30 days loss of
18 ADL, you get $25,000, continuous loss. If it
19 extends for the 60th day, you get another
20 $25,000 and so forth up to a maximum of four
21 months, $100,000.
22 There was a little wrinkle in

1 there with TBI it was on a slightly different
2 schedule. If you had loss the Activities of
3 Daily Living due to Traumatic Brain Injury,
4 that first segment kicked in at 15 days and
5 not 30, the $25,000; another $25,000 at the
6 30th day; and then the final two increments
7 were 30 days further and 30 days further out.
8 So that is slightly different than a loss of
9 ADLs for other traumatic injuries, other than
10 TBI.
11 So, the ADL was troublesome. It
12 was hard to adjudicate. It was sometimes hard
13 to determine. And we also looked at the
14 length of the stays. And we determined that
15 anyone who was hospitalized for 15 consecutive
16 days from the time of the injury, and that
17 includes the medical transport and treatment
18 of the battlefield, so if they were
19 hospitalized for that period of time, they
20 would automatically get the first $25,000
21 payment, as if they had lost ADL for $25,000.
22 So that was again, "a liberization." In

1 theory, it was not going to bring too many
2 more people in because we decided that if you
3 are hospitalized for 15 days, you are probably
4 going to be losing your ADL for a long period.
5 And that has been a benefit enhancement.
6 So, those were some of the things
7 that came out of the Year One Review.
8 So with that, if there are no
9 questions, I am ready to move on to slide 7.
10 The three main players who support
11 the program is VA, the branch of Service, and
12 Prudential, who operates by law under an
13 organization called the Office of
14 Servicemembers' Group Life Insurance, which we
15 call OSGLI.
16 So, VA's role is to propose
17 legislation or regulatory changes, which we
18 have. And the changes I just mentioned were
19 all done through regulation. Another change
20 that has since occurred after the Year One
21 Review was the additional of genital urinary
22 losses. And that was added through

1 legislation in December of 2011. Most people
2 who lose their reproductive organs or have
3 injuries a loss of use of were already being
4 paid maximum because it was often tied with
5 double amputations and so forth. But there
6 were some people who, independently, had these
7 losses and they are now on the schedule of
8 losses.
9 We provide oversight to OSGLI's
10 operations, Prudential. We travel there. We
11 look at how they process. We know what their
12 time frames are for processing claims. So, we
13 have very strong oversight. We meet with them
14 periodically.
15 Some years ago after the program
16 started, some questions arose and the General
17 Accounting Office was asked to do a little
18 study of the program, primarily for its impact
19 in TBI. But in the course of it, one of their
20 -- they found the program worked pretty well.
21 They were satisfied. But one thing they
22 pointed out was that because you have four

1 different branches of Service processing
2 claims, you have an inherent opportunity for
3 inconsistencies in how they adjudicate. So,
4 they wanted VA to play a bigger role, which we
5 now do.
6 We travel at least once a year to
7 each branch of Service and review a sampling
8 of their cases, preselected, and how we judge
9 them, their accuracy and so forth. We also do
10 that analysis once a year, much more
11 sophisticated, of approval rates, disapproval
12 rates, the types of claims that are being
13 approved or disapproved, so that we can get a
14 sense of a consistency.
15 And we also play a big role in
16 outreach regarding TSGLI benefits, everything
17 from a call like we are having today, we
18 frequently meet with casualty groups and HRC
19 conventions and scatterings and website and
20 tweets and all this kind of stuff.
21 And we do have, actually, a
22 specific outreach unit, a member separates

1 from service and has injuries that our special
2 outreach group thinks could result and make
3 them eligible for TSGLI payment, we call that
4 person and we look at their medical and
5 discuss with them and send them a claim, if
6 they think they are entitled. So, that is one
7 of the things in our role.
8 Now turning to the branches of
9 Service, by law, they are the ones that have
10 to determine the eligibility for TSGLI. As
11 Kristan mentioned, they have established a
12 process to handle these claims, some of which
13 is just additional training to the CACOs that
14 were already on the job. Others, by adding
15 some staff with medical background and setting
16 up a referral process within their own chain
17 where their doctors in the branch review cases
18 as needed.
19 They also developed a formal
20 appeal process that if a member is not happy
21 they appeal back to the branch and there is
22 certain levels of administrative review they

1 do. And they also conduct their own outreach.
2 And they also, to varying degrees, for
3 example, the Marines are very attentive to
4 having their staff go to these medical
5 facilities, say Bethesda, and assist members
6 with filing claims on the spot, gathering
7 medical information and, therefore, making it
8 a more fully developed claim so the branch can
9 process it more easily, the adjudicators. So,
10 that is part of what they do.
11 Finally, OSGLI, not to get
12 technical but the TSGLI is not really life
13 insurance. Prudential administers it for us
14 under something called an ASO, Administrative
15 Services Agreement, and that basically means
16 for the TSGLI portion, Prudential has no
17 financial risk like they do in the life
18 insurance portion. So, what they do is the
19 branch of Service adjudicates the claim, sends
20 the information to OSGLI, Prudential.
21 Prudential then releases payment or a denial
22 letter, based on what the branch told them to

1 do. And they are the ones that conduct some
2 of the annual claims analysis with us in
3 collaboration with us.
4 So that is really the end of the
5 program except for slide 8, which is really
6 just telling you how each of us reaches out
7 and tries to make sure people are aware of the
8 program and taking advantage of it.
9 So, with that, I will shut up. I
10 will be glad to answer any questions you might
11 have.
12 LT COL KEANE: I have a question.
13 This is Lieutenant Colonel Keane.
14 MR. WURTZ: Yes, sir.
15 LT COL KEANE: Has any data been
16 gathered on how TSGLI is spent by our
17 Servicemembers?
18 MR. WURTZ: How the money is
19 spent?
20 LT COL KEANE: Correct.
21 MR. WURTZ: Yes, that is the
22 question. Okay.

1 As I mentioned earlier, there is
2 nothing in the law or the reg, the
3 Congressional record that requires any kind of
4 review of how they spent it. There is no
5 restrictions on how they spend it.
6 Anecdotally, I wouldn't be
7 surprised if some members ended up buying an
8 SUV with some of it. But I believe that also
9 a goodly portion of it is used exactly as
10 intended. But as you think about it, it would
11 really become cumbersome, if not impossible to
12 tie it directly to expenses. You know, you
13 have pairing and filing airline bills and
14 assessing whether it was legitimate and all
15 this kind of stuff. So, Congress went in a
16 different direction and that is the way it is
17 right now.
18 We have toyed with the idea of a
19 survey, of asking people how they used it.
20 But I am not sure exactly what the benefit
21 would be of that.
22 LT COL KEANE: The reason I ask is

1 that one of our site visits, we were walking
2 with the cadre who was taking us around and he
3 pointed out that you knew we were getting to
4 the SFAC because you could see all the brand
5 new vehicles. And we have been kicking around
6 here, a couple members of the Task Force, of
7 how to assist Servicemembers in possibly
8 mandating some financial management classes,
9 which would probably be pretty hard to do.
10 Another thing we have kind of
11 kicked around is what if we made a
12 recommendation for TSGLI recipients to get
13 their $100,000 in installments, $25,000 each
14 year, with a waiver. So, for those members
15 who needed $100,000 now to modify their house
16 or for whatever other reasons, they could get
17 that but the initial thing or the standard
18 would be if you get your $100,000, you would
19 get it over four years in increments, for an
20 example. Do you have any thoughts on that?
21 MR. WURTZ: Right. Two things.
22 To our first point, a number of years ago

1 Prudential created a program for their -- we
2 are one of 20,000 groups that Prudential
3 insures in their group insurance department,
4 IBM, Ford Motor, very large companies. And
5 they made available to most of them something
6 called beneficiary financial counseling
7 service. It was a free service to the
8 individual, to the beneficiary. So largely it
9 was if the member dies, their beneficiary can
10 get this free counseling. And working with
11 Prudential, they enlarged the program for VA;
12 whereas, their other private companies they
13 insure, the individuals have maybe a year to
14 apply for this service and get advantage of
15 it. We have now reached a point where
16 beneficiaries of deceased Servicemembers and
17 TSGLI recipients are all notified that they
18 have free lifetime access, 24/7 calls, plus
19 very sophisticated personalized financial
20 plans at no cost to them by independent people
21 that sell no products and recommend no
22 products.

1 So, the TSGLI recipients do in
2 fact are informed of the availability of this
3 very good service. When they get their claim,
4 they are told of this service. And these
5 people who provide the service are also
6 familiar with other VA and military benefits.
7 So, they can give a comprehensive picture of
8 how TSGLI or SGLI proceeds for deceased member
9 to the family might fit in.
10 MS. HOFFMAN: Steve, before you go
11 on to Lieutenant Colonel Keane's second
12 question, I just wanted you to know that if
13 you go and look at the TSGLI application as
14 well, we have added a section to that claim.
15 As Steve said, the member is informed of this
16 benefit. Obviously, you can go on our website
17 and look at it but they are informed at the
18 point of claim. However, if a member is very
19 interested, they can actually check off on the
20 TSGLI application that they want someone to
21 call them and then the company that provides
22 independent service will actually call them to

1 initiate the service for them.
2 MR. WURTZ: Yes, there was even
3 some consideration of making the counseling
4 mandatory but that was, I don't know, too big
5 brother maybe. It wasn't my decision either
6 way but it was determined not to make it
7 mandatory.
8 To your second point, I can't
9 speak for VA. I understand your concern and
10 I am sure other veteran stakeholder groups and
11 advocates would understand it. My guess, if
12 I had to guess is their opinions would
13 probably be split. There are cases where they
14 might need the money sooner, like you said a
15 waiver. So, that would have to be looked at
16 and to think through the pros and cons of that
17 and how administratively you would keep it as
18 simple as possible, not make it too
19 cumbersome.
20 So, a recommendation is a
21 recommendation and we can look it. And I am
22 sure our staff here in insurance would have

1 input into that but the final decisions would
2 be made above us.
3 LT COL KEANE: Thank you very
4 much.
5 MR. WURTZ: And of course I think
6 it might require -- I don't know if it would
7 require legislation or regulation offhand. I
8 would have to look at that. Probably just a
9 regulation.
10 CDR MARTIN: Steve?
11 MR. WURTZ: Go ahead. Anybody
12 else?
13 CDR MARTIN: Steve, hi. This is
14 Kirsten.
15 MR. WURTZ: Hi, Kirsten.
16 CDR MARTIN: I was just going to
17 add on that. That yes, if it required a
18 regulatory change or possibly a legal change,
19 that is something the Services work on
20 annually, updates to the unified budget and
21 legislative process. So those ideas would
22 generate from the Services up through OSD for

1 consideration. And if it took root, we would
2 work with VA, if it did require actual change
3 to the title. So if that is a genesis from
4 this group, there is a body in place that
5 takes all those recommendations forward and
6 moves them forward from the DoD perspective.
7 MR. WURTZ: Maybe I should have
8 added, we don't leave the branches out there
9 on an island. We provide extensive training
10 materials to them. And we also, we used to
11 speak with -- is it monthly?
12 MS. HOFFMAN: Quarterly now.
13 MR. WURTZ: It was monthly when
14 the program started for a number of years but
15 since we have been stood up and up and running
16 pretty well, we speak to them quarterly, both
17 Prudential and VA and DoD staff. We hear
18 their concerns. We tell them about changes.
19 We ask them questions.
20 As far as I know, this has never
21 been brought up by the branches themselves.
22 So, for what that is worth, it is not an

1 existing concern of the branches or OSD, as
2 far as I know, the misuse or how the money is
3 used. I don't want to say misuse.
4 MR. REHBEIN: Sir, one question on
5 outreach. This is Dave Rehbein, one of the
6 members of the Task Force.
7 You said that when you identify
8 someone that may be eligible, you send them a
9 claim form, essentially. How do you work
10 around HIPAA? How do you find out someone's
11 medical condition is bad enough that they may
12 be eligible?
13 MR. WURTZ: Oh, okay. Well, first
14 of all I see a huge percentage of TSGLI claims
15 are filed while the member is in service, in
16 the hospital with the help of his branch of
17 Service.
18 I was referring to someone who is
19 separated. They are now a Veteran. We get a
20 feed, one from DoD for anybody that is 50
21 percent service connected from a medical
22 standpoint, a medical rating.

1 MS. HOFFMAN: Military disability
2 rating.
3 MR. WURTZ: Military disability
4 rating. Thank you. Or if it has been
5 adjudicated quickly enough, a VA service
6 connected rating, which has details of both
7 the severity and the nature of the rating of
8 the injuries. DoD's is only a percentage.
9 So, we are largely this
10 organization was really stood up to bring the
11 Veterans Group Life Insurance Program. When
12 you come out of service with SGLI, you have a
13 certain period of time to convert to VGLI
14 without any health questions and this is a
15 very important benefit for someone who has
16 been severely injured in the military and may
17 have trouble getting insurance at call it a
18 standard rate or maybe not getting insurance
19 at all due to their injuries in the military.
20 So, this group was stood up to
21 call them to make sure they know about their
22 VGLI and encourage them to take it, if they

1 need life insurance. And by the way, if your
2 injuries are such from what we have determined
3 from the VA rating, that we suspect they might
4 be, we just discuss it with them broadly and
5 encourage them if they want it, they can
6 either go on the website and pull down a claim
7 form or we will send them one at their
8 request. That has a HIPAA statement on it for
9 branch of Service use because that is where
10 the claim gets filed.
11 MR. REHBEIN: Okay, thank you. I
12 appreciate that.
13 MR. WURTZ: You're welcome.
14 MS. MALEBRANCHE: This is Ms.
15 Malebranche, the VA rep here.
16 I am just wondering, in terms of
17 loss of use, and loss of limb, are they
18 evaluated differently?
19 MR. WURTZ: Well, they are paid
20 the same --
21 MS. HOFFMAN: Not loss of use. We
22 don't pay for loss of use.

1 MR. WURTZ: We don't pay for loss
2 of use?
3 MS. MALEBRANCHE: So, if someone
4 has the loss of use of a right arm but it is
5 not amputated, they are paid differently than
6 someone who has lost an arm?
7 MR. WURTZ: Go ahead.
8 MS. HOFFMAN: I was going to say
9 that one of the reasons for loss of use not
10 being covered, we pay individuals. So, if you
11 are covered under paralysis and your arm is
12 paralyzed under uniplegia, we are going to pay
13 you that benefit because it is a scheduled
14 loss.
15 If on the other hand, you don't
16 have an amputation which we are going to pay
17 you $50,000 and you don't have paralysis and
18 you have some other loss of use that maybe
19 paresis or something like that, you could also
20 be covered under the hospitalization benefit
21 if there were issues or the Activities of
22 Daily Living benefit that Steve talked about.

1 Specifically, loss of use is not
2 covered under this program mainly because of
3 the original design modeled after Accidental
4 Death and Dismemberment, which does not cover
5 loss of use.
6 MR. WURTZ: And so keep in mind
7 again, this is a transitional benefit. The
8 member with some loss of use may not need the
9 family being with him and all these many
10 months of recovery. And of course, loss of
11 use is a covered service-connected disability
12 by the VA on a lifetime basis.
13 So sometimes it is hard even for
14 me still after all these years, to tease out
15 the difference that this is not compensation.
16 You know, it has got a different plan design.
17 The compensation program is totally
18 independent. The member gets compensated, VA
19 comp whether they have TSGLI claims or not.
20 So, it is not like the member is not going to
21 be compensated for that loss but the Congress
22 didn't believe it fell within the same

1 categories as the other losses.

2 MS. MALEBRANCHE: Okay and one

3 last question. How do you get this

4 information on TSGLI out to the Guard and

5 Reserve, if you don't get their names from

6 medical records or other venues? How do they

7 know about this benefit?

8 MS. HOFFMAN: You know, this is

9 Kristan. If I may say so, this is the group

10 that we are most concerned with as well

11 because I think your question is an excellent

12 one. We are all nodding here because they are

13 the hardest group to identify. I mean

14 frankly, some of them I actually, before we

15 got on the field was looking at a claims study

16 of someone who was burned in a grill fire.

17 They were off duty.

18 I think we do that a couple ways.

19 I know both a VA and the military go to many

20 Guard and Reserve conferences. We have also

21 tried to reach out at different times in the

22 program to like State and National Guard

1 chiefs with information letters. We also do
2 a lot on Facebook, PSAs, et cetera, on YouTube
3 that we work with individuals identified by
4 Kirsten, who is there on a communications team
5 too that are specifically active duty, Guard
6 and Reserve, family members, et cetera.
7 And also, we are getting those
8 individuals on that telephone outreach list
9 that we just talked to you about. They are
10 both active duty and many Guard and Reserve.
11 And again, if we see that they have these
12 conditions, we will inform them, even if they
13 are Guard and Reserve and it didn't happen on
14 duty or in a combat situation.
15 MR. WURTZ: And I would add, this
16 is Steve, that the HR functions, I understand
17 the Reserves, they are not there as often and
18 so forth, but there is an HR function of each
19 branch who are trained to know the rules and
20 the benefits. And if a member doesn't show
21 for drills because they have been injured, the
22 HRC has the opportunity there to solicit a

1 TSGLI claim. And I can't tell you how often
2 and well they do it but that is also, in
3 addition to everything else, as Kristen said
4 the units themselves have some opportunity to
5 do that.
6 MS. MALEBRANCHE: Thank you.
7 CDR MARTIN: Ma'am, if I could add
8 to that just a minute. We have a Guard and
9 Reserve compensation reps on our compensation
10 team at the OSD level. So any programmatic
11 changes regarding TSGLI, they definitely get
12 notified of that.
13 Like Kristan said, we have an
14 overarching coms team that we have really
15 beefed up within the last few years to get the
16 word out on programmatic changes to the
17 various members. But if you all had any
18 suggestions, we would gladly take those for
19 action. So, if you had specific conduits to
20 get information out at a better level, we are
21 happy to receive that.
22 CO-CHAIR CROCKETT-JONES: All

1 right. I think that we are good.

2 MR. WURTZ: Anything else?

3 CO-CHAIR CROCKETT-JONES: No, I

4 don't think we have any more questions. Thank

5 you very much for providing us with this

6 information. It is definitely, we have a much

7 clearer picture, I think. Thank you.

8 MR. WURTZ: We appreciate the

9 opportunity and are here to help you in any

10 way, either administratively, legislatively,

11 analysis, anything we can help you with,

12 please do not hesitate to contact Kirsten

13 Martin there. Kirsten is the easiest way but

14 there is contacts on our website, too.

15 Thank you, everybody.

16 CO-CHAIR CROCKETT-JONES: Thank

17 you again. And at this time, our Task Force

18 is breaking for lunch. We will reconvene at

19 one o'clock.

20 (Whereupon, at 12:04 p.m., a lunch

21 recess was taken.)

22

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

2 (1:02 p.m.)

3 CO-CHAIR CROCKETT-JONES: Okay,

4 welcome back. We now welcome Mr. Kevin

5 McDonnell, the Director of the SOCOM Care

6 Coalition to update us on the SOCOM Care

7 Coalition.

8 The Task Force last received a

9 briefing in February 2012. During this

10 briefing, Mr. McDonnell will elaborate on

11 initiatives and other vocational and

12 employment services available to the Special

13 Operations Population. We have the

14 information at Tab E.

15 I am going to turn this over to

16 you, now, Mr. McDonnell.

17 MR. McDONNELL: Thank you very

18 much. And thanks again for the opportunity

19 come and update the Task Force. The work you

20 all do is extremely important and sharing best

21 practices and lessons learned. So, I hope

22 something out of this transitions into that

1 capacity.

2 I will go to the next slide. I

3 just want to review a couple of things, so

4 everybody is on the same page. I have four

5 principle lines of operation: recovery,

6 rehabilitation, reintegration, and transition.

7 And that covers down on the whole SOCOM

8 population. What I am specifically addressing

9 here today, though, is I am focusing very

10 heavily on the transition mechanisms that we

11 are using now along those four lines of

12 operation.

13 Our primary role was, from the

14 time we were chartered, was to return wounded

15 ill and injured Servicemembers to active duty,

16 to their units. That was from General Brown's

17 original inception to Admiral McRaven's idea

18 today. That is our primary focus.

19 We work directly for the

20 Commander. We don't work through the Surgeon.

21 We don't work through the Chief of Staff.

22 This is a true Commander's initiative.

1 We leverage everything that the
2 Services do. I am going to say that one more
3 time. We leverage everything that the
4 Services do. We would not be able to do the
5 things we do, unless the Services do the great
6 things that they already did.
7 What we do, though, is we look for
8 the gaps case by case and then we look for
9 capabilities, whether it is within a
10 government program, DoD, VA, Labor, or if it
11 is in the private sector through a private
12 company, or through benevolent organizations
13 to close and fill in those gaps.
14 So, as I said, partnering,
15 building coalitions of support for families,
16 for like groups and working by, with, and
17 through other organizations really is the
18 model. We don't want to recreate anything
19 that somebody else has already perfected. We
20 want to go out and leverage what other people
21 are already doing. I have never been to the
22 Marine Corps and asked Colonel Buell for help

1 on a project where he said no, even if it came
2 to leveraging a service they had for someone
3 who was not a Marine. We work through those
4 things. So, this really is a coalition and it
5 is a partnership.
6 This, like I said, this is the
7 Admiral's initiative. And last week our
8 Acquisition Executive, which is a separate
9 acquisition authority from the Services came
10 back and told us we had 166 percent of DoD's
11 goal of service-disabled, veteran-owned small
12 businesses, totaling almost $120 million. And
13 that is just a huge achievement. It is a huge
14 plus. And it really shows that the efforts
15 that we are making for wounded ill and injured
16 transition all the way across the command and
17 don't simply reside here within the care
18 coalition.
19 This is where we are. And this is
20 a very flexible footprint. So, by the
21 contract that we have, say I have an aircraft
22 crash in Afghanistan and, as a result, I have

1 50 severely burned troops and a large part of
2 that population will go to SAMMC, I can surge
3 capability at SAMMC overnight and build that
4 network of advocates up very quickly down
5 there.
6 The footprint that you see here,
7 you might recognize a name or two that is
8 familiar on there. The footprint that you see
9 here is the large majority of these folks are
10 retired senior SOF personnel. I have five
11 former Brigade Command equivalents on here and
12 I believe 19 or 20 former Command Sergeant
13 Major equivalents on here and those are the
14 advocates. And because of the seniority in
15 the advocate network, they can really cut
16 down, cut to and focus on the crux of the
17 problem, in most cases, pretty quick.
18 So this is the population. One of
19 the things that make SOCOM different is the
20 seniority of the troops that we have. I do
21 have some junior troops assigned to us in
22 support roles. We rely very heavily on the

1 services, as I said earlier, for basic
2 capabilities. But the thing that makes the
3 population different, operationally, is the
4 judgment, the maturity and experience that
5 comes in our operational units. This comes
6 from a huge investment both monetarily and in
7 time that can't be replicated overnight. And
8 so, everything that we do, the Commander sees
9 as a readiness issue. This is about taking
10 the talent that we have and reinvesting that
11 talent back in the Command. If I can't put a
12 wounded ill or injured troop back on a team,
13 finding another place in the Command that that
14 individual can continue to serve and that
15 becomes a top priority.
16 The Command is made up of an Army
17 component, a Navy component, a Marine Corps
18 component, an Air Force component, the Joint
19 Special Operations Command, and Reserve and
20 National Guard components as well. So, we
21 have a slice of about everything. And we are
22 one of the few organizations in DoD that

1 actually can see the differences between what
2 the Army and the Navy does, for example, in
3 terms of programs pretty much, excluding
4 medicine because that is uniform, but in terms
5 of programs for troops, we see those
6 differences.
7 So this is a different view of the
8 population. The total number in our tracker
9 right now is up to 7188 as of Friday. And we
10 are seeing about a 12 percent annual growth in
11 that population. Next summer, as operations
12 tend to start to wind down in Afghanistan,
13 because of our global footprint and because of
14 the footprint Admiral McRaven expects to
15 retain in Afghanistan, we don't expect that
16 number to change a whole lot. I'll give you
17 a minute with that slide.
18 MR. REHBEIN: Sir, because of the
19 way you operate, define combat zone for me.
20 Is combat zone -- I know you have people in
21 the Philippines. I know we have people all
22 over the world that are assisting indigenous

1 troops. Is that part of combat zone?
2 MR. McDONNELL: I think -- look
3 down on the bottom. I think that is what we
4 try to do on there. We are defining the
5 combat zone in the same way that the Services
6 define the combat zone. It is a declared
7 combat zone.
8 But I also have troops that, for
9 example, we have a lot going on in Africa.
10 And our charter is wounded ill and injured.
11 So, we pull somebody out of Africa, we are not
12 counting that as a combat zone. We are
13 counting that as other, unless there is some
14 sort of designation that determines that
15 different.
16 So, if I can further define some
17 of these numbers. In FY13, these are answers
18 to specific questions that we were asked and
19 I hope I am answering them in the way that you
20 asked them and if not, I will go back and try
21 to refine the answers.
22 In FY13, we added a total number

1 of 973 to our roles, wounded, ill, and
2 injured. Of the 973, 967 are still serving on
3 active duty. The medical hold population,
4 which is the way the Services define MEDHOLD
5 or they will define it a little bit
6 differently, but the way we are defining the
7 numerical values of the MEDHOLD there of the
8 973 total, 287 returned to duty, to full duty
9 and 686 are in the process of either limited
10 duty or doing MEBs this time.
11 The total number of combat injured
12 or combat wounded was 276. And evacuation
13 from theater for non-battle injuries globally
14 was 180.
15 So, that gives you a picture of
16 the demographic. And if you are through with
17 that --
18 Okay, so now I am going to talk
19 specifically about transition initiatives. We
20 use the transition initiatives that the
21 Services have in place. We also use the
22 transition initiatives OWF, E2I that OSD has

1 put in place. But we also believe very
2 strongly that the greatest opportunity for our
3 transitioning Servicemembers is in the private
4 sector. Whatever it is, it is what they
5 define it to be. And the goal here is purpose
6 and relevance in a way that the Servicemember
7 defines it. And I spent 29 and a half years
8 in uniform and I took my uniform off on my own
9 time line. But someone who is injured in
10 combat and either the Servicemember, the
11 Service, or maybe the spouse decides enough is
12 enough and it is time for you to get out, how
13 that individual defines purpose and relevance
14 when they take their uniform off, we think is
15 very important. We also think it is key to
16 the long-term well-being of the individual and
17 of the family after Service.
18 So, what I have got up here is
19 just from the law that Congress passed in
20 2011, allowing us to do internships and
21 apprenticeships in the private sector down to
22 the authorities and the policies and the

1 program that we have in SOCOM that charter the
2 program we have up and running now.
3 And so the model for transition
4 that we are really looking at has three
5 components to it. And we start this
6 discussion with them, with Servicemembers and
7 families early on.
8 The first component of it is a
9 career direction. It is not what job do you
10 want to have when you take your inform off.
11 It is what are the kinds of things that would
12 make you look forward to doing, make you look
13 forward to Monday, make you look forward to
14 the weekend being over? You know, as Steve
15 Jobs said, if money is not an issue and for
16 the most part money won't be an issue, and you
17 know you can't fail, what would you do? How
18 would you spend your time? And that is really
19 where we want to start the conversation. With
20 that, we will combine educational
21 opportunities, some from the VA, some from the
22 Service, some from benevolent organizations to

1 help fill in the gaps of where the individual
2 is, as opposed to where they want to be,
3 moving toward that career focus down the road.
4 And the third piece of this, we
5 think is absolutely vital, is a mentorship
6 program that surrounds each troop as they go
7 through this process and get out. And
8 sometimes these mentors are alumni out of our
9 community that have gotten out and want to
10 continue to serve and give back. Sometimes,
11 that mentor is somebody who has been very
12 successful in the private sector for several
13 decades in an area where that troop wants to
14 get into. And so, we will go to them and we
15 will say would you step in and serve as a
16 mentor for this individual? Not asking them
17 to give him a job but asking him to serve as
18 a mentor for this individual as they make that
19 transition and head down the path that they
20 were successful in. And we have never had
21 anybody tell us no in that.
22 There are actually a couple of

1 organizations, benevolent organizations that
2 we use that put on forums that will bring
3 corporate executives and CEOs in to do one on
4 one or actually three on one time with
5 transitioning troops to make sure that their
6 plans are shut, that they thought through what
7 it is they are going to do, that they are
8 resourced to be successful and that they have
9 got people to fall back on to ask questions as
10 they make that transition.
11 So, these are some of our
12 transition goals. It is about hunting versus
13 fishing. We want to have that conversation
14 with them over the whole period of recovery.
15 We don't want to wait until the med board is
16 complete. We don't want to wait until they
17 have orders and a DD214 to start this process.
18 Because if I can use that period of time that
19 somebody is in the recovery stage for
20 education, for internships, for
21 apprenticeships, to help them get ready for
22 that transition, I think we are saving them a

1 whole lot of time. And the cases that we have
2 been through have proved that model out.
3 So there are a couple of tools
4 that we have started using. The one that we
5 have established the longest now is actually
6 at the bottom. It is the Wounded Warrior
7 Athlete Reconditioning Program. And we tie
8 this into many of the great environments that
9 the VA has the different Service programs, the
10 Warrior Games and that is not just athletic
11 competition. That is a great environment for
12 mentorship. That is a great environment to
13 bring people in to partner, to coach an
14 individual or a group of people with similar
15 injuries that were injured several years
16 before and they have already figured out how
17 to do a lot of things. And so if we can skip
18 more newly injured troops ahead in the
19 process, athletic competition is a phenomenal
20 opportunity to do that.
21 Team Room is a platform, it is an
22 automated platform we are testing right now.

1 It looks a lot like YouTube. My goal right
2 now is to have this opened up to the Services
3 by the end of March. Under the contract I
4 have, the contractor will make 20 videos for
5 us a year, plus four or five videos a year.
6 So, the intent is to open it up to allied
7 programs as well.
8 And we are building communities of
9 collaboration. So, the three core communities
10 we are looking at right now are wounded
11 troops, caregivers, and then GOLD STAR
12 families. And to give you an example, we have
13 got an Air Force EOD Tech who is a triple
14 amputee. And one of his biggest challenges,
15 initially, was getting in and out of his
16 wheelchair without his wife's help. And one
17 day he was at yoga and figured out if he
18 locked the wheelchair behind him and was in
19 his tripod stance, he could just flip himself
20 up into his wheelchair. So he set his iPhone
21 up, made a video of it himself, and we posted
22 it on the platform.

1 The second video he made was how
2 he goes out and swims for physical exercise
3 every day. He gets out of the chair, into the
4 pool, does laps, comes back, gets out of the
5 pool, back into the chair completely by
6 himself.
7 The third video has to do with him
8 and his van and his considerations on where he
9 needs to park, where he needs to find a
10 parking spot in order to get into this chair
11 in the van and out of the van.
12 And so on the wounded side, the
13 goal is to take this platform and share
14 lessons learned among Wounded Warriors so that
15 while a newly injured troop is still laying in
16 the bed at Bethesda, he can access this
17 through an iPad, through an Android, through
18 an iPhone, through any kind of platform and
19 watch the lessons learned of previously
20 injured troops. This is a platform that was
21 originally used by the EOD community. JIEDDO
22 is funding it for us to test. And they were

1 using it to share lessons learned among the
2 EOD community, among EOD Techs that had been
3 injured to get the word back out on the
4 battlefield immediately.
5 The third program that we just got
6 under contract on Friday is SOF X-ROADS and
7 this is an algorithmic mechanism of matching
8 talent up with opportunity. It is a
9 capability that can right now identify about
10 4.5 million open job requisitions out in the
11 private market, as well as in the private
12 sector. And rather than using key word
13 searches, it uses latent semantic indexing and
14 math, which makes it almost language agnostic
15 to line talent up with opportunity. We were
16 really excited to have this onboard as a tool.
17 I think with the model of the population that
18 we have, we don't have troops that are just
19 transitioning one time. We have troops that
20 will transition back to the guard or back to
21 the reserve. And then we do have those troops
22 that will transition out on a permanent basis.

1 This gives us the ability to hunt.
2 This gives us the ability to find things that
3 we wouldn't have normally found through
4 Monster or through USAJOBS and it opens up a
5 tremendous level of accuracy and fidelity that
6 we did not have before.
7 And if anybody is interested in
8 learning more about that program, the
9 innovators of the program are sitting right
10 there in that first row and I am sure they
11 will be more than happy to talk to you.
12 In addition to us, OSD has seen
13 this. The Services have seen it. The VA has
14 seen it and loves it. The Department of Labor
15 has seen it and I believe there is a
16 conversation going on between right now them
17 and the Army Reserve to do a pilot with Army
18 Reserve as well.
19 These are some of the things that
20 make the tool a little bit different than what
21 has been out there before. It takes a lot of
22 the emphasis of the resume away by actually

1 matching the talent and matching the
2 experience much more to what the job
3 requisition is asking for. And we have had
4 people tell us that if you have got somebody
5 that is an 85 percent match in this system to
6 send them straight to an interview with us.
7 Because you look at some of the companies that
8 we are developing MOAs with to do internships
9 and apprenticeships with is we move their open
10 requisitions into this tool. It just helps us
11 match that talent up a whole lot better than
12 a human being or a head hunter can do. No
13 offense to the head hunters in the back.
14 So, the tool is also being
15 socialized right now at the VA under a term
16 called Vet Connector. And if I have got a
17 Marine stationed at Camp Pendleton and he
18 wants to move back to where his wife's family
19 is in Augusta, Georgia but doesn't really know
20 a whole lot about Augusta, Georgia, this is a
21 great tool for him to find out what the
22 opportunity would be back in a different part

1 of the country, away from where he is
2 currently stationed and away from probably
3 where the resources on that installation would
4 routinely focus.
5 One of the things I really like
6 about this tool is that through from OSD we
7 are responsible for building a comprehensive
8 recovery care plan for each trip that is going
9 through the recovery process. It is probably
10 better called the clinical recovery care plan
11 than a comprehensive recovery care plan
12 because the focus on what comes after you have
13 recovered really isn't there or isn't there to
14 the level that we are comfortable with and
15 what we want.
16 So starting very early on in the
17 injury, when we start that discussion with a
18 troop on how do you define purpose and
19 relevance when you take your uniform off, what
20 do you want to do? What makes you look
21 forward to Monday coming after the weekend?
22 We can use this tool to help find

1 apprenticeships and internships. I can take
2 this tool and, for example, someone says I
3 want to go be Tim Cook's replacement at Apple.
4 Using this tool, I can pull up a picture of
5 what Tim Cook looks like and 25 other people
6 serving in a similar capacity of what Tim Cook
7 looks like. I can see where they went to
8 school. I can see previous jobs. And from
9 that, it will help us build a pattern of
10 things we need to do with that individual.
11 And if he has got two and a half to three
12 years in the recovery system in the MEB&PB
13 system before he gets that DD214, this tool
14 gives us a tremendous way to use that time
15 effectively. So, he is not simply sitting and
16 waiting from one appointment to the next, from
17 one rehab or physical therapy session to the
18 next. So that we have education that we have
19 skills training built in there that he is
20 actually focused in on and feels it very
21 valuable.
22 Okay, so talk a little bit more

1 about numbers and metrics. We have currently
2 done as of today, about a year after we stood
3 this program up, 111 internships. Of those,
4 you can see the numbers between civilian and
5 government. All the ones through government
6 we have done through OWF and those are great
7 connections. But what we find a lot of times
8 with the federal government internships is
9 after the internship is over, the individual
10 may not really have the skills to qualify for
11 a job in that organization. I have got one,
12 a young Marine who had a polygraph TSSEI, went
13 out to NCTC and worked, passed the polygraph
14 after he was injured. But when he got out of
15 the Marine Corps, there really wasn't a job at
16 NCTC where he was working because NCTC is sort
17 of a collection of other agencies. And he
18 didn't have the experience and the background
19 really to have a job there. So even with that
20 security clearance, he opted not to take a job
21 with the federal level and go back to school
22 instead. And I am going to show you where he

1 is now.
2 So, we have about 27 internships
3 pending right now. As you see, the
4 relationship there 25 in the private sector,
5 2 in the public sector. Pretty good success
6 rate in transitioning the internships to jobs.
7 And one of the things we like
8 about these, whether they are in the public
9 sector or the private sectors, the way these
10 are being done is that most of these troops at
11 the end of the internship, especially in the
12 private sector, I am convinced that if they
13 have 100 resumes sitting on their desk in
14 their HR Department for a job and we have had
15 somebody and they are working as an intern,
16 that it is probably going to be that
17 individual's right of first refusal to that
18 job opportunity and that is what we are
19 seeing.
20 Of the ones that haven't taken the
21 jobs mostly it is because hey, you know what,
22 this was a phenomenal opportunity. I love

1 sticking my head inside the corporate world
2 and seeing the way it operated but this is not
3 for me. I want to do something different.
4 Or, the opportunity is in Minnesota and
5 Minnesota is just way too cold in the winter
6 and I want to geographically work somewhere
7 else.
8 Sir, did you have a question?
9 CO-CHAIR NATHAN: What have you
10 got cooking at USF?
11 MR. McDONNELL: Oh, sir, I could
12 spend a whole day talking about USF.
13 CO-CHAIR NATHAN: And why USF,
14 just its proximity to the military
15 headquarters in Tampa?
16 MR. McDONNELL: In part, sir. But
17 a retired Marine Lieutenant General Marty
18 Steele is at USF and is on their faculty. And
19 he heads the Veterans Reintegration Committee
20 is just busting down doors of opportunity left
21 and right for Veterans to come there to go to
22 school, to partner USF with other initiatives.

1 USF is one of the campuses that we
2 are looking helping DHS partner one of their
3 initiatives I am going to talk about in a
4 minute. They are right across the street from
5 the Haley VA Center. So that connection to
6 the VA is there. They have a phenomenal
7 nursing program.
8 But it is a very Veteran-friendly
9 school. And because of the leadership that is
10 down there at the University, they are not
11 inclined to tell us no for anything we ask
12 them to help us pilot. They have come to us
13 on a number of occasions and wanted us to help
14 them find wounded Veterans to test prosthetic
15 devices. So it is just a great relationship
16 and the fact that they are there in Tampa with
17 us, just makes it great for opportunity.
18 We also have a tremendous
19 relationship with all 17 universities in North
20 Carolina. Three of our five components are
21 based in North Carolina. And so we work very
22 closely with the Board of Trustees in North

1 Carolina. But North Carolina's education
2 system and Florida's is set up differently.
3 All 17 schools in North Carolina operate under
4 a single Board of Trustees and all the schools
5 in Florida operate as separate LLCs.
6 So, going and doing something with
7 a North Carolina school is just a different
8 procedure. And an example of that is last
9 year North Carolina dropped their requirement
10 for Servicemembers to take an SAT to come to
11 an UNC school, which is huge. What we are
12 trying to do now is get them to drop their
13 requirements for out of state tuition for all
14 Servicemembers.
15 Just tremendous opportunity,
16 though, through the university systems. USF
17 is just right there next to us and with the
18 majority of my staff.
19 Two slides of the 157 companies we
20 either have memorandums of agreement with or
21 developing memorandums of agreement with. And
22 that is for the internships and

1 apprenticeships.
2 Some of these have spun out of
3 opportunities that the Services introduced us
4 to and some of them have come out of
5 opportunities that have come from literally
6 360 degrees of direction.
7 Okay, I want to talk about a
8 couple of the programs specifically. A little
9 over a year ago, a non-profit approach about
10 taking some of the very high-end talent we had
11 and recycling it but not into our own
12 organization and into law enforcement and the
13 focus was on them funding some very high-end
14 cyber forensics training and then partnering
15 the trainees back with federal law enforcement
16 for about a ten-month internship. The
17 training finished ten days ago and last Friday
18 DHS Secretary Beers and HSI Director Dinkins
19 officiated the first graduation of this
20 program. We had 17 graduates of the program
21 and they are out across the country right now.
22 Starting last Monday, they reported for duty

1 in their internships hunting down people
2 online that are trafficking children. And a
3 large majority of the people in our community
4 were doing man hunting-type operations
5 overseas for years. And the opportunity to
6 step back into a role like this, supporting
7 law enforcement or as a law enforcement
8 officer is that kind of purpose and relevance
9 that a lot of Veterans are looking for.
10 The nonprofit spent about $800,000
11 of their own money on equipment and training.
12 And can you get that video to play? I wanted
13 to show you the video that DHS did of this.
14 VIDEO: When I got hurt, I
15 physically couldn't perform my job any longer
16 and I had to tell the guys that I had laughed
17 and bled with and sweated with that I can't do
18 the job anymore. And that was really, really
19 a tough pill to swallow for me.
20 I joined the Army and I was what
21 they called a lifer. I was going to retire
22 from the Army. That was my goal. I got early

1 retirement due to my injuries. What am I
2 going to do now?
3 And as soon as I read the first
4 two paragraphs, protect -- the National
5 Association to Protect Children, HSI, all
6 these guys involved in it, it was a simple,
7 simple decision.
8 If you do this long enough, you
9 are going to realize what a two and a half
10 inch hard drive looks like.
11 You spend time overseas going
12 after terrorists, things like that. But there
13 is a whole lot of even worse people right here
14 in our own back yards doing unspeakable things
15 to children. Why would you not want to do
16 anything you can to prevent that, to stop
17 these people from harming children?
18 Number one purpose is to rescue
19 the children. Now they are going to have a
20 guardian angel coming up. I am going to do
21 something for them.
22 From the bottom, look to see if

1 you see any icons.

2 Are we qualified? We are

3 qualified because we are Special Operations.

4 We are the topnotch guys. We are the guys

5 that you don't want us coming knocking at your

6 door.

7 I am chomping at the bit to be

8 able to apply what we have learned. For me,

9 I was trying to find a new mission.

10 I am looking forward to

11 contributing to my community so I can help get

12 some of these people off the streets in the

13 communities in which I am raising my family.

14 I do solemnly swear that I will

15 support and defend the Constitution of the

16 United States against all enemies, foreign and

17 domestic; that I will bear truth, faith, and

18 allegiance to the same; that I take this

19 obligation freely, without any mental

20 reservation or purpose of evasion; that I will

21 well and faithfully discharge the duties of

22 the office on which I am about to enter, so

1 help me God.

2 I'm not done saving my country. I

3 fought the foreign enemies. It is time to get

4 those bad guys that are here in my back yard.

5 And that is the whole reason we

6 are here.

7 This program means so much to me.

8 I have an eight-year-old sister and I have a

9 fourteen-year-old brother. The reason I

10 joined the military was to protect my family.

11 That is what I have to do.

12 MR. McDONNELL: Thank you.

13 So, that program was a partnership

14 between us, a nonprofit, and DHS. And it is

15 that collaborative nature of a lot of these

16 opportunities that I think just creates

17 tremendous opportunity for troops to find that

18 purpose and relevances they all clearly

19 annotated there.

20 The young man there with the dog,

21 Justin Gartner, he was the Marine that was out

22 at NCTC and did a year at USF. And then the

1 opportunity for this program came up and we
2 couldn't slow him down to get in it.
3 I'm sure you all recognize Chris
4 Mackenzie. Chris is our first intern at
5 American Airlines. And American Airlines
6 magazine, we have a great relationship with
7 American Airlines and American Way. And what
8 the CEOs of those two companies have told is
9 that they will hire as many people as we can
10 push their way.
11 So, through the internship program
12 that we have with them, what they have the
13 opportunity to do is look at the talent. And
14 so Chris is the first one out there on the
15 ground, beating down the door. American Way
16 did a phenomenal article on Leroy Petry, a
17 Medal of Honor recipient who is also one of
18 our Care Coalition advocates stationed out at
19 Joint Base Lewis-McChord.
20 Intelligent Waves is another
21 company. It is a very small company. It is
22 an IT company here in the D.C. area and they

1 have taken in a couple of our troops under the
2 auspices of an internship, provided a
3 significant amount of training to them.
4 And all those companies you saw up
5 there that we are working MOAs with, what the
6 Memorandums of Agreements do is it defined the
7 left and right limits of what they can and
8 can't do with our troops while they are doing
9 an internship. Obviously, they can't work on
10 anything or sell anything, develop anything
11 that the company is going to turn around and
12 sell back to the government. But it is folks
13 like Jared Shepard that have been so
14 incredibly generous and helpful. And if one
15 of these troops doesn't want to go to work for
16 Intelligent Waves but finds somebody else out
17 there that Intelligent Waves does business
18 with, that they are interested in, it is folks
19 like Jared that are going to open the doors
20 and help further that on. So, by default,
21 these leaders that open the doors to the
22 companies become part of the mentorship chain.

1 Merrill Lynch, another great
2 example. I had a SEAL, an E7 who was
3 finishing his med board and he wanted to go to
4 work in the financial sector. And my
5 conversation with him is you have been kicking
6 in doors and hunting people for the last 13
7 years. What do you know about financial
8 instruments? And he started talking. And he
9 could talk about financial instruments the way
10 most kids his age could talk about football
11 stats or hockey stats.
12 So, we went and talked to the head
13 of Merrill Lynch's Private Client Group out in
14 Los Angeles. And she opened the doors and let
15 him. And their whole role there was to
16 prepare him and his internship was to prepare
17 him to take his Series 7 exam. And they
18 absorbed every bit of the expenses of that.
19 The day he got his DD214 in his
20 hand, they offered him a stunning offer and he
21 took it.
22 But when I talk about building

1 opportunity around an individual based on what
2 an individual wants, that is the kind of
3 opportunity that we are talking about. And
4 those tools that I showed you are going to
5 allow us to find those opportunities with a
6 lot more specificity than what we have been
7 able to do in the past.
8 ACADEMI is another great
9 organization. They have a huge training
10 facility down in North Carolina where again,
11 three of our five components are. A lot of
12 our troops, when they want to retire, they
13 want to stay and they would like to stay in
14 the same general area, especially if they have
15 kids that have rooted into that and families
16 that have rooted into that area.
17 Those are just a couple of
18 examples. I will give a little bit of time
19 back to you and certainly open it up if you
20 have any questions.
21 MR. DRACH: On your SOF X program,
22 it appears to be to me, and I may not

1 understand it totally, that it is very wounded
2 ill and injured oriented. If an employer
3 wanted to get involved, who does the employer
4 contact and how do they interface into it?
5 MR. McDONNELL: Well, the tool
6 itself will have access to -- it is an
7 analytical tool that crawls through other
8 people's databases. And if I am absolutely
9 butchering that, please say something. But it
10 is not a database in and of itself. It is an
11 analytical tool that will go out and crawl
12 through other databases.
13 If somebody wants to, I mean there
14 are a variety of ways -- you know, when I go
15 around and meet with company executives, I can
16 connect that tool with the company executive's
17 HR database so that open requisitions flow
18 through the tool, rather than them having to
19 reach out. But I think there are a variety of
20 ways that could actually work.
21 Right now, we have let this
22 contract under an innovation contract. So it

1 is a pilot. In looking for something that
2 would do something like this for the two years
3 I have been in the job, I haven't seen
4 anything else like this that comes close.
5 Most of the head hunters I have
6 talked to say they do things one at a time.
7 They do things in inches. But something that
8 can take groups of people and it learns. The
9 more information you give it, the smarter it
10 gets.
11 So, if I put my population of
12 7,188 in it, it is going to be pretty smart on
13 my population. But if Admiral McRaven decides
14 down the road that he wants to open this up as
15 a supplemental tool, and that is not a
16 decision that has been made, but I would
17 imagine that this, being so attractive, that
18 that might be the case, it is going to get a
19 whole lot smarter with 66,000 people in it
20 than it is with 7,100.
21 If the Army Reserve and the
22 National Guard wanted to open it up because of

1 the tool, because of the requirements of the
2 Guard being different than that of the active
3 service where people are constantly mobilizing
4 and demobilizing and mobilizing and
5 demobilizing and just with SOCOM the
6 population that we see that represent the
7 Guard and the Reserve, we have tremendous
8 struggle among troops that demobilize. And
9 then it is not that the job that they had
10 before wasn't there, the company that they
11 worked for before is no longer there. So now
12 what do they do?
13 So, for us, this becomes a
14 tremendous tool in helping reconnect that
15 talent to civilian opportunity so that we can
16 still keep the talent on our roles to be
17 mobilized later in a crisis.
18 Sir?
19 MR. REHBEIN: Sir, you talked
20 about the one individual that did the
21 internship with Merrill Lynch. What sort of
22 a procedure do you use to identify what a

1 particular person's interests are, what
2 direction they should go? Granted your
3 population is older, more focused, knows
4 themselves better but many of them, the
5 military life is all they have seen.
6 MR. McDONNELL: That's exactly
7 right.
8 MR. REHBEIN: So what procedure do
9 you use to help acquaint them with what is out
10 there that maybe they could aim towards?
11 MR. McDONNELL: I'm really glad
12 you asked that question. This is where our
13 advocates start the conversation and start
14 probing into this subject matter with the
15 troop and with the family as early as
16 possible. Because I mean I might have, I have
17 got two officers on my roles, actually three
18 right now, that are completely blind, that are
19 still on active duty. One retires this
20 Friday, two are still on active duty. And I
21 am constantly having the conversation with the
22 three of them, personally, me and them, but

1 their advocates are also having the
2 conversation with them. And we are talking
3 about all these other opportunities that are
4 opening up.
5 One of those officers is an Army
6 officer who right now is stationed in Spokane,
7 Washington at Gonzaga. He has got an MBA from
8 Duke that he got after he was injured. The
9 world is completely open to him. But right
10 now, the way he defines purpose and relevance
11 is getting up every day and putting on that
12 uniform and going out and helping ROTC
13 students. And so we are going to continue to
14 have the conversation with him. We are going
15 to continue to put opportunity in front of
16 him. And when he gets to the point, when he
17 and his wife get to the point where they want
18 to zero in on opportunity, with this tool, we
19 can do it geographically. We can do it
20 functionally. So either a particular career
21 field or, in Tiffany's case, I want to live in
22 the Northwest. I want to live around my

1 family. I know operations on the East Coast
2 for innovation are phenomenal. I want to live
3 on the West Coast. Okay, that's great.
4 So, it is a conversation that
5 evolves over time. And then through that
6 triangular model we showed you, we will bring
7 mentors in over the course -- through the
8 process. And it might be a little bit more
9 subtle. I might invite somebody to an event
10 to speak at the event. And after they speak,
11 three or four people in the audience are going
12 to come up and start talking to them. So, in
13 as many different ways as we can encourage
14 somebody to think about the future and think
15 about their definition of purpose and
16 relevance, that is exactly what we want to do.
17 And it is not the same for any two people.
18 CO-CHAIR NATHAN: You talk about
19 leveraging support. Can you give some
20 examples of your bullet military treatment
21 facility initiatives?
22 MR. McDONNELL: Sir, which page

1 was that on? I just want to see the context
2 of --
3 CO-CHAIR NATHAN: Page two. So,
4 leveraging support provided by DoD programs.
5 MR. McDONNELL: Yes, sir. I mean
6 inside the hospitals there are all kinds of
7 different programs that go on inside the
8 hospitals. Some of them are service-driven,
9 whether it is bringing education actually into
10 the hospital, that is what I am talking about.
11 We don't want to replicate anything else that
12 is already out there. So, military medical
13 treatment facilities, if there is a program
14 out there that works that may not be where
15 that individual currently is, we are going to
16 use that. But if not, we are going to outside
17 the military medical treatment facilities.
18 CO-CHAIR NATHAN: And do you
19 pretty much restrict your level of effort to
20 those people who have been formally marked as
21 wounded, as having either a disability or an
22 injury, either a visible or invisible wound of

1 war that is being followed by some sort of
2 provider or requires something? In other
3 words, what about the day to day operation of
4 the SOF member, who just needs counseling or
5 family advocacy, those sorts of things.
6 MR. McDONNELL: Yes, sir. We use,
7 I think probably to the fullest ability
8 possible, the entire network of military
9 family life counselors. But I think there are
10 two separate initiatives within the Command
11 and they are separate and distinct. The
12 Preservation of the Force Initiative is one
13 initiative. We are completely separate from
14 that.
15 So, if you think of a Venn
16 diagram, the Preservation of the Force
17 Initiative is really designed to keep
18 everybody that is out there operational, fully
19 operational. Our focuses is on wounded, ill,
20 injured troops and families and helping them
21 return to that full duty. But they are two
22 separate and distinct initiatives.

1 CO-CHAIR NATHAN: Thanks for the
2 clarification. I bring it up because through
3 my experiences, I have observed that number
4 one, the ethos of support and of loyalty that
5 is your hallmark in the field of battle,
6 taking care of each other, continues to extend
7 throughout the entire lives of the bands of
8 brothers and sisters that are together in the
9 special warfare community. That said, you are
10 pretty well resourced compared, per capita, to
11 the other services. And so you are able to
12 enjoy some concierge type programs that the
13 Services at large can't or don't yet. And I
14 do worry sometimes about -- and it sounds like
15 more in the force preservation side because
16 the special warfare community will go out and
17 get money to hire or contract psychosocial
18 services, primary care, in some cases
19 specialty care that is sort of their own
20 parallel universe to what the Services are
21 doing.
22 And I worry about that from two

1 standpoints. One, I applaud the initiative
2 but I worry about it from two standpoints.
3 Number one is who is auditing the resource
4 use? Are you getting the bang for the buck
5 when you do that? If I hire a psychologist,
6 there are ten people over me watching that
7 money and seeing if it is going to go to good
8 use or not. I'm not sure where the checks and
9 balances are in the SOF community for that
10 kind of thing.
11 And secondly, sometimes the
12 quality assurance of these personnel who are
13 hired in the medical, I call it sort of the
14 paramilitary or para-MHS world, how well we
15 are doing. And again, I am not asking you to
16 defend or attack that because I don't think
17 that is in your bailiwick.
18 MR. McDONNELL: No, sir.
19 CO-CHAIR NATHAN: But that is
20 something I think is as, either rightly or
21 wrongly, as the kinetic action starts to
22 decrease or at least that the country sees.

1 And we know that there is a lot of stuff going
2 on kinetic in your community right now that
3 never makes the headlines. You have a very
4 highly deployed, highly taxed community that
5 most people don't appreciate the degree of
6 recycling that your warriors do on a day-in,
7 day-out basis.
8 But that said, there is going to
9 be more and more scrutiny now on resources and
10 how they are spent and how they are applied
11 throughout the various communities. And so
12 those communities that have traditionally been
13 given not blank checks but large checks, are
14 going to be scrutinized as to okay, how is the
15 bang for the buck.
16 Do you have any comments to offer
17 in that way as far as our resourcing and how
18 you do your own sort of QA as to determine if
19 you are spending a million there or spending
20 a million here that it is getting the best
21 effect for the money you can get?
22 MR. McDONNELL: Yes, sir. I think

1 the initiative that you are referring to in
2 the Command has, like I say, it is a
3 completely separate organization and falls
4 under General Sekaulek (phonetic) and FMD,
5 where an initiative that works directly for
6 the Commander. I don't have anywhere near the
7 budget that that organization has but I do
8 have some authority.
9 CO-CHAIR NATHAN: Nobody has
10 anywhere near the budget that that
11 organization has.
12 MR. McDONNELL: No, sir. But I do
13 have some authorities that they don't have.
14 One authority I have chartered by the
15 Commander is the ability to go out and work
16 with benevolent organizations. So, and I
17 guess I can describe the relationship between
18 the Care Coalition and POTF is that is a pot
19 of money that is buying resources to put down
20 at the tactical level for tactical unit
21 commanders to use to preserve the capability
22 that they have. Those resources are what my

1 advocates use in some cases to connect with
2 specific people. And what my advocates do is
3 there is one slide from our generic brief that
4 has got all these different blocks up here.
5 It has got benevolent organizations. It has
6 got VA. It has got Department of Labor. It
7 has got Service. It has got medical. And
8 what my advocates do is sequence those things
9 in time, based off a need, so that the family
10 can focus on what is most immediate. And that
11 is our role.
12 So regardless of where the
13 resources come from, those resources out there
14 at the tactical level are for my advocates to
15 use to help family members and troops. And
16 that is our focus.
17 The other focus that I have not
18 put up here and emphasized is our GOLD STAR
19 population. That is mine, too. And that
20 extends to, like you said, it is for the rest
21 of your life. That was General Brown's
22 charter. It was Admiral Olson's and it is

1 Admiral McRaven's. It is for the rest of your
2 life.
3 And we don't violate Title 10 and
4 Title 38 by doing that. I have VA employees
5 on my staff as well. I have one of the 22
6 FRCs that sits in my headquarters in Tampa.
7 And Adam has his own caseload for the VA well
8 beyond SOCOM. But we ask them to sit in our
9 headquarters so we could see and completely
10 see into the VHA and all the capabilities that
11 the VHA has. I also have somebody from the
12 VBA that sits in there, a fairly senior
13 person.
14 So both the VBA and the VHA I have
15 complete reach in. So when Veterans call in -
16 - because we are what they are with. They may
17 not be familiar with the VA. And when only 35
18 to 45 percent of Veterans use VA services, I
19 can be the conduit to connect them back with
20 those services.
21 And so and then the last part of
22 that is benevolent organizations. I probably

1 leverage three benevolent dollars. I don't
2 know, I have never really calculated it
3 because it is a really hard number to come up
4 with but I leverage benevolent dollars far
5 greater than I leverage Title 10 dollars
6 because they are out there.
7 But our perspective is that the
8 most corrosive influence on a recovering
9 Servicemember or a family, other than the
10 injury itself is unchecked benevolence. So,
11 we want to make sure that the benevolence that
12 is coming in to a recovering warrior or a
13 family member is needed and it is value-added
14 to the recovery. We want to steer it away
15 from entertainment or entertainment-like
16 functions. And we want to steer it away from
17 benevolent gestures that are given to make
18 really for the donor to feel better about
19 giving something than really for the benefit
20 of the troop. So we keep a very close eye on
21 that.
22 And before we allow any of that to

1 take place, we vet both the benevolent
2 organization very well and we vet the troop
3 and the need very well.
4 So, two very different initiatives
5 that I think overlap. But I think the whole
6 initiative of the POTF got off the ground in
7 a great direction with a great intent and I
8 think it will definitely morph and probably
9 morph quite quickly over time into something
10 that is quite sustainable.
11 CO-CHAIR NATHAN: Thank you. And
12 you weren't here earlier, perhaps, but that
13 was one of the themes of trying to chase the
14 benevolence dollar and make sure that it is
15 making some sort of life value added for some
16 body, as opposed to just some sort of instant
17 gratification.
18 MR. McDONNELL: Yes, sir.
19 CO-CHAIR NATHAN: And the reason
20 my interest was piqued by the USF is that boy,
21 if you can figure out a way to template that -
22 - I recognize that you have proximity and you

1 have some of the locale there with the
2 headquarters, but if we can template those
3 kinds of things across the academic spectrum
4 of the country, and you are not going to get
5 everybody, but there is a lot of grain to be
6 harvested out there if we can figure out how
7 to break down doors and universities.
8 I get the fact that when you have
9 seen one in Florida, you have seen one.
10 MR. McDONNELL: Yes, sir.
11 CO-CHAIR NATHAN: As opposed to
12 North Carolina, where it all sits under one
13 Board of Regents. But, nonetheless, that is
14 fertile ground, I think, in other parts of the
15 country to try to tap into. And so the Task
16 Force, I think, unless it changes, is headed
17 down that way. And that may be something we
18 want to take a closer look at is to understand
19 the partnerships there and see how we can
20 build an algorithm for templating that,
21 without having to build a base next door to
22 the university.

1 MR. McDONNELL: Yes, sir. Well, I
2 also sit on that Board of Veterans
3 Reintegration at USF at General Steele's
4 invitation. I would strongly encourage you to
5 go down there. I mean, having senior military
6 leaders like him down there makes all the
7 difference in the world. Being able to follow
8 him in on an initiative somewhere in the
9 school right now, the HERO program for the
10 next iteration of the HERO program, we are
11 trying to get that tied in to a major
12 university and USF is one of the ones we are
13 looking at that already has a cyber-forensics
14 program up and running. And if it is tied
15 into that program, then the troops that go
16 through the program can actually use their GI
17 Bill to go through the program. That saves
18 part of that $800,000 that that nonprofit that
19 can go over and recycle into something else.
20 So, that is exactly the direction
21 we see that really adds merit to a lot of
22 these initiatives that are out there as well.

1 CO-CHAIR NATHAN: Did the North
2 Carolina schools participate in the Yellow
3 Ribbon Fund do you know, for the GI Bill?
4 MR. McDONNELL: Sir, I don't know
5 the answer to that.
6 CO-CHAIR NATHAN: Basically, it
7 provides, as I understand it, it provides in-
8 state tuition rates for people who are GI
9 Bill-eligible.
10 EXECUTIVE DIRECTOR DAILEY: Kevin,
11 can I -- so, I am going to ask a question
12 about their employment initiatives.
13 Page 16, you have 111 internships,
14 a lot of them with civilian agencies, civilian
15 companies, I assume. Right?
16 MR. McDONNELL: Yes.
17 EXECUTIVE DIRECTOR DAILEY: And
18 you did that all before you got your new
19 algorithm onboard. So the alignment of your
20 interns with those companies was basically
21 face-to-face and through your MOUs with them
22 and through your personal going out and

1 sitting in their offices and saying this is
2 what we have.
3 MR. McDONNELL: Every single one
4 of them.
5 EXECUTIVE DIRECTOR DAILEY: Okay.
6 MR. McDONNELL: A lot of legwork.
7 EXECUTIVE DIRECTOR DAILEY: Okay.
8 MR. McDONNELL: And for each one
9 of them that is there and up and running,
10 there was another one where there might have
11 been two more that we looked at and just said
12 this isn't a good fit.
13 EXECUTIVE DIRECTOR DAILEY: Okay.
14 MR. McDONNELL: If you look at the
15 157 partners that we either have MOAs with or
16 we are developing MOAs with, I think that
17 shows you sort of a test of the opportunity
18 that is out there, the private sector wants
19 the talent. And when you look at the -- I
20 mean I was the JSOTF Commander in Iraq from
21 2005 to 2007. Nothing I did in Iraq, nothing
22 we ever achieved was my idea. It was because

1 of the sergeants and the lieutenants and the
2 captains that were out there on the ground
3 solving really, really difficult problems that
4 we never taught them how to approach. And if
5 we can take that talent now and get that
6 talent into the private sector to solve the
7 problems that the private sector is facing,
8 that is just huge. And so they want the
9 talent.
10 EXECUTIVE DIRECTOR DAILEY: Right.
11 MR. McDONNELL: Finding the
12 talent, I mean, finding the talent is the
13 challenge for the private sector.
14 EXECUTIVE DIRECTOR DAILEY: I mean
15 that is my next question here. You have 111
16 internships. What do you think your pent-up
17 demand is? How many people do you have in
18 line for those internships?
19 MR. McDONNELL: Let me answer that
20 in about 180 days when we have been using this
21 tool for about six months.
22 EXECUTIVE DIRECTOR DAILEY: Okay.

1 MR. McDONNELL: Because I think
2 that is the kind of question that the VA wants
3 to know, too. Because they are trying to
4 figure out what is the right tool that the VA
5 can use. I think that is a question that the
6 Reserve components and the Guards probably
7 want to ask, too.
8 And you know how much of an
9 exchange is there going to be between
10 geography and opportunity between someone who
11 is getting out and where really is that right
12 fit? And so I think through connecting
13 several different tools, several different
14 programs together, we will get a better
15 fidelity on that answer but I don't really
16 know.
17 EXECUTIVE DIRECTOR DAILEY: Okay.
18 MR. McDONNELL: I don't know the
19 answer to that. I do know that I have, within
20 my veteran population, I have a lot of people
21 who are 100 percent disabled who will get out
22 and who will privately tell us, I will stick

1 a gun in my mouth if I don't find something to
2 do. I am absolutely going crazy.
3 So, going back and again purpose
4 and relevance and helping them figure out what
5 that means for them. And I think some
6 companies that don't have a tight affiliation
7 with the military, they may not have a lot of
8 Veterans in the population, they express
9 anxiety over what does it mean to hire
10 somebody with post-traumatic stress. And how
11 much of a risk am I actually taking? So, what
12 the internships give them the ability to do is
13 look at the talent. They get to test drive
14 the talent. And the numbers of the companies
15 of those 111 in the private sector, the
16 majority of them come back within about 30
17 days of having that person operating in their
18 space and say I would like five more just like
19 that. The same background, the same degree of
20 intensity, just like that.
21 So, literally, part of the problem
22 I have is finding troops that are at the right

1 stage of recovery to step into an opportunity
2 that is ripe. And I will just say for the
3 record, we don't limit putting people in those
4 opportunities to just people who have served
5 in SOF units. Only 10 of the 17 folks in that
6 HERO program ever served a day in SOCOM. We
7 took the other 17 from the Veteran population
8 that somehow connected with us. We vetted
9 them just like we did our own. We resourced
10 them through benevolent organizations just
11 like we did our own because it is about
12 finding the best opportunity to match the
13 opportunity.
14 EXECUTIVE DIRECTOR DAILEY: And I
15 see you have published guidance. It would be
16 great if we could get a copy of it.
17 MR. McDONNELL: Certainly.
18 EXECUTIVE DIRECTOR DAILEY: That
19 would be great.
20 CO-CHAIR NATHAN: Okay, well thank
21 you. We appreciate everything you have said
22 and we welcome maybe down the road if you

1 could let us know how the software is working,
2 how the IT interface is working so we can
3 migrate from some amazing successes you had,
4 which so far have been a little bit based on
5 I know a guy who knows a guy --
6 MR. McDONNELL: Yes, sir, exactly.
7 CO-CHAIR NATHAN: -- to one that
8 creates a panacea of awareness across the
9 private sector, the academic sector, and
10 matches up so they can migrate beyond the SOF
11 forces to all our wounded warriors.
12 But again, thank you for your
13 presentation. Sir, thank you for your service
14 as well.
15 MR. McDONNELL: My pleasure.
16 CO-CHAIR NATHAN: And again, I
17 think we are on time now so we will let you
18 off the hook.
19 MR. McDONNELL: Thank you, sir.
20 EXECUTIVE DIRECTOR DAILEY: Yes, I
21 would like everyone back by 2:15 please. We
22 are setting up a panel. We have a number of

1 people who will be talking to you at 2:15.
2 (Whereupon, the foregoing matter
3 went off the record at 2:07 p.m.
4 and went back on the record at
5 2:18 p.m.)
6 MR. DOROTHEO: Hello. Good
7 afternoon, ladies and gentlemen of the panel.
8 I'm assuming it is appropriate to start right
9 now.
10 CO-CHAIR NATHAN: I can actually
11 introduce you.
12 MR. DOROTHEO: Okay.
13 CO-CHAIR NATHAN: I'm educated
14 beyond my means. So, at this time, we welcome
15 several attorneys -- everybody there is an
16 attorney?
17 MR. DOROTHEO: Yes, sir.
18 CO-CHAIR NATHAN: Okay. It is a
19 rich environment for a doctor here -- are
20 participating on our IDES lawyer panel. And
21 please correct me if I have this wrong, but as
22 the Army representative we have Mr. Duke

1 Dorotheo.

2 MR. DOROTHEO: Dorotheo, sir.

3 CO-CHAIR NATHAN: Dorotheo. Okay,

4 Mr. Dorotheo. For the Marine Corps we have

5 Major William Collins.

6 MAJ COLLINS: Yes, sir.

7 CO-CHAIR NATHAN: Okay. For the

8 Navy we have Ms. Karen Morrisroe?

9 MS. MORRISROE: Yes, sir. Good

10 afternoon, members.

11 CO-CHAIR NATHAN: Good afternoon.

12 And Ms. Elizabeth Moores.

13 MS. MOORES: Yes, sir. Hello.

14 CO-CHAIR NATHAN: Very good. And

15 for the Air Force we have Mr. Rick Becker.

16 MR. BECKER: Yes, sir.

17 CO-CHAIR NATHAN: And is

18 Lieutenant Colonel Tara Villena here?

19 MR. BECKER: No, sir, she is not

20 going to be coming. It will just be me.

21 CO-CHAIR NATHAN: Okay. So each

22 Service representative, as I understand it,

1 has prepared some slides. They will discuss
2 their thoughts on the IDES process and the
3 legal support during the MEB phase. The
4 members can find this information in Tab F of
5 your briefing book.
6 And if we could, we will begin the
7 panel with Mr. Dorotheo.
8 MR. DOROTHEO: Thank you, sir.
9 Again, my name is Duke Dorotheo. I am the
10 Acting Deputy Director of the Office of
11 Soldiers' Counsel. Currently, just for
12 situational awareness, we have approximately
13 101 attorneys on mission. We have 39 that are
14 dedicated to the PEB level and 62 that are
15 dedicated to the MEB level.
16 And when I am not in my acting
17 capacity, actually my permanent job is as the
18 Regional Supervisory Counsel and I still
19 represent Soldiers going through the process
20 both through the MEB and PEB level.
21 I want to start off with a
22 disclaimer. The following information I am

1 going to share with the Board, a lot of it is
2 my personal opinion and they do not
3 necessarily represent the opinion of the Army,
4 DoD, U.S. Army Medical Command as well.
5 Let's see, we were asked to
6 identify our top five changes that we would
7 like to see made to the IDES process. Number
8 one for my point of view would be to improve
9 transparency. We have a lot of Soldiers that
10 go through the process. It is rather
11 complicated with various levels of
12 understanding, due to physical and mental
13 disabilities. But one of the most, again, the
14 most frequent complaint is the transparency.
15 Soldiers often do not know exactly where their
16 case is in the system. The system is making
17 progress. There are initiatives underway to
18 create a DoD, Department of the Army dashboard
19 so that Soldiers can log onto the system and
20 see exactly where their case lies.
21 One of the issues that we have
22 seen within that was put forth in the National

1 Defense Authorization Act of 2008 was a system
2 set up where a Soldier can request an
3 impartial medical review of their MEB
4 findings. We ask one of the things to improve
5 the transparency is that Soldiers assume that
6 the impartial medical reviewer is someone who
7 is independent of the MEB. We ask that in
8 order to improve transparency, request that
9 the IMR providers are not members of the MEB.
10 And this is two-fold. There may be some
11 concern that some MEB physicians serving in
12 the IMR role may be hesitant to contradict
13 another MEB physician. That may not
14 necessarily be the case but there are some
15 appearances where that may be case. In order
16 to remove that, we request that providers who
17 are part of the IMR not also be members of the
18 MEB.
19 Number two was the elimination of
20 the TDRL backlog. We, in the Office of
21 Soldiers' Counsel understand that there are
22 more than 16,000 Soldiers in the TDRL process.

1 It places a strain on every level with every
2 stakeholder in the Soldiers' Counsel process.
3 There are some mechanisms, because
4 remember, our office represents Soldiers who
5 both want to be found fit for duty and may not
6 be achievable at that point in time and a
7 Soldier is going through that process. A lot
8 of times they want to be placed in the TDRL to
9 be given the opportunity to be found fit for
10 a later time.
11 One of our recommendations is once
12 the Army reduces its TDRL backlog, we
13 encourage that there is a formation of some
14 type of group to review those conditions,
15 where maybe prudent to place Servicemembers on
16 the TDRL. Again, because it is such a large
17 resource, very few of the Soldiers that go
18 through the process are eventually found fit
19 and some actually perceive the TDRL as a
20 possible reduction in benefits for later on
21 down the road when there is an 18-month review
22 or earlier.

1 Number three was to increase the
2 quality of IDES documentation. We want to
3 encourage initiatives already underway to
4 improve the quality of information that is
5 provided by the MEB. One of the
6 responsibilities that the MEB and both the PEB
7 have, while they are adjudicating the case, is
8 to determine whether a condition is either
9 independently unfitting or unfitting in
10 combination with other conditions.
11 Now, we know that conditions that
12 fall below Army retention standards require a
13 certain amount of information and we are
14 working with our stakeholders through the
15 physical disability agency and also through
16 the Army Medical Command to enhance the amount
17 of information that is provided for even those
18 medical conditions that meet Army retention
19 standards. While they may not individually
20 render that Servicemember or the Soldier
21 within the Army to be found unfitting, the
22 combined collective -- the combined effect may

1 render that condition unfitting. And if there
2 isn't an adequate work-up of that medical
3 condition, there is a potential that the
4 Servicemember may be denied benefits they may
5 otherwise be eligible to receive.
6 Number four is to increase the
7 Commander involvement in the IDES process.
8 One of the two most important pieces of
9 information for the PEB to adjudicate the case
10 within the Army is something we call the
11 physical profile. What are the
12 Servicemember's limitations physically and
13 mentally in their ability to complete their
14 basic Army -- basic Soldiering skills?
15 Number two, what does that
16 Commander opine for that Servicemember whether
17 they should be found fit for duty or if their
18 limitations are too severe to prevent further
19 duty?
20 A lot of times, again, what
21 Commanders are asked to complete Commander
22 statements. Sometimes the most fidelity to

1 obtain the best information may be back with
2 their Commander in their indigenous unit, or
3 possibly with their first line supervisor.
4 We talked about some of the
5 Servicemembers are in internship programs.
6 Perhaps sometimes that information that the
7 Commanders can reach out to the supervisors to
8 understand their level of limitation that
9 Servicemember has. We could use that
10 information, perhaps, to help assist
11 Servicemembers to be found fit for duty.
12 So we ask, it is not necessarily
13 any barriers we are facing but I think it is
14 an education component for Commanders to reach
15 out to the person who is most able to provide
16 an opinion on what type of restriction that
17 Servicemember has.
18 Number five is an Office of
19 Soldier's Counsel access to all electronic
20 databases that relate to the Servicemember's
21 disability. When I first started representing
22 Soldiers through this process, we didn't have

1 access to a lot of basic information of the
2 Soldier's case. Let me backtrack. In order
3 to get access to that information, we had to
4 request a tactical pause in that Soldier's
5 election period so we can request access to
6 that Servicemember's record. Now, since we
7 have gone fully electronic, in a lot of cases
8 if a Servicemember approaches us, and
9 sometimes only with the most minimal amount of
10 information, we can go into the database, go
11 through AHLTA, go through eMEB and figure out
12 what is that Servicemember's specific
13 documents that are generated in that case.
14 Now, we made a lot of inroads but
15 there are a lot of technical barriers. That
16 is not to say there is anyone who is saying
17 no, that is not necessarily the case. But
18 there are a lot of technical barriers and we
19 ask assistance to overcome those barriers
20 because not everyone is on Army Medical MEDCOM
21 service. They may be on HQDA service. So we
22 ask that up to date case files that the MEB

1 have and that all the stakeholders that rely
2 on the system to issue a decision that we
3 continue to have access to.
4 The next one is what resources, as
5 an IDES attorney, would I like to see
6 implemented in the PEB process.
7 Number one is a dedicated full-
8 time healthcare provider that would be tasked
9 to the Office of Soldiers' Counsel. Now, we
10 have a lot of assistance through a lot of the
11 MEB providers, a lot of the medical members
12 who are part of the Physical Evaluation Board.
13 To the extent possible, we have always
14 received a lot of assistance from them but at
15 certain times, they are just pressed with
16 providing either healthcare to the Soldiers or
17 adjudicating cases. So, their ability to
18 provide information assistance to us, because
19 a lot of times especially in the cases that
20 arise out of the Bethesda, very severely
21 injured multiple modalities of medical
22 conditions, in order to make some heads or

1 tails of it, because we are not medical
2 doctors, sometimes we need a medical
3 consultant to explain the process the medical
4 information to us so we can better advocate
5 and also manage expectations of the
6 Servicemember as well.
7 With that, I will pass it over to
8 Major Collins.
9 MAJ COLLINS: Good afternoon,
10 ladies and gentlemen. I am Major Bill
11 Collins. I am the Program Manager for the
12 Marine Corps Disability Counsel Program and
13 with me is Ms. Karen Morrisroe, the Program
14 Manager for the Navy's Disability Counsel
15 Program. And as a Navy Marine Corps team, we
16 are providing this presentation together. So
17 Ms. Morrisroe is going to take the first of
18 the questions and then we will go from there.
19 MS. MORRISROE: Thank you. Good
20 afternoon. I am Karen Morrisroe, Navy
21 Disability Attorney Program Manager.
22 What we have prepared for you

1 today, we have two changes that we would like
2 to see made and the first one is a centralized
3 electronic case management system. And what
4 the ultimate vision would be, it would be
5 essentially access to the case file for any
6 IDES stakeholder who is involved in the MEB
7 process. That would include the IDES Counsel,
8 PEBLOs, and the MTF healthcare providers. So
9 the way hopefully it would work, and the point
10 would be to make it more efficient and to
11 streamline process. And I know that as a
12 community we have discussed electronic files
13 online now for some time and I think it is
14 just an issue of logistically how that could
15 actually ever really come to pass.
16 But for example, you could have a
17 wounded or injured Servicemember referred into
18 the DES, come to seen attorney, it would be
19 wonderful if we could simply pull up that
20 person by name or whatever identification
21 process that we are utilizing and see the
22 referral sheet. And as you go along through

1 the process, to literally see the NMA, to have
2 it online, to have immediate access to it, and
3 to see that electronic case file. And perhaps
4 you don't need the entire medical record but
5 those portions that are pertinent to the case
6 file.
7 So for example, what is on the
8 referral sheet, unfitting conditions. Did any
9 additional unfitting conditions get added? If
10 so, we would like to see the addenda. So
11 let's say you have a Servicemember who has
12 been in for 20 years. Quite honestly, I don't
13 know that we really need all 20 years of that
14 case file in terms of being practical for what
15 it is that we are charged to do. But what we
16 would like is immediate access or within
17 reason of what is pertinent to us conducting
18 appropriate review of this case file in order
19 to help the Servicemember. And right now that
20 doesn't exist.
21 And some of the problems that we
22 run into, we have a Servicemember come see us.

1 They will have volumes of a hard copy of a
2 case file. They don't want to leave it with
3 us and we don't want them to leave it with us.
4 So I mean somebody has got to make copies.
5 As it stands right now, for Navy
6 and Marine Corps, we are one deep for the most
7 part and we are working with our own
8 institutions in order to obtain some
9 additional administrative support. But until
10 that happens, these attorneys are one deep,
11 these MTFs and so you have individuals who are
12 very upset, many of whom have mental health
13 conditions who would like some type of
14 reassurance or some type of answer. They want
15 to leave you with what it is you need to have
16 in order to help them. And quite honestly,
17 although it seems simple, it is very
18 difficult. Literally, you have got to direct
19 them to a copier and then there is issues with
20 supplies and so on and so forth. But is an
21 MTF environment, so you have a lot of people
22 using sort of joint supplies and logistics and

1 so on. And quite honestly, it just doesn't
2 really like a whole lot of sense at this point
3 in the process. So, if there was some
4 mechanism by which we could have electronic
5 access to what it is we need in order to
6 review the case, we wouldn't even need to make
7 copies and keep these files. We could also
8 conduct our own work product on our own shared
9 drive and that wouldn't -- there would be no
10 PI issue or HIPAA issue with whatever process
11 could eventually get developed for us to have
12 this information.
13 And oftentimes it is not -- some
14 cases are very complex, others are not. And
15 all we need to do is look at the file. That
16 is all we need. And what takes so much time
17 is getting access to the file. And so, that
18 is our vision and I think it dovetails a
19 little bit with what the Army was suggesting
20 as well.
21 Well, our second point regarding
22 MTF facilitated attorney contact will be

1 briefed by Ms. Moores.
2 MS. MOORES: Yes, hello. I
3 remember last year we discussed this at
4 Bethesda and I have to say things have
5 improved quite a bit about having cases
6 referred, once the Servicemember is referred
7 to see an attorney. Just a world of
8 difference. So we are getting access to that
9 now right away. And I wish that all the Med
10 Boards, all the MTFs would just as well as
11 they are doing at Bethesda with that.
12 So right now what they are doing,
13 and I know the Army has always had this where
14 they have a form that they have generated now
15 just to make sure that each Servicemember is
16 informed -- the Marines and the Sailors that
17 that is taking place now with our information.
18 They always receive the form with the
19 information but that was in a folder. Now,
20 there is actually a form that is going in the
21 package and I think that would be a wonderful
22 idea if that could happen at all MTFs for the

1 Navy and the Marine Corps as well, just to
2 ensure that our outliners where we don't have
3 attorneys at those for Annapolis, Newport,
4 Rhode Island, and a number of ones on the East
5 Coast where they would have to have this as
6 part of the package like the Army does. I
7 think that is really important the sooner that
8 they are referred to see an attorney if they
9 need the assistance. And I don't think I have
10 ever had one who hasn't.
11 So, that I think, would be the
12 most helpful. But I did want you know that
13 things have improved considerably since last
14 year.
15 CO-CHAIR NATHAN: Can I ask you a
16 question before we move on to the Air Force?
17 One of the process changes -- and
18 I ask this because I happen to be in the Navy
19 so I know a little bit more about it, although
20 Suzanne and I were talking about how even some
21 of the things brought up so far have been
22 recurrent themes for all our visits. One of

1 the process changes the Navy made and, again,
2 at your point of contact with this, you may or
3 may not have germane information, was then
4 NARSUM is dictated by the provider who sees
5 the patient, as opposed to an Army system
6 where there is a centralized NARSUM that
7 dictates. And there is pros and cons for each
8 system.
9 So, the good news is that the
10 provider in the Navy dictates these NARSUMs
11 and, as a rule, the things that the member
12 wants in them is usually there. It doesn't
13 have to go back. One-stop shopping. My
14 concern is how many of those get kicked back.
15 How many of those is it problematic where the
16 MEB comes back and says there is not
17 sufficient information for this diagnosis or
18 whatever?
19 MS. MOORES: Sir, I was going to
20 say since you have left Walter Reed at
21 Bethesda, they have changed --
22 CO-CHAIR NATHAN: It has gotten so

1 much better, right?

2 MS. MOORES: No.

3 CO-CHAIR NATHAN: That is what you

4 were going to say.

5 MS. MOORES: No. They have

6 changed the format, though, where I agree with

7 you when you said pros and cons because I

8 prefer the addendums definitely. When we went

9 to the Army way, where they do the

10 consolidated narrative summary, and so now

11 that they are doing it there, that it did

12 cause some issues last year with that. All of

13 a sudden you are not getting addenda with all

14 the other conditions. Now, they are doing the

15 Army way of the consolidated narrative

16 summary.

17 But you are right, for all the

18 other locations that they are doing it the way

19 you are talking about, and that works very

20 well if you do have someone that you have a

21 relationship with, and so that they will

22 actually sit down and talk to them and make

1 sure everything is included in that for the
2 other MTF locations. I think that is correct.
3 But still, if there are some that
4 they disagree with that they want to have
5 added, I think it helps to have us talk to
6 them about the case.
7 MAJ COLLINS: And to this last
8 point here, which is the mystery of case
9 management, and by that we mean we are looking
10 at more in terms of we have got our attorneys
11 at the MTFs with the MEBLOs, the PEBLOs, the
12 VA representatives and they are co-located and
13 yet you may have four different receptionists.
14 You have got one section a lot of toner and
15 copy paper, another section that is doing
16 without or making due with minimal resources.
17 Also, each MTF seems to have its own kind of
18 unique deal that goes on on how the service
19 will be provided. And so I think what we are
20 looking for would be some type of uniformity,
21 consolidation, and collaboration in spread
22 loading these resources among people who are

1 doing basically the same mission in the
2 various aspects of it from the med phase with
3 MEBLOs, the PEBLOs, our counsel and the VA
4 representatives.
5 I think also it would also enhance
6 the fact that they are all sharing those
7 resources. You are going to be talking to
8 each other and enhancing the ability to
9 communicate with one another and to better
10 serve the clients as well. And in times of
11 fiscal restraints that we are having, it would
12 be a better management of resources, too, to
13 do it in that way.
14 CO-CHAIR NATHAN: Okay, thank you.
15 Questions? All right, move to the
16 Air Force.
17 MR. BECKER: Thank you, General.
18 I have the same disclaimer that
19 Duke does. Eighteen years of doing this, I
20 definitely have my own opinions. You all have
21 already heard them in some other visits and
22 over the years and some of them are still the

1 same. So, these may be repeating some old
2 areas.
3 The top five changes, one of the
4 ones that you all are very well aware of and
5 I know is getting much more attention is
6 dealing with Reservists, particularly in
7 making sure that their lines of duty the
8 paperwork is done and done well because that
9 makes all the difference as far as them being
10 able to get their benefits.
11 It would be nice to be able to
12 have us have them mandated to actually come to
13 our office, to where we would be able to brief
14 them and find out what is wrong, if they
15 haven't gotten the documentation, and
16 hopefully be able to have enough time to do
17 something.
18 Many times, by the time we get a
19 hold of them, there is simply no time for us
20 to be able to go back and do the changes in
21 the line of duty because of the command
22 document, you have to go back to the unit and

1 start from scratch. And, unfortunately, there
2 a lot of times where it seems very obvious but
3 you have got to have the line of duty in the
4 paperwork and they end up having to go to the
5 BCMR to finally get it done.
6 Number two, again, this is nothing
7 new but it sounds a little bit like some of
8 the other services. The Independent Medical
9 Reviews are very important, in my opinion. I
10 remember when the whole idea behind it was
11 people were saying I am getting these
12 narrative summaries, I am getting this medical
13 information, I am not a doctor. I don't know
14 if it contains everything. I need help. And
15 the idea was they get a medical person who can
16 explain to them and answer their questions.
17 And like with the Army, there is
18 this idea that in many of the facilities, too
19 often, and I was a medical law consultant,
20 which in the Air Force meant I worked in
21 hospitals and I was over in USAFE for the
22 whole Surgeon General of USAFE. I know that

1 Surgeon Generals Air Forces are very strained.
2 Everyone's are very strained. But the
3 Independent Medical Reviewer does need to work
4 for the individual. They need to actually
5 meet with them, talk with them, answer their
6 concerns. And I understand that some of their
7 concerns, and you all particularly know this
8 in-depth, will be concerns that most people
9 might think is not that big of deal. But of
10 course to the member, they want the answer,
11 even if it is not the answer that they want,
12 they at least want to know why something is or
13 is not being considered. And as Duke brought
14 up, having all the conditions, individually
15 and collectively, which need to be considered
16 is very important.
17 So having the IMR physicians be
18 trained a little bit better would be one of
19 those things I think would really help.
20 This manning control option is, of
21 course, unique to the Air Force. Each Service
22 does it a little differently. We don't

1 actually have medical retraining. So, we get
2 quite a few people that come through who have
3 some physically challenging career that they
4 have gone into like EOD or forward controller,
5 something in the Security Forces. And so they
6 end up having the physical disabilities that
7 end their career but it is not so much that
8 they can't do something. They just can't do
9 that job, that physically challenging job.
10 And they often feel like they are being put
11 out because they are kind of being punished
12 for having chosen that. And the ability to be
13 able to try to medically retrain them into
14 another specialty code or area would be
15 something that I know a lot of them would
16 appreciate.
17 The second part is Excess Leave.
18 Allowing Excess Leave would give them option
19 for people who have lengthy processing,
20 especially if you think about two areas which
21 are very legalistic. One is where they may be
22 dual processed administratively for something

1 that they have done that is like
2 administrative discharge or even a court
3 martial. They may be someone who needs to
4 basically not be on that base and not be in an
5 area where they might get in trouble again.
6 And this would allow them to be able to leave.
7 The other good example would be
8 individuals who have serious conditions who
9 want to be able to go back to be with their
10 family and to also make connections and start
11 hopefully getting into the great job like the
12 SOCOM guy was showing. And this will allow
13 them to maybe start doing that, even before
14 the process if over.
15 This next one is very much to the
16 Air Force's role. We don't have the outreach
17 attorneys, as you know, with the other
18 Services. And some of them have different
19 degrees of who many they have. So often, we
20 will get individuals who have not been able to
21 talk to us before they actually come to
22 Randolph. So when they get to Randolph Air

1 Force Base, particularly some of the
2 Reservists whose bases don't know the process,
3 and I know you all heard that over and over,
4 because they may have somebody that only, you
5 know, one weekend out of a month, that person
6 can show up on my doorstep and I have got 24
7 hours to meet with them, establish a rapport,
8 figure out what they need to do, what they
9 want to do, what is the best thing to do, get
10 evidence, and have the hearing the very next
11 day. And that is something that I think is
12 just a little bit too short a time line.
13 Right now everyone is very
14 concerned about time lines and we do get the
15 ten-day notice but the individual may be
16 someone we can't get a hold of in that ten
17 days. And just a few more days of being able
18 to work with that individual I think could
19 make a lot of difference.
20 This next one is again specific to
21 the Air Force. We have Limited Assignment
22 Status, which I know that some people have

1 talked to you all about, which is where the
2 individual basically has an accommodation of
3 their disability. They can stay in a limited
4 assignment position, where we basically can
5 accommodate them by having some work-arounds
6 or having them do some other type of job.
7 Right now, if you have between 15
8 and 19 years, you can apply for this but once
9 you go over 19 years and a day, you can't. So
10 we have a lot of individuals who would be at
11 19 years and a month or two months or three
12 months or four months and they may end up
13 getting severance pay and they are so close to
14 their 20 years, you can understand why every
15 time that happens, we get people calling and
16 people getting upset saying why are you
17 putting out someone so close to 20 years.
18 My best example was a nurse who
19 had 19 years, 11 months and 10 days and got
20 severance pay and everyone says there is no
21 way that can happen. Well, it can because
22 there was no way for them to be able to do

1 Limited Assignment Status.
2 Now of course combat is different.
3 Combat Veterans over the years have got the
4 ability to do this at any time. But for the
5 average person, it still would be something
6 that they could let it happen at 19 years.
7 And that used to be the rule. And so I just
8 think it would really help if that could come
9 back.
10 Resources. Duke already kind of
11 touched on the fact that we are not trying to
12 cast dispersions on anyone. And I know if it
13 was up to you all on the Task Force, you would
14 just pay for all these things yourself and
15 take care of it. The dedicated psychiatrist
16 and physician idea has come up over and over
17 again. And I do think it helps a lot. Our
18 office expanded, as you know, four times to
19 what it was previously and we got a lot of
20 young captains, very, very smart, very sharp
21 attorneys. But, unless you have some kind of
22 medical background doing medical disability,

1 medical law, or something like that, it is
2 very hard on some of these conditions to come
3 up to speed and understand them well enough
4 and also understand why the Board's physician
5 might be concerned about some of the
6 limitations. And having someone just like
7 some of the other Services have mentioned to
8 be able to talk to us could do two things.
9 One, it could improve our ability
10 to advocate and make sure that the individuals
11 who should get what they should are getting it
12 not because we just didn't know something.
13 And secondly, there may be cases where once we
14 talk to the individual, we can go back to the
15 Servicemember and say here is why. Here is
16 what is happening. Here is what is going on.
17 Here is what it means. You need to talk to
18 your doctor. And then that may have them at
19 least once again feel like they understand
20 what is going on and why they are maybe not
21 being kept or they are not getting the
22 percentage they want.

1 The second part on there I know
2 you kind of heard a little bit also from
3 everyone, like with the Navy, some kind of
4 internet network or something that would allow
5 us to interconnect with not just the bases
6 that we have, facilities where we can see
7 people, but for those that are more remote or
8 those that don't always have someone from
9 personnel, that we could talk to them. And I
10 know that Skype has some issues with privacy
11 and particularly with HIPAA. Some way to be
12 able to use something similar to that or be
13 able to have an electronic connection with an
14 individual earlier would really help so that
15 they don't have to, again, come up to speed
16 sort of at the last minute.
17 CO-CHAIR CROCKETT-JONES: Just a
18 second. So, was it Bragg where they were
19 increasing the use of VTC in the Counsel's
20 Office? Was that where we saw it? Where did
21 we see?
22 EXECUTIVE DIRECTOR DAILEY: We saw

1 VTC that wasn't being used in the National
2 Guard at North Carolina National Guard and Air
3 Guard, I believe.
4 CO-CHAIR CROCKETT-JONES: I
5 remember seeing that but we also went into a
6 counsel's office. That was Alaska?
7 CO-CHAIR NATHAN: That was Alaska.
8 CO-CHAIR CROCKETT-JONES: So, it
9 would seem to me that someone has figured out,
10 I don't think they were using Skype, though.
11 So there must be a platform that is more
12 secure. And so we need to perhaps get you
13 connected to that counsel's office as an idea.
14 EXECUTIVE DIRECTOR DAILEY: In
15 Alaska they used the VTC ubiquitously in the
16 WTUs and the WTU resources in order to
17 facilitate connectivity. And this was an Army
18 initiative to field and to put the VTC
19 capabilities in Alaska due to the geographical
20 hazards of traveling. So, that was Army
21 unique and it was probably Alaska unique.
22 CO-CHAIR CROCKETT-JONES: You know

1 I still thought that there was another place
2 where we saw a Physical Evaluation Board that
3 sometimes met via VTC.
4 MR. BECKER: The Air Force has
5 used VTC, ma'am, for Boards. But what I am
6 really talking about is --
7 CO-CHAIR CROCKETT-JONES: I
8 understand what you are talking about but I am
9 saying that obviously a secure platform
10 exists.
11 MR. BECKER: Right.
12 CO-CHAIR CROCKETT-JONES: So, I
13 know you put in there for instance Skype but
14 I am just trying to say that this is one small
15 portion of that or additional resource that
16 you won't have to reinvent the wheel.
17 MR. BECKER: Hopefully, yes,
18 ma'am.
19 EXECUTIVE DIRECTOR DAILEY: Video
20 teleconferencing is done throughout DoD
21 through the VTC. They have not fully adopted
22 the Skype concepts.

1 Now, that said, the reason you
2 don't see it everywhere, you don't see it
3 Mount Home Air Base or might not be accessible
4 to an airman in Mount Home Air Base is because
5 it is expensive and it is probably up in the
6 Command group and he has got to go up to the
7 Command section and sit in the Command
8 conference room and talk to the lawyer.
9 MR. BECKER: That is why we would
10 like to see if perhaps there is some way to
11 have some type of network where, as an
12 attorney sitting in my office, I could
13 literally call and maybe get a hold of someone
14 and be able to have that interaction with them
15 right then without having to say can you meet
16 me Tuesday at 8:33 in the Command section for
17 the VTC.
18 CO-CHAIR CROCKETT-JONES: I'm
19 understanding now, thank you.
20 MR. BECKER: Sorry, ma'am, I was
21 probably not clear.
22 Finally, this is, I know,

1 repetitive from what everyone else has said
2 but the electronic database really does make
3 a difference, not only as the Navy was
4 explaining that it helps us get up to speed
5 quicker but as Duke and the Army was
6 explaining, people want to know where they are
7 in the system. And one way that we have
8 found, now that we are using the CFT platform
9 in the Air Force is that except for the
10 reserves and some other places, if you call
11 me, I can often bring up your file and then I
12 can be a thousand times better advocate by
13 telling you where you are, what is going to
14 happen next, what you can anticipate when that
15 happens, maybe who you could talk to. And the
16 problem is sometimes there is just huge gaps
17 in what is in that file. So, as everyone else
18 has said, as an attorney, we hate having gaps
19 because we don't know what is there. And of
20 course, then if we want to give advice or they
21 ask us a question, if we don't have, you are
22 very uncomfortable telling them anything

1 specific, unless you know what is in there.
2 So, making a more robust electronic medical
3 record and MEB, PEB record, I believe would be
4 probably one of the best resources that any of
5 the Services could have. Thank you.
6 CO-CHAIR NATHAN: Any other
7 questions?
8 EXECUTIVE DIRECTOR DAILEY: I
9 would like to ask Ms. Moores for
10 clarification. You were talking about a form
11 that the Army fills out for referrals. The
12 visual you have here is not what they have.
13 So, could you start again on that?
14 MS. MOORES: The form they are
15 using at Walter Reed now for Sailors and
16 Marines is a form that says that they have
17 explained to them that they have the right to
18 talk us and the names, the contact names for
19 the attorneys, the Navy and Marine attorneys
20 there. The Army have their own form that they
21 use, I believe, Duke? Yes, they do.
22 So, this is a new form that was

1 just recently created. I wanted to add that
2 we have had great help from them over the last
3 year but this is really, I think, even better
4 to have that form so that for certain we know
5 that that has been given to each
6 Servicemember.
7 EXECUTIVE DIRECTOR DAILEY: Okay,
8 so that is from the PEBLO to the
9 Servicemember. And so it is a positive
10 handoff of the information for who the lawyer
11 is, what their name is, and how to contact
12 them.
13 MS. MOORES: And they have to sign
14 it, correct.
15 EXECUTIVE DIRECTOR DAILEY: And
16 they have to sign that they have been duly
17 informed that there is a lawyer available.
18 And does it include the IMR information?
19 MS. MOORES: It does.
20 EXECUTIVE DIRECTOR DAILEY: It
21 does?
22 MS. MOORES: It does.

1 EXECUTIVE DIRECTOR DAILEY: All
2 right.
3 MS. MOORES: And so it has
4 everything. It is really well done to have
5 that in there, I agree. So, that has really
6 made a big difference. But they were
7 compliant. I just thought that would be a
8 great form to use for all MTF locations for at
9 least for the Navy and Marine Corps.
10 MR. DOROTHEO: And ma'am, just to
11 bridge on that as well. Not only do the
12 PEBLOs, as part of their Soldier in-processing
13 checklist that they have to make that positive
14 confirmation referral over to our office, we
15 also have the responsibility under a MEDCOM
16 operational order to provide 100 percent
17 mandatory legal briefing, not to make Soldiers
18 clients but to provide them a briefing on what
19 their rights and responsibilities in this
20 process. That includes also Soldiers in the
21 reserve component as well who may not be on
22 active duty orders. So, that is one of the

1 things that the Army does that we want to
2 ensure. We have a metric, internal client
3 tracking database that tracks contacts to
4 ensure that we try to get as close as
5 possible, that is our goal to get 100 percent
6 contact.
7 EXECUTIVE DIRECTOR DAILEY: And
8 you do that primarily through a group briefing
9 as people are being brought into the IDES
10 process.
11 MR. DOROTHEO: Yes, ma'am. There
12 are mass briefings. And also just what we
13 talked about as a Reserve Component and also
14 the TDRL population who are not on active duty
15 orders, we also have mass call-in lines where
16 we email our PowerPoint presentation to the
17 Servicemember. They call in. We confirm
18 their roster to ensure that we try to get as
19 close as possible to 100 percent coverage.
20 CO-CHAIR NATHAN: You know in our
21 travels, it seems that these IDES issues
22 usually fall into one of two broad categories.

1 One is information, people seeking your
2 assistance for either information/status or
3 advocacy for the system. And usually, one can
4 lead to the other. I don't like my status;
5 now, I need your advocacy.
6 Hence, a recurrent theme of a more
7 centralized system; one that is more
8 transparent, one that you can tap into
9 electronically, not relying on paper that is
10 being carried from one person to another.
11 I would like to ask you one of the
12 things that is a point of tension, sometimes
13 healthy, sometimes unhealthy tension, is that
14 no man's land between disability, fitness for
15 duty, return to duty, conditions limiting
16 fitness requiring admin separation, how well
17 or poorly do you think this system does in
18 handling those individuals who have sometimes
19 non-discernible injuries that are found unfit
20 for duty and cannot necessarily be referred to
21 the IDES system? Does that come up much in
22 your advocacy or in your practice?

1 MR. DOROTHEO: Well, sir, most of
2 the Servicemembers who are going through --
3 first of all there is UCMJ and there is also
4 chapter actions within the Army process. If
5 it is in the enlisted or officer and they are
6 going through the med process, they can be
7 found unfit. They have to go through, at
8 least for enlisted, complete the med process,
9 the four officers that complete both the
10 MEB/PEB. Then it is referred over to the
11 GCMCA to make the proper decision of what
12 takes precedence.
13 Now, even if someone is not picked
14 up through the medical evaluation side who may
15 be going under UCMJ or a separation action,
16 there are some operational orders that state
17 that even if it is not documented but they
18 allege some PTSD or TBI, they have to go
19 through some medical screening which may, in
20 and of itself, lead to medical evaluation.
21 Are there some Servicemembers or
22 Soldiers that may fall between the cracks?

1 There may be, sir. But at least on the Army
2 side there are tools there that if the
3 Servicemember is alleging PTSD or TBI, that
4 they will get a medical evaluation before they
5 are adversely separated or UCMJ side.
6 MR. BECKER: General, in the Air
7 Force there is a provision as well that is
8 very similar to the Army's. But if someone is
9 being put out, the provision states that if it
10 is raised by the individual or say their
11 defense counsel, that their actions which are
12 making them appear not to be compatible with
13 service may be due to a medical or a mental
14 health condition, that issue is to be reviewed
15 and looked into before it goes forward,
16 whichever direction it goes into. And we
17 haven't really had a problem with it to our
18 knowledge.
19 MS. MOORES: Admiral, I was going
20 to say the ones that I have seen, I have seen
21 some cases where they have been sent to an
22 administrative board, for example, mental

1 health issues that you can, you are supposed
2 to go to the med board. I think we have a
3 good connection with the legal service office
4 in the Navy and the Marine Corps that if they
5 are being sent, they can seek counsel there.
6 They will refer it over to us as well, since
7 we are able to make sure they get a med board
8 started in those cases. And I have worked
9 with the Personnel Command in ensuring that
10 and they can always stop that when it is sent
11 up, if they are made aware of it if this is a
12 case that should go to a med board.
13 So, I don't see too many of those
14 anymore. It seems like people are pretty well
15 educated about it. But every once in a while
16 you do get a Command that just doesn't want to
17 go through the time consuming process. And I
18 think maybe some better education would be
19 useful in that way, that if they were being
20 briefed on it.
21 But it seems to be mainly Commands
22 that are far away from a major MTF that aren't

1 aware of how to send someone to go to a med
2 board process.
3 CO-CHAIR NATHAN: Thank you. I
4 appreciate that. We worry sometimes about the
5 recovering warrior or the active duty member
6 who has been injured or who subjectively
7 believes they have been injured and you cannot
8 find the objective criteria for it, yet the
9 individual is not fit for duty, cannot
10 maintain the duties that are required. And
11 what is the escape valve for them? The
12 carburation of it, you don't want to make the
13 system too rich because then everybody raises
14 their hand and says well, my back hurts, too.
15 You don't want to make it too lean because you
16 don't want to have people who have legitimate
17 complaints left out in the cold.
18 And so sometimes I would think
19 your shops become sort of where the river hits
20 the road there on these cases. And it sounds
21 like to you, you all across the Services, feel
22 like there is at least an algorithm for this

1 and it doesn't, from your perspective, doesn't
2 seem to be a big deal.
3 MR. DOROTHEO: For those specific
4 cases, it is a big deal for that Servicemember
5 when they are being put out.
6 We partnership up at the JAG
7 school, we provide basic instruction, a basic
8 officer course, the senior course to SJAs,
9 advising them about the IDES process, who are
10 in turn advisors to commanders out in the
11 field. We try to be as robust as much as
12 possible and reach out to TDS, Trial Defense
13 Services Counsel so they know if there is a
14 nexus to some type of medical condition, as
15 Ms. Moores has alluded, that they reach out to
16 the Office of Soldiers' Counsel in an attempt
17 to have their medical condition addressed.
18 CO-CHAIR NATHAN: And do you have
19 to get involved at times with people who do
20 have, in your opinion, a referable issue, an
21 IDES referable issue but the Service is not
22 referring them?

1 MS. MORRISROE: Sir, we do. We
2 have, at least from part of the Navy and the
3 Marine Corps programs, we have had situations
4 where you will have a particular MTF or a
5 particular physician, for example, who will
6 believe that what we think is a referable
7 condition that individual may believe that it
8 is not and that it is a condition and not a
9 disability.
10 So for those instances, as a
11 program for at least on the part of the Marine
12 Corps and the Navy, we literally just call the
13 CO of the hospital to try to sort it out. And
14 at least from my experience, when we are aware
15 of those types of trends, we have been
16 successful in being able to talk to the MTF
17 about whether or not the individual has the
18 appropriate training or what the analysis is
19 for why it is they are coming to that
20 conclusion.
21 Just very recently, actually I
22 think today it was brought to my attention

1 that that is still going on. It is my
2 understanding you will hear a brief about that
3 from another individual I think probably
4 tomorrow. But at least from experience within
5 this program, when we are made aware of those
6 trends -- and typically we are made aware one
7 way or another. For example, we will have
8 legal assistance attorneys or a defense
9 attorney or someone call us to tell us that
10 there is an issue that they are not quite sure
11 how to handle and then we will take it from
12 there. But as opposed to merely counseling
13 and providing DES advice to the individual, we
14 will call the MTF. Sometimes it works out
15 well. Sometimes it is a little contentious
16 but we just try to work it out at that level
17 directly with the CO, the XO, or the DFA to
18 try to sort it out. And we have had some
19 success in that regard but there are always
20 those individuals who will disagree or who
21 believe that they have a referable condition.
22 I think one of our points earlier

1 discussing what Ms. Moores was talking about
2 at Walter Reed, the form where you have
3 positive contact, a sign-off sheet at
4 referral, that is very helpful for us to get
5 to all the other cases. But if your issue is
6 that you didn't get referred in the system, I
7 don't know what the remedy is, unless they
8 know that there are IDES counsel available to
9 assist.
10 And if those individuals are
11 brought to our attention, even though they are
12 not referred, the Navy and Marine Corps
13 programs will still assist that person. So
14 part of our right and left lateral limit would
15 include any individual who we believe would
16 rate a board as well.
17 CO-CHAIR NATHAN: Thank you. We
18 are having all your slides are being sent over
19 to the heads of your Services at the Pentagon
20 right now and they all would like to see you
21 in their office before you go home tonight.
22 (Laughter.)

1 CO-CHAIR NATHAN: But thank you
2 for your candor your information.
3 CO-CHAIR CROCKETT-JONES: I
4 actually have a question about the TDRL issue.
5 Your slide, it seemed that if the
6 folks processing the TDRLs had more time by
7 getting rid of the backlog, if they could,
8 that they could then have a better procedure
9 with the TDRL. I just want you to talk to me
10 about it a little bit more because it seems to
11 me it has gotten clear to me that TDRL seems
12 to have sort of two populations. The folks
13 who want to be on TDRL so that they can return
14 to duty and the folks who don't want to be on
15 TDRL because they feel that it is a guillotine
16 waiting to fall.
17 Is the one process appropriate for
18 both those groups? That is my question to
19 you, just an opinion I am asking. And do you
20 know if the Services have developed anyway to
21 sort of funnel people not into TDRL? I know
22 I hear about Return to Duty programs. I am

1 wondering if you know how they bump into TDRL.
2 MR. DOROTHEO: Well, ma'am, again,
3 my office represents both sets of folks, folks
4 who want to be found fit for duty but aren't
5 able at that point time and also Soldiers who
6 want to maximize their appropriate disability
7 benefits and want some finality in that case.
8 I do think that because there are
9 large administrative burdens associated with
10 a TDRL, I think the overall process should be
11 looked at to identify those medical conditions
12 which would benefit the Servicemember to be
13 placed on a TDRL. I know that is a lot easier
14 said than done but I do believe there is some
15 utility. Again, those Servicemembers who want
16 to be found fit but aren't able to, they want
17 that chance, that hope to be found fit for
18 duty upon their 18-month review. I have had
19 Servicemembers successfully be found fit for
20 duty, a very small percentage, but are able to
21 return to duty through that process.
22 The perception is, again, for

1 Servicemembers who are on the TDRL, there is
2 a perception that there is, again, you may say
3 there is not that finality at all. Their
4 conditions may improve and may not
5 necessarily. They may have whole retirement
6 status but come their 18-month review, they
7 may be found fit for duty or may be offered
8 severance pay. So that is one of the concerns
9 that is there as well.
10 So, I can't say or think of
11 something else because, right now, that is the
12 process we have to represent Soldiers to again
13 either found that they are fit for duty or try
14 to maximize their benefits.
15 CO-CHAIR CROCKETT-JONES: How many
16 of those each of those sort of groups would
17 you say do you see one much more often than
18 the other?
19 MR. DOROTHEO: The majority of the
20 Soldiers that we see that are placed in the
21 TDRL, again, upon the 18-month review, very
22 few, very small want to be found fit for duty

1 within the system. That is not necessarily to
2 say the same thing when they are initially
3 placed in the TDRL. A lot of Servicemembers
4 still have that fight in them and you have to
5 give them tough love.
6 But for the ones that come up upon
7 their 18-month review, for various reasons,
8 some of them are used to their civilian status
9 already, they may have initially wanted to
10 stay in in a military capacity, so again, it
11 is a very small percentage of Soldiers who
12 want to be found fit off the TDRL.
13 CO-CHAIR CROCKETT-JONES: What
14 percentage of those that you see who are in
15 TDRL have the change in their percentage of
16 their disability rating? Do you see most
17 folks who come to you, do they wind up staying
18 at the same rating? Do you know? Can you say
19 how common that is?
20 MR. DOROTHEO: I don't have that
21 stat, ma'am. That is something that probably
22 the Physical Disability Agency would have upon

1 their 18-month review. They would probably
2 have the most amount of information.
3 What I can tell you is that yes, I
4 don't have the hard number but the
5 Servicemembers that come to see the Office of
6 Soldiers' Counsel, I am sure it is the same
7 across everyone at this table, they may not
8 exactly get what they want from the system but
9 I think, generally on a whole, they are
10 probably in a better position in comparison to
11 where they were in the past. Or if they do
12 not receive what they want, they are armed
13 with better information about their case,
14 ma'am.
15 CO-CHAIR CROCKETT-JONES: I'm
16 seeing some disagreement. Go ahead, tell me.
17 I want to hear.
18 MAJ COLLINS: Actually, ma'am, I
19 would rather talk about that offline, if
20 possible. It's personal opinion.
21 CO-CHAIR CROCKETT-JONES: That's
22 fine.

1 CO-CHAIR NATHAN: Okay, gang,
2 thank you very much. Very informative. We
3 appreciate it.
4 Ms. Dailey, any administrative
5 comments before we adjourn?
6 EXECUTIVE DIRECTOR DAILEY: No,
7 sir. That was the last briefing of the day
8 and I am very appreciative of everyone's
9 attention today. We will reconvene again
10 tomorrow at nine o'clock. Yes, nine o'clock.
11 (Whereupon, at 3:09 p.m., the
12 foregoing proceeding was adjourned
13 to reconvene at 9:00 a.m. on
14 Tuesday, October 29, 2013.)
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A

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C E R T I F I C A T E

This is to certify that the foregoing transcript

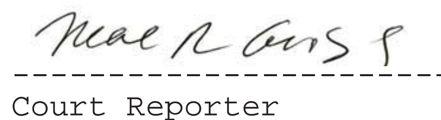
In the matter of: Recovering Warriors Task Force
October Business Meeting

Before: US DoD

Date: 10-28-13

Place: Arlington, VA

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.



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