

UNITED STATES OF AMERICA
DEPARTMENT OF DEFENSE

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RECOVERING WARRIORS TASK FORCE

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OCTOBER BUSINESS MEETING

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TUESDAY

OCTOBER 29, 2013

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

PRESENT

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

SUZANNE CROCKETT-JONES, Co-Chair

RONALD DRACH

TSGT ALEX J. EUDY, USAF, USSOCOM

LTCOL SEAN P.K. KEANE, USMC

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

MG RICHARD P. MUSTION, USA

DAVID K. REHBEIN, MS

ALSO PRESENT

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

LUCILLE BECK, Department of Veterans Affairs

LAKIA BROCKENBERRY, RWTF Staff

DAVID CHANDLER, Department of Veterans Affairs

JAMES DAVIS, Director, Physical Disability
Board of Review

COL JILL FARIS, Deputy Surgeon, ARNG

RACHEL GADDES, RWTF Staff

RAYMOND HOLDEMAN, Deputy Division Chief for
Personnel, Army National Guard G-1

CROSBY HIPES, RWTF Staff

COL CARL JOHNSON, Director, Army Physical
Disability Agency

JOHN KUNZ, RWTF Staff

SUZANNE LEDERER, RWTF Staff

STEPHEN LU, RWTF Staff

MATTHEW MCDONOUGH, RWTF Staff

DAVID MCKELVIN, RWTF Staff

JOSEPH NAGORKA, RWTF Staff

MICHAEL PARKER, Wounded Warrior Advocate

LISA PERLA, Department of Veterans Affairs

JOHN RICHARDSON, Navy Reservist, Wounded
Warrior

ASHLEY SCHAAD, RWTF Staff

JOEL SCHOLTEN, Department of Veterans Affairs

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

2 (9:10 a.m.)

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

12 MR. PARKER: Thank you and good
13 morning.

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

1 conditions are properly evaluated and
2 compensated by the DES.

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

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

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

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

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

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

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

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

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

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

18 MR. PARKER: Okay.

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

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

3 MR. RICHARDSON: Good morning.

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

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

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

1 my hard-earned promotion was withdrawn.

2 Second, once discharged, I had to direct my
3 own medical healthcare, which was a complex
4 task for my extremely competent MEDHOLD case
5 manager. For over a year, I attempted to
6 handle referrals to five different civilian
7 providers in preparation for the TDRL Board I
8 am to face this spring. Despite my education
9 and experience, this proved impossible.

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

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

1 separate legal actions, and burdened with over
2 \$40,000 in debt.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 MR. REHBEIN: Thank you.

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

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

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

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

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

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

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

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

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

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

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

1 Senate for nepotism.

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

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

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

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

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

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

6 CO-CHAIR CROCKETT-JONES: Thank
7 you.

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

17 The information for their briefing
18 is found under Tab H.

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

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

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

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

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

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

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

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

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

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

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

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

15 When I came here, I couldn't move.

16 David was broadsided on the
17 highway.

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

20 An IED wounded Mike in
21 Afghanistan.

22 I don't remember all of the blast.

1 It was over 500 pounds of explosives.

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

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

8 TBI is as serious as any
9 battlefield injury.

10 You are just not the guy you used
11 to be.

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

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

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

22 DR. BECK: Okay, thank you. The

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

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

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

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

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

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

20 MR. DRACH: May I ask a question?

21 DR. BECK: Yes.

22 MR. DRACH: If you have got 50,000

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

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

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

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

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

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

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

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

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

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

1 a traumatic brain injury.

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

4 DR. SCHOLTEN: Can you hear me?
5 Okay.

6 So, but in addition, any
7 Servicemember or any Veteran that access the
8 VA for healthcare will be screened for TBI if
9 their separation date is after September 11 of
10 2001. So that screen becomes active and then
11 if they are previously diagnosed, the screen
12 is completed but they are still consulted to
13 the TBI specialist.

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

18 MR. DRACH: Okay, thank you.

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

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

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

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

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

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

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

22 So, we began with our four

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

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

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

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

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

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

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

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

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

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

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

22 All right. So, our fifth

1 polytrauma center opened in San Antonio in
2 2011. It is a state of the art facility.
3 Although, as you go around, our centers are in
4 Tampa, Richmond, Minneapolis, Palo Alto. We
5 generally distribute it around the country and
6 then in San Antonio.

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

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

22 All right, so I think to

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

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

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

20 Yes?

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

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

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

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

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

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

22 DR. SCHOLTEN: We have shamelessly

1 recruited from some of the larger military
2 treatment facilities.

3 DR. BECK: Yes.

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

6 DR. BECK: It is, right.

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

9 DR. BECK: It is for patient care.

10 DR. PHILLIPS: I was hoping to
11 hear that.

12 DR. BECK: Yes.

13 DR. PHILLIPS: The personnel.

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

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

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

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

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

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

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

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

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

1 of what we do.

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

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

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

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

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

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

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

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

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

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

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

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

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

18 Drivers' training, what is the
19 number one thing you want to do when you are
20 22 years old? Right? And if you have an
21 amputation, you have a traumatic brain injury,
22 well, yes, you are right about that. I saw

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

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

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

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

17 And so we have had a very
18 excellent team working with us, probably since
19 2006 or 2007 assessing the needs of patients
20 and families and staffs in studying the
21 issues. I will give you one example.

22 We did what we call a

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 EXECUTIVE DIRECTOR DAILEY: Ma'am?

22 DR. BECK: Yes?

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

6 DR. BECK: No, --

7 EXECUTIVE DIRECTOR DAILEY: Okay.

8 DR. BECK: -- it's not through the
9 JEC. And I am going to give you an overview -
10 -

11 EXECUTIVE DIRECTOR DAILEY: Good.

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

14 EXECUTIVE DIRECTOR DAILEY: Good.

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

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

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

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

19 EXECUTIVE DIRECTOR DAILEY: And
20 real quick, approximate time frame, 2007 to
21 2008, 2009?

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

1 DR. SCHOLTEN: Six to seven.

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

4 EXECUTIVE DIRECTOR DAILEY: Okay.

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

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

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

14 DR. SCHOLTEN: And that was the
15 same time that the common definition was
16 developed and that was rolled out in early
17 2007. So that work had started about a year
18 before that.

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

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

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

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

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

1 families and TBI patients.

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

4 DR. BECK: Sure.

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

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

1 healthcare system.

2 And actually the VA has a program
3 called the Veterans Health Initiatives. And
4 what they are are curricula that look at a
5 number of conditions that occur to -- have a
6 much higher incidence in the military than
7 they do in the general sector, general public.
8 I think there are ten or twelve of them.

9 Traumatic brain injury is one. And we have an
10 extensive program which is available online
11 and we did mandatory training for all of our
12 clinical providers a number of years ago and
13 it is also included as part of new orientation
14 so that all of our providers can understand.

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

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

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

3 Okay, so moving on to results
4 driven, if I could. We wanted you to see some
5 of the numbers. Since March of 2003 through
6 2013 in our Polytrauma Centers, we have
7 treated 2,735 patients; 56 percent of them
8 were active duty Servicemembers; and 74
9 percent of the active duty were injured in
10 foreign theater.

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

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

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

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

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

1 functioning in recovery.

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

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

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

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

1 home has been a goal that we have attained at
2 83 percent for our combat injured.

3 MR. DRACH: Dr. Beck, excuse me.

4 DR. BECK: Yes?

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

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

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

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

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

1 ready them for going home.

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

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

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

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

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

16 MR. DRACH: Yes.

17 DR. BECK: Okay, thanks.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 So, --

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

22 DR. BECK: Yes?

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

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

22 DR. BECK: Yes, I would say, first

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

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

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

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

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

1 centers.

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

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

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

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

1 part of this, I will go over this again.

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

4 DR. BECK: Sure.

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

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

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

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

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

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

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

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

1 the Veteran.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 DR. PHILLIPS: Let me ask --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 DR. SCHOLTEN: Mothers and wives.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 Lifetime care needs and thank you

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 So, thank you.

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

15 DR. BECK: Oh, good.

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

20 DR. BECK: He did know.

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

1 DR. BECK: We did know.

2 EXECUTIVE DIRECTOR DAILEY: Okay.

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

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

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

16 EXECUTIVE DIRECTOR DAILEY: Great.

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

1 other piece that VA has really been working
2 hard on.

3 EXECUTIVE DIRECTOR DAILEY: Good.

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

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

8 DR. BECK: Good. Great.

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

13 DR. BECK: Great.

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

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

1 doing like an Eden sort of mix.

2 EXECUTIVE DIRECTOR DAILEY: Okay.

3 And just you had mentioned that there were
4 locations where our charter -- we care about
5 all Veterans but our charter centers around
6 the OEF/OIF. You had mentioned there are
7 centers where this OEF/OIF population are
8 living.

9 DR. BECK: There are a couple.

10 EXECUTIVE DIRECTOR DAILEY: There
11 are a couple.

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

19 EXECUTIVE DIRECTOR DAILEY: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 DR. BECK: Yes, I would really

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

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

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

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

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

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

1 there.

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

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

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

13 That's my commercial.

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

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

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

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

11 So yes, thank you.

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

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

17 (Whereupon, the foregoing
18 proceeding went off the record at
19 11:13 a.m. and went back on the
20 record at 11:33 a.m.)

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

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

17 DR. PHILLIPS: I plead the Fifth.

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

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

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

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

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

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

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

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

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

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

17 In our IDES process, we have --

18 DR. PHILLIPS: Could I --

19 EXECUTIVE DIRECTOR DAILEY: Yes,
20 please go ahead.

21 DR. PHILLIPS: I will keep my
22 microphone on.

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

9 I mean it is easy to say. It is
10 very hard to do, related to the political
11 environment and everybody's sandbox. But I
12 think it is something that at least the Task
13 Force should try to emphasize that we need to
14 have the experts develop some way that health
15 information transfer can somehow be harmonized
16 between the three systems because that is a
17 bottom line issue. We just heard that nearly
18 50 percent of the Veterans don't even go to
19 the VA except occasionally.

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

1 systems. And that is an issue.

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

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

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

22 And then Recommendation 20 was an

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

13 DR. PHILLIPS: May I just add?

14 EXECUTIVE DIRECTOR DAILEY: Yes,
15 go ahead.

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

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

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

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

22 Okay, so you had two issues here,

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

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

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

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

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

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

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

22 So, it is something that this Task

1 Force can address in more detail.

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

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

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

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

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

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

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

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

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

10 EXECUTIVE DIRECTOR DAILEY: Okay.
11 We got the message. We will bring back that
12 warm handoff recommendation that we had in
13 2012 -- 2013.

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

19 EXECUTIVE DIRECTOR DAILEY: Well,
20 we --

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

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

3 EXECUTIVE DIRECTOR DAILEY:

4 Correct.

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

7 EXECUTIVE DIRECTOR DAILEY:

8 Correct. Correct.

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

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

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

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

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

18 DR. PHILLIPS: Yes, ma'am.

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

1 efforts.

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

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

1 down.

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

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

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

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

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

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

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

22 MR. REHBEIN: One of the other

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

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

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

1 duty.

2 EXECUTIVE DIRECTOR DAILEY: Right.

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

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

22 So, the transition units, I think

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

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

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

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

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

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

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

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

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

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

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

1 people don't get lost into the interstitial
2 spaces.

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

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

1 outside their medical service area.

2 EXECUTIVE DIRECTOR DAILEY: Okay,
3 good. Next slide.

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

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

17 So, this has some traction. It
18 had traction up on the Hill also. They also
19 wanted to see greater empowerment of the DCOEs
20 altogether.

21 DR. PHILLIPS: Can I jump in
22 again?

1 EXECUTIVE DIRECTOR DAILEY: Sure.

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

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

22 So, I know we haven't talked about

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

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

1 traumatic stress.

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

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

15 So, --

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

22 You know I am wondering -- I know

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

4 EXECUTIVE DIRECTOR DAILEY: Okay.

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

8 EXECUTIVE DIRECTOR DAILEY: Okay.

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

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

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

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

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

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

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

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

17 You have heard our quotes before.
18 Up to this point in the war, about 1,600
19 Warriors have suffered amputations. That is
20 1,600 too many but it is 1,600. As you know,
21 the figures in the military produced about
22 1,600 a month of people with mild-moderate-

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

22 So again, this is, I think, going

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

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

15 EXECUTIVE DIRECTOR DAILEY: Good.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 DR. PHILLIPS: That's the theory.

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

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

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

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

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

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

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

20 Okay, that is my conclusion.

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

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

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

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

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

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

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

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

(1:05 p.m.)

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

Mr. Davis, the floor is yours.

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

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

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

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

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

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

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

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

18 What do we review? Well, DoD
19 6040.44 talks about a lot of things. But if
20 you look in red here, that is kind of the nuts
21 and bolts of what we do. If you have a
22 combined disability rating of 20 percent or

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

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

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

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

5 Any questions on fitting and
6 unfitting? Okay.

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

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

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

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

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

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

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

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

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

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

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

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

3 And then our last mailing was the
4 third mailing on the 18th of October, almost
5 10,000 on that one. We expect future mailings
6 about every eight weeks.

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

13 These are our metrics. The
14 numbers won't add up necessarily because we
15 have some duplicates up there in the total.
16 But about 6,800 total applications to date
17 have been received. We have adjudicated
18 3,800. And 27 percent of those were re-
19 characterized to retirement. So almost a
20 third of those that submitted a package were
21 brought to retirement, just under a third.
22 And there is a split out by Service.

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

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

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

15 MR. DAVIS: Sure.

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

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

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

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

20 MR. DAVIS: The Sabo lawsuit.

21 CO-CHAIR CROCKETT-JONES: Yes.

22 MR. DAVIS: I think that was under

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

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

6 CO-CHAIR CROCKETT-JONES: Thank
7 you.

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

10 CO-CHAIR CROCKETT-JONES: No.

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

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

7 Questions on this?

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

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

18 EXECUTIVE DIRECTOR DAILEY: Okay.

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

21 EXECUTIVE DIRECTOR DAILEY: Okay.

22 MR. DAVIS: Okay, one of the

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

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

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

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

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

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

17 MR. JOHNSON: They are totals.
18 They are totals.

19 EXECUTIVE DIRECTOR DAILEY: Yes,
20 they are totals.

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

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

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

5 MR. REHBEIN: Okay.

6 MR. DAVIS: And those are
7 additional.

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

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

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

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

19 MR. DRACH: Excuse me. Last year,
20 you had a little over a third and this year, -
21 - or 2012 you had a little over a third and
22 2013 you had a little less than a third.

1 MR. DAVIS: Right.

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

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

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

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

1 are the raw numbers that go with those.

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

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

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

14 MR. DAVIS: It is all
15 encompassing.

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

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

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

3 MR. DAVIS: Questions on these
4 slides?

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

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

9 MR. DAVIS: Okay.

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

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

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

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

10 CO-CHAIR CROCKETT-JONES: Thank
11 you.

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

22 And so the Sec Def, in response to

1 that, has committed to a thorough review of
2 that. We went to all the Services, that the
3 Services looked at everyone from the period of
4 9/11 all the way up until 30 April of last
5 year. And they came to us. They did, like I
6 said, a thorough review, each one of the
7 Services of Mental Health records of every
8 individual. And then they brought all those
9 records to us. And working with the VA, we
10 sent out a mailing. About 10,000 personnel,
11 I will show you that in a couple of minutes.
12 And we are reviewing all of those, to make
13 sure that those were properly adjudicated.

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

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

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

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

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

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

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

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

12 MR. DAVIS: Sure. Yes, sir.

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

18 MR. JOHNSON: I don't know.

19 MR. DAVIS: I don't know.

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

22 MR. DAVIS: Someone in the back is

1 saying yes.

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

5 MR. DAVIS: Right.

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

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

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

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

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

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

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

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

19 MR. DRACH: Thank you.

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

1 very thorough in getting us numbers. And I
2 think it was one of those we would rather be
3 safe than sorry things. We want to make sure
4 that everyone that possibly could have been
5 under this review is there. And that is what
6 we have done. Again, almost 9,000 of those,
7 8,898 were Army members. And again, that is
8 self-identified by the Army. They brought
9 them to us.

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

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

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

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

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

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

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

1 that.

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

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

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

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

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

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

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

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

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

19 MR. DAVIS: Yes.

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

1 that where it is coming from?

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

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

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

19 MR. DAVIS: Yes, ma'am.

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

1 MR. DAVIS: Right.

2 CO-CHAIR CROCKETT-JONES: Thank
3 you.

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

17 MG MUSTION: I have a couple of
18 questions.

19 MR. DAVIS: Yes, sir.

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

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

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

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

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

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

1 considered by the PEB or not.

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

11 MR. JOHNSON: Yes, sir.

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

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

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

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

14 MG MUSTION: I understand.

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

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

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

3 MG MUSTION: Well, if you are
4 identifying, if your Board is identifying that
5 27 or 28 percent of the time you are finding
6 the service was in error, that is basically
7 what you are saying.

8 MR. DAVIS: Right.

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

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

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

3 MR. DAVIS: Sir?

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

6 MR. DAVIS: Yes, sir.

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

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

21 Greg, do you have anything on
22 that?

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

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

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

10 MR. DAVIS: Right.

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

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

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

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

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

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

16 MR. DAVIS: It has actually gone
17 down.

18 CO-CHAIR NATHAN: How much?

19 MR. DAVIS: It has actually gone
20 down.

21 CO-CHAIR NATHAN: Thirty-six to
22 twenty?

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

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

7 MR. DAVIS: The Services --

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

13 MR. DAVIS: I think so, right.

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

18 CO-CHAIR NATHAN: Right.

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

22 CO-CHAIR NATHAN: Do you have a

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

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

6 MR. JOHNSON: Two percent.

7 CO-CHAIR NATHAN: Not a large
8 number.

9 MR. DAVIS: Not a large number at
10 all.

11 MR. JOHNSON: Two percent, very
12 few.

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

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

1 can bring counsel with you.

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

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

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

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

14 CO-CHAIR NATHAN: Okay.

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

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

1 that is why it is 77,000.

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

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

17 MR. DAVIS: Yes.

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

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

1 give you some developments that we are working
2 on.

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

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

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

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

19 Do we need a brief break?

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

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

4 (Whereupon, the foregoing matter
5 went off the record at 1:46 p.m.
6 and went back on the record at
7 1:57 p.m.)

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

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

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

22 I'm going to turn it over to you

1 all.

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

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

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

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

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

22 (Laughter.)

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

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

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

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

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

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

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

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

1 can do in their military vocation.

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

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

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

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

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

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

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

22 These people are nurses, for the

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

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

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

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

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

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

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

12 Now, it is not a science, in that
13 at 365 days you are going to turn into a
14 pumpkin if we don't make a determination on
15 what is happening with you medically, but we
16 would have a really good idea. And there are
17 some circumstances that we will waive beyond
18 12 months for Mr. DP, if we feel like a
19 Soldier is still making process, let's say in
20 physical therapy for a rotator cuff or a bad
21 knee or something like that.

22 So, the whole idea of case

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

1 like.

2 Or we may find out we get a
3 definitive diagnosis and we don't have to wait
4 12 months. We know that for whatever the
5 diagnosis is, we found out they are a Type II
6 diabetic. That means they don't meet medical
7 retention standards and they are at their
8 medical retention decision point and an action
9 needs to happen as such.

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

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

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

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

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

22 And so, during this time frame, it

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

13 Ray, it is yours now.

14 MR. HOLDEMAN: Thanks, Colonel
15 Faris.

16 As Colonel Faris indicated, the G-
17 1 and the medical community across the
18 National Guard work very closely together
19 because this is ultimately a G-1 function
20 managing people with a medical component. And
21 that medical component is what drives all the
22 actions that relate to pay benefits and

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

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

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

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

1 benefits and entitlements.

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

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

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

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

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

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

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

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

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

4 MR. HOLDEMAN: Yes, great benefit.

5 COL FARIS: Are you ready for the
6 next slide?

7 MR. HOLDEMAN: Yes, please.

8 Thanks.

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

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

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

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

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

7 COL FARIS: For the most part,
8 what this program helps us with is the number
9 one issue that we have with Soldier, because
10 we do have a job of rating them, is ortho.
11 And so 99 percent of the people that have been
12 through the program because of ortho issues
13 and everyone, except for I think two Soldiers
14 during the pilot, were able to get resolved in
15 less than 179 days. And I think, Ray, we
16 averaged about 88 days of Soldiers being on
17 12301(h) orders.

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

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

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

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

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

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

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

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

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

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

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

6 MR. HOLDEMAN: Through December
7 '15, correct, 31 December '15.

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

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

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

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

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

22 I have noticed that -- do we have

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

3 Right. So, the numbers are still
4 significantly low. The total number from both
5 mobilization and training is right at I want
6 to say a little over -- right around 200. And
7 the reason, again, is we originally only had
8 14 states that participated in this. It is a
9 small population to begin with because of low-
10 risk low acute criteria. And our roll out to
11 the 54 states and territories was somewhat
12 delayed early on in '14 by sequestration,
13 training issues associated with funding. We
14 overcame most of that. We had to push some of
15 our training to the right. And we just
16 started really rolling this out to all the
17 states and territories back in September.
18 Well, we know what happened 1 October.

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

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

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

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

14 COL FARIS: Plan of care.

15 MR. HOLDEMAN: Plan of care.

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

1 MR. HOLDEMAN: Correct.

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

4 MR. HOLDEMAN: Right.

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

7 COL FARIS: Yes.

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

11 COL FARIS: Correct.

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

15 COL FARIS: And we have done that
16 twice.

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

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

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

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

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

1 10 status.

2 COL FARIS: Less mobilization.

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

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

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

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

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

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

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

13 So, this helps us immensely. IDES
14 Dashboard is a great innovative program. It
15 is a great process and it provides clarity all
16 the way down to the Soldier and Commander
17 level.

18 COL FARIS: And I think Colonel
19 Johnson is going to talk to this after us.

20 MR. HOLDEMAN: Yes, great partners
21 over at USAPDA and the Department of the Army.
22 We have rolled this out. We have access at

1 all 54 states and territories to the system.
2 They are very diligently pushing this access
3 to this web-based automated system down to the
4 lowest level, Unit Commander, First Sergeant
5 Soldier. There is different authorities at
6 those levels. So the Soldier can only read
7 their file. The Commander can only see
8 Soldiers in their organization.

9 But this gives us some clarity,
10 allows us to be proactive, rather than
11 reactive and help the Soldier transition when
12 they need it most.

13 COL FARIS: All right, so now I am
14 going to talk to about what the Army National
15 Guard is doing to try to bring some more
16 transparency to the Medical Board Process.

17 So one of the things that happened
18 is that a few years ago, about three years
19 ago, there was this retired general by the
20 name of General Franks who did a study and
21 said hey, there is disparaging going on
22 between the Active Component and Reserve

1 Component, when it comes to the Integrated
2 Disability Evaluation System, or at that time,
3 it was just the Disability Evaluation System.

4 And so, we stood up an
5 organization down in Florida, and I believe
6 that they have come and spoke to your
7 organization here, at Pinellas Park, the
8 Soldier Reserve Component Medical Support
9 Center. And so they helped us get Reserve
10 packets validated before they went into the
11 process.

12 And so there was some great things
13 that we learned out of standing up Pinellas
14 Park. And so on the left side, we identified
15 some of the friction points and problems that
16 we had. We had lack of standardization and
17 MEDCOM freely admits it. So, if you were in
18 the great State of Texas and there was five or
19 six MTFs there, there were five or six
20 different standards for packets to go into the
21 Medical Board process. So, it just depended
22 on where you were going as to what your

1 checklist looked like.

2 So one of the efficiencies that we
3 got right away was a standardized 17-item
4 checklist. So that has helped facilitate
5 success enormously. If that were the only
6 thing that we got out of the experiment, it
7 would have been a win but we got some other
8 things out of it as well.

9 So, there was a lack of
10 standardization of looking and validating the
11 records. And so what we looked at are some of
12 the ways that we could mitigate that. So a
13 lot of it is about education and training.
14 And one thing about the Army, is it is in a
15 constant state of change. People are always
16 coming and going from different positions.
17 And so some of the things we did from the
18 Guard is we mandated the use of eProfile
19 Training because we went to the electronic
20 solution for having all profiles. And so that
21 has really helped us a lot because you have
22 got to do the training before you have access

1 to be able to use this system.

2 We did some mandatory basic
3 profile training when we get together as a
4 Guard entity in our Medical Team Conference.
5 We have developed some sources, working
6 through the folks down in Crystal City, a PDES
7 course, and we have done, I believe, three of
8 them that are Reserve-component focused. It
9 is always, I have learned, that if you know
10 what you need to study for on a test you do
11 better on a test. So, if we can understand
12 what the end process looks like in the Medical
13 Board Process, then it helps the people in the
14 front understand why it is important that they
15 do it this way. And so that course has been
16 very, very beneficial to State Surgeons,
17 understanding what the end process looks like.

18 And we have also worked on
19 developing, and what I am going to show you a
20 couple of screen shots of a process called MEB
21 Prep, which is an electronic solution; instead
22 of doing a paper Medical Board process, doing

1 an electronic one.

2 And Ray talked about the fact that
3 having transparency. So, if you have a
4 process and you don't have transparency, what
5 happens to that poor PEBLO? They are on the
6 phone all the time answering calls. Where is
7 my packet? Where is it at? Where is it at?
8 So, when they are on the phone, they are not
9 actually doing their work or the work that
10 gets things through the process.

11 So, we are like we want to create
12 a solution because the Guard has always been
13 about how we can create solutions to be a win-
14 win for everybody. So, we created this system
15 that is called MEB Prep.

16 So, I think Mr. Scott has been
17 here before to talk about the electronic LOD
18 module. MEB Prep is very similar to that.
19 So, it is role-based. You initiate a case.
20 It gets assigned a number. And what you do,
21 is there is a 17-item checklist and you scan
22 and upload all the information into the 17-

1 item checklist.

2 Once all 17 items have been
3 uploaded, all the information that is in the
4 Health Readiness Record, which is our
5 electronic repository for all of our medical
6 information. Everything is scanned, indexed,
7 and uploaded in that because you have to
8 understand the Guard doesn't do treatment. We
9 don't have treatment facilities. So,
10 therefore, we don't use AHLTA. So, we have
11 created our own version of AHLTA for the Guard
12 and Reserve. And so, everything in HRR gets
13 scanned, indexed, and is also zipped and
14 compressed into this.

15 Now, what we did on the other side
16 is that MEDCOM now has access to this. PEBLOs
17 now have access to this. We did a beta test
18 with his last year with the Indiana Guard and
19 we did a beta test between Indiana and
20 Pinellas Park. So, Pinellas Park would
21 receive and we got information back and forth
22 about how things went, how they didn't go,

1 what we needed to change, and all those kinds
2 of things. So, it has now evolved from a beta
3 test.

4 We did a pilot with the first six
5 states. And so now it goes from the state to
6 the MEBTO. Those are the folks I call them
7 like the head cashier. Like at Target, if a
8 line gets too long, Bill, I need you on 14.

9 So what the MEBTO does is they
10 regulate the cases. We got a backlog at Fort
11 Gordon. We have got to move some to the MEBTO
12 at Fort Carson and they regulate to make sure
13 that we are getting Soldiers at the shortest
14 line so we can get them more timely through
15 the process. So, we created roles for them.

16 So, now what happens is the state
17 does an electronic MEB record, no paperwork
18 whatsoever. Once they are done, it has been
19 validated, it goes across the berm from the
20 State of Ohio, down to the MEBTO office. They
21 receive it electronically. They get an email
22 that says Colonel Faris, you have an

1 electronic case from the great State of Ohio.
2 And I go in, log into the system, and I start
3 checking and validating that I have all of the
4 required information that is needed for this
5 packet to go forward.

6 If there is something delinquent,
7 Colonel Faris, I need your most recent PHA,
8 there is a tool within the tracking tab here,
9 where they can write a message and say Ohio,
10 I need the most recent PHA and you forward it
11 back electronically. It doesn't get mailed.
12 You don't have to -- so, it goes back.

13 And then there is ding, Mr.
14 Holdeman, you forgot Faris' PHA. So Holdeman
15 goes in and gets the most recent PHA, uploads
16 it into the system, sends it back to MEBTO.
17 They validate it, then they discern where it
18 goes to.

19 Right now there is two locations
20 that these electronic cases go to, Fort Gordon
21 and the MEBTO at Fort Carson. And right now,
22 they are able to keep up with it because we

1 have started implementing the full transition
2 away from Pinellas Park, which will be
3 sunsetting September 14. And we have got 14
4 states that have already transitioned over to
5 this electronic process. And the MEBTO is
6 able to regulate to those two locations. And
7 we do monthly IPRs with our friends at MEDCON.
8 And we have a new revision that is going out.
9 The Guard likes to build things while we drive
10 it and fly it. We don't wait until we have
11 the Cadillac. We get a Yugo and we go. And
12 then we add the other options, like a sunroof
13 and electronic steering and stuff like that.

14 So, this is our time line here.
15 We fully expect these folks that have been at
16 it actually got trained last week, Friday, so
17 I can change them into trained. So, you can
18 see by the end of June, the Guard will be
19 fully transitioned.

20 Now, the USAR is also
21 transitioning and I believe their transition
22 they are starting in January. They have four

1 regions that they are doing and they are going
2 to do their process a little bit differently
3 because they are organized and structured
4 differently than us. But this has been hugely
5 successful.

6 So someone will ask me, well,
7 Colonel Faris, what are the efficiencies that
8 are gained from this process? The
9 efficiencies are just in the first step, the
10 first step of sending a packet down to
11 Pinellas Park to validate it, to get it to the
12 MEBTO and regulate it to an MTF takes on
13 average, it was averaging about 30 days. This
14 process takes about three days, which is
15 great.

16 It doesn't help the end where the
17 backlog is piling up but what it provides it
18 transparency because now the Medical Readiness
19 NCO can go into the system and say where is
20 Faris' packet and can look at the tracking tab
21 and see that the PEBLO from Fort Gordon has
22 had it for three days and they are getting the

1 appointment scheduled to do the COMP and PEN
2 at the VA in Dayton, Ohio, closest to my home.
3 And now I am not calling the PEBLO and I can
4 go into the system.

5 And oh, if I have got a question,
6 in the system when you hover your mouse over
7 in the tracking over the person's name, it has
8 got all their contact information. So, you
9 can send them an email, call them on the
10 phone, do all those kinds of things. So, we
11 are very excited about it.

12 So, because of all these
13 efficiencies, Faris is all about readiness.
14 Readiness is my game.

15 This is what we looked like
16 November 28th of 2012. We were at 77.4
17 percent MRC 1 and 2. And today, this is what
18 the Guard looks like or we did. We are at
19 84.8 because we had this government shutdown
20 thing that kind of impacted our readiness for
21 a few weeks.

22 And oh, by the way, the standard

1 changed. The DoDI says all Services will be
2 at 85 percent ready, effective December of
3 '14. So, that is our measurement pole that we
4 changed effective 1 October. And the Guard is
5 the only Service -- the Guard is the highest
6 Service to all the other two Services in the
7 Army. And we are very excited about these
8 efficiencies that we have taught you about
9 with case management, MMPS, Reserve Component
10 Managed Care Orders, the things that we are
11 doing to try to automate IDES to make it
12 better and more efficient for our Soldiers to
13 go through are all things that build to this
14 overall medical readiness that you see at 85
15 percent.

16 MR. HOLDEMAN: Yes, Jill is
17 absolutely right. The EMMPS is the base and
18 all the other things that we piled on top
19 contributed significantly to this.

20 The last little piece, and it is
21 not insignificant is better data management
22 and that is part of what my team has done in

1 coordination with the State Surgeons and the
2 Surgeon's Office at NGB, is manage the data
3 better. And we put a great deal of effort
4 into more accuracy in our reporting and
5 qualifying and quantifying what we call
6 medical ready.

7 COL FARIS: So that is my last
8 slide and Ray's last slide. Does anyone have
9 any questions of us?

10 CO-CHAIR NATHAN: Going once,
11 going twice. Thank you. This was a very
12 comprehensive review and, clearly, you
13 understand your business model and you are on
14 the right trajectory.

15 So, thank you Mr. Holdeman and
16 Colonel Faris. We appreciate it.

17 MR. HOLDEMAN: Thank you all. Ms.
18 Dailey, thank you.

19 EXECUTIVE DIRECTOR DAILEY: A
20 pleasure to see you all again. I have had
21 Colonel Faris up here three times, I think,
22 Mr. Holdeman two. It might be good news to

1 know we probably won't get you up here again.

2 You, as a Task Force have made a
3 number or at least one recommendation talking
4 about RCMC as being a model for other Reserve
5 Components, low acuity, low-risk individuals
6 being in their home community on Title 10,
7 managed by their units, receiving care in
8 their community. It keeps them out of the
9 WTUs. It keeps them from being separated from
10 their families. You have identified that in
11 previous recommendations as a model for
12 managing our Reserve Component.

13 So, thank you, Colonel Faris and
14 Mr. Holdeman.

15 COL FARIS: It was a pleasure.

16 MR. HOLDEMAN: Thank you.

17 EXECUTIVE DIRECTOR DAILEY: We are
18 way ahead, ladies and gentlemen. I'm not sure
19 how we did that. I have a quarter 'til three.
20 Our next briefer is starting at 3:30 but he is
21 here. Would you all like a break or would you
22 like to roll into your last briefing?

1 CO-CHAIR CROCKETT-JONES: If we
2 have time, we might get a cup of coffee.

3 EXECUTIVE DIRECTOR DAILEY: Cup of
4 coffee, five minutes.

5 CO-CHAIR NATHAN: Cup of coffee,
6 five minutes.

7 EXECUTIVE DIRECTOR DAILEY: Five
8 minutes, yes, yes.

9 CO-CHAIR NATHAN: Army time, five
10 minutes; Navy time, six minutes.

11 (Whereupon, the foregoing matter
12 went off the record at 2:42 p.m.
13 and went back on the record at
14 2:53 p.m.)

15 CO-CHAIR NATHAN: Okay, Colonel
16 Johnson?

17 COL JOHNSON: Yes, sir.

18 CO-CHAIR NATHAN: Great. So, we
19 have Colonel Johnson who is from the IDES
20 Transition Office. He is the Director of the
21 Army Physical Disability Agency. Colonel
22 Johnson is going to be briefing us about the

1 overall improvements being made to address the
2 timeliness, the efficiency, and the
3 effectiveness of the challenges that are
4 specific to the Army.

5 You can find Colonel Johnson's
6 information in Tab L. Sir, the floor is
7 yours.

8 COL JOHNSON: Thank you, Admiral.

9 All right, ladies and gentlemen, I
10 have been duly informed that I am the last
11 person standing between you and leaving. So,
12 we will move through this and we will move
13 through it as quickly as you would like.

14 CO-CHAIR NATHAN: For the record,
15 this is important stuff. So, we will take as
16 long as you think is necessary.

17 COL JOHNSON: Very well, sir.

18 I was asked a series of questions
19 but they all kind of boiled down to two
20 things. One was how did you improve
21 performance between FY12 and FY13 in the Army.
22 And then the second major question was what

1 about your timeliness for informals.

2 So, what I did was get a pat on
3 the back and then a kick in the tail about,
4 hey, you have improved performance over all
5 this stuff but now your formal rate stinks and
6 what are you doing about it. So, that is what
7 we are going to talk about here today.

8 As we look at the improvement of
9 performance, I kind of tried to break that out
10 into three subcategories, just a snapshot in
11 time of where we were and where we are now,
12 the progress, and then how did we get there.

13 Here were the specific questions.
14 And I tried to provide some very basic short
15 answers first and then we will look at the
16 metrics that support my answers because I have
17 learned, been in the Army long enough to know
18 that you don't just give an answer if you
19 don't have the background or the information
20 or details behind it to make it stand the
21 test.

22 So, give examples of process

1 improvements, et cetera. And I think was a
2 desire to say okay, Lean Six Sigma, Lean
3 Enterprise, any other Baldrige programs, et
4 cetera. What did you do to get after this?

5 We had the IDES system in the Army
6 over the course between about 2009 and 2012
7 was the most studied process in the Army.
8 Multiple Lean Six Sigma programs, multiple
9 Lean Six Sigma reviews, multiple process
10 improvement teams coming in, IG inspections,
11 IG assistance visits, Army Audit Agency, you
12 name it. So, everything, except I think
13 Baldrige. I don't remember Baldrige. Rand
14 Corporation studies, et cetera.

15 So, we did a lot of studies. The
16 challenge was had was we were doing so much
17 studying, we weren't doing a lot of
18 improvement. And we could see it coming but
19 we didn't get out ahead of it. So, we started
20 to have a problem in '12 or '11. It really
21 became acute in '12 and then we got after it.
22 So, we had a lot of studies.

1 Active Army IDES days are below
2 the goal -- are above the goal of 295. What
3 are we doing? Essentially, the Army is
4 meeting standards, actually exceeding
5 standards in everything we control. Every
6 single step that we control we are exceeding
7 the standards.

8 Our VA partners, as we moved the
9 backlog that we had and we moved it to them,
10 some call it the pig and the python, the rat
11 and the snake, it moved to them and that is
12 where it is at. So, they are dealing with
13 that now.

14 CO-CHAIR NATHAN: What is your
15 current MEB average?

16 COL JOHNSON: Below 100 days, sir.
17 It is, I think, across the enterprise the
18 whole MEB phase is approximately 79 days, the
19 entire MEB phase. That is all the sub-stages
20 within it.

21 The VA has had a challenge
22 recently within the MEB phase on the medical

1 exam part, where they have started to miss
2 goals here recently in the medical exam
3 portion. They are working that and they are
4 driving that back down. So, they are back
5 within tolerance. So, we are still well-below
6 the standard across the MEB piece.

7 We noted drastic improvement.
8 What did we do and did we share it?
9 Absolutely. We have multiple forums that we
10 meet with our counterparts from the other
11 Services with the other Service MNRAs and
12 their representatives, their IDES leads, the
13 other Service PEB leadership, the other MTF
14 leadership. And we share constantly.

15 Some of the things that we did to
16 improve our performance were actually based on
17 discussions we had had with the other
18 Services. How do you do better here? What
19 can we adopt? And we adopted those things.
20 So everywhere we could mimic them, copy them,
21 we did. So, the two-member Board that the Air
22 Force had gone to well in advance of us, we

1 said okay, we requested permission using their
2 model, their template, we received permission
3 from OSD to do that and then we executed it
4 and that helped us. So, a lot of sharing.

5 Where were we? What did we do?
6 The blue bars are where we were in '12 and it
7 is a snapshot end of '12. And then '13, a
8 snapshot end of '13. So, where was the work?

9 So, if you look here in
10 particular, these areas that are highlighted,
11 this is the benefits phase here, the
12 preliminary rating phase here. This is done
13 at the DRAS. This is done at the DRAS. This
14 is where the Army's workload is now, almost
15 9,000 cases. And this is information a little
16 dated based on the most current data at the
17 end of September and then 4,150 here.

18 The VA has started to make some
19 progress against this backlog, which was much
20 higher. It has started to come down. This
21 backlog remains relatively stagnant. It has
22 gotten a little worse each month. Last month

1 they added 39 to it. The month before 400 and
2 something. The month before, 50 some-odd.

3 CO-CHAIR NATHAN: So Colonel, let
4 me ask you a question because not much more
5 than a year ago the Army sort of went on
6 record saying it needed -- because what I see
7 here is if this is true, and I have no reason
8 to believe it isn't, you pretty much
9 controlled the processes that you had to
10 change and amp up to control your piece of it.

11 COL JOHNSON: Yes, sir.

12 CO-CHAIR NATHAN: But a little
13 over a year ago, the Army came in and said we
14 need a thousand FTEs at something like 150
15 million -- please don't quote me on the
16 figures. It was a pretty large number, chunk
17 of people for a large chunk of change to throw
18 at IDES to get it under control. You never
19 got that. So, what happened?

20 COL JOHNSON: Sir, we did get some
21 increase in resourcing. We did get a number
22 of folks. We didn't get the number that we

1 had originally requested. We used internal
2 Army resources.

3 The senior leadership of the Army,
4 frankly, the Vice Chief of Staff was quoted in
5 front of the Congress at that time as saying
6 the Disability Evaluation System in IDES is
7 the single greatest threat to readiness in the
8 Army. At that point, that is what it was.

9 And so, when you have the Vice
10 Chief of Staff of the Army making that
11 statement and then executing things like
12 monthly meetings with every senior mission
13 commander in the United States Army, with the
14 Chief of Staff of the Veterans Administration
15 sitting to his left every month, that gets
16 leadership attention. That gets leadership
17 action.

18 So, I would tell you that that is
19 the single greatest factor in our improvement
20 is this leadership attention. And I will go
21 through some other specifics we did. But that
22 was the first thing we did.

1 What we also did, and this was
2 equally important to that, was establish
3 measures of performance. You, doctor, when
4 you come in, are going to produce X number of
5 NARSUMS every day. Absent that, we are going
6 to take action to dismiss you or something
7 else. You, PEB adjudicator, are required to
8 do X number of cases a day. And that is what
9 we did.

10 MG MUSTION: Sir, --

11 COL JOHNSON: In addition to that,
12 sir, it was just plain old hard work.

13 CO-CHAIR NATHAN: Right, I applaud
14 that. Admittedly I don't walk in your shoes
15 but I was concerned when the Army came in and
16 said if you can just throw thousands of more
17 people at this and millions of more dollars,
18 we can get this fixed. And it seems like
19 necessity here was the mother of invention.
20 The leadership of the Army sort of got
21 engaged. And you made some process changes.

22 My next question is -- and let me

1 say this. If it ever seems like I am picking
2 on the Army, I tell everybody that will listen
3 that your numbers alone make it difficult for
4 the other Services to comprehend. I mean the
5 Marine Corps has got a chunk of people, too,
6 but the Army is dealing with tremendous
7 numbers of individuals and that is almost an
8 unwieldy number to deal with. So, you have
9 all our respect for that.

10 That said, the other Services also
11 are dependent on the VA and certain choke
12 points but they are coming in under the 295.
13 Is it sheer numbers that is preventing the
14 Army from doing that? What is it about the VA
15 hold up in the Army that is not congruent with
16 the Navy or the Marine Corps?

17 CO-CHAIR NATHAN: I believe that
18 is the single greatest factor, sheer numbers,
19 sir. I think that is the single greatest
20 factor.

21 And just for clarity, we did put
22 additional resources at this problem. My

1 organization, the Physical Disability Agency,
2 which includes, we are organized with three
3 PEBs and the headquarters, my organization
4 more than doubled in size for a time. But
5 what we also did was everyone who was wearing
6 a uniform worked six days a week. Everyone
7 who was wearing a uniform worked a minimum of
8 12 hours a day. Everyone who was wearing a
9 uniform got one day off for Thanksgiving and
10 got two days off for Christmas. We got no
11 four-day weekends and half the federal
12 holidays because we knew that we had to take
13 care of our fellow Soldiers.

14 And I had to go around as the
15 Director -- Deputy Director, at the time, and
16 kick people out of the office. You have done
17 enough. Because they understood the severity
18 and the importance of the issue and they just
19 kept coming back for more. I couldn't be more
20 proud of them.

21 MG MUSTION: Thank you, sir. I
22 think there are two things that Carl didn't

1 mention, in addition to the Vice's partnership
2 with the VA in driving things through is there
3 an investment. The Army has put assets on the
4 ground at the DRAS, 31 Soldiers that help with
5 the administrative work, which allows the DRAS
6 to try to focus on the benefits, stuff that
7 they need to accomplish making some progress.

8 The second is, in the past year we
9 have really matured to eMEB and ePEB
10 electronic systems. So much of what Colonel
11 Johnson's team used to do. If you walked into
12 the PEB before, it was just mounds of paper.
13 Now, when you walk into the PEB, it is all
14 electronic and stuff is moving in a much more
15 efficient matter.

16 CO-CHAIR NATHAN: I mean the
17 classic photo was you walk in, the desks. You
18 cannot see anybody at a desk because the
19 records that are stacked up.

20 MG MUSTION: Absolutely, sir.

21 Sir, a year ago, I went to visit
22 the PEB in San Antonio and it was exactly that

1 in the main adjudicator. And I was there
2 three weeks ago on a visit and you could
3 actually see people in the room actually doing
4 work, which was freaking amazing.

5 COL JOHNSON: Our storage area,
6 sir, just at the Agency level held 14 tons,
7 that is no exaggeration, it was weighed
8 because we moved in a BRAC move, 14 tons of
9 paper. It has now one filing cabinet that
10 goes along the wall that is about 15 feet.
11 That is how much it reduced.

12 Where is our problem? When you
13 look back here, to look at this and start to
14 peel this out into its fundamental parts, this
15 is where we are at. This is where we went
16 over the course of those years.

17 So, our rating, what the Physical
18 Evaluation Board is, our standard is 15 days,
19 we were upwards of 25 days a year ago. We are
20 not down to about ten. So, we more than -- we
21 increased that by more than 100 percent.

22 The time of disposition, which is

1 all of that administrative action that get the
2 Soldier's Counsel, get the election back, the
3 processing that was done at the physical
4 disability agency to issue orders on behalf of
5 the Secretary of the Army separation to ensure
6 that his DoD benefits started, that we were
7 taking upwards of 90 days. We are not
8 consistently below 50.

9 This, I own. That is mine. So,
10 if it is good, it is my fault. If it is bad,
11 it is my fault. This is mine. If it is good,
12 it is ours. If it is not, it is mine.

13 And this is where we are at with
14 the DRAS. This number, when we talk to the
15 DRAS, we work with them, et cetera, that
16 number is going to get worse between now and
17 January of 2014. What we should see about
18 February 2014 is that number should start to
19 come down. The time limit should start to
20 improve and the VA is confident that by the
21 end of the fiscal year, they will be back to
22 standards.

1 So, they are going to go from
2 their confidence that they can go from about
3 146 days, which I think is what they averaged
4 so far this month, to 15 days by the end of
5 the FY.

6 So, how did we improve it? Again,
7 no silver bullets. It is just leadership,
8 proper resourcing, right sizing organizations,
9 and then hard work. Just do it.

10 What did we do? You asked for
11 specific improvements that we made based on
12 studies and Task Forces, et cetera. You can
13 see there is a plethora of improvements that
14 we put into the process. And Admiral, I think
15 that goes to your point. We had to do this
16 simultaneously. We couldn't just throw
17 resources at it because we didn't have enough
18 resources to throw at it, if we didn't improve
19 our efficiencies. One of the most significant
20 efficiencies we gained is within two months of
21 fielding the new electronic Physical
22 Evaluation Board System, within two months we

1 gained 31 percent efficiency in every admin
2 process in the organization. We sat down and
3 we did internally without Lean Six Sigma, we
4 stop watched people without them knowing, so
5 you can get an honest assessment how long was
6 it taking them to move a case through the
7 process. How long did it take them to do
8 something?

9 We then put those into metrics,
10 built the algorithms that gave us what the
11 measures of performance should be for each
12 position, fed that to the employee, fed to
13 that to the supervisor, the established
14 standards and moved the cases through the
15 process.

16 And we did this, we did not have
17 an increase in the rate of formals, as an
18 indicator of did we just do the bum rush
19 through. Our rate of formals remained
20 generally the same throughout this process.

21 One of the things that the Guard
22 talked about, standardized checklist. That

1 was an initiative that the Agency took to make
2 everybody's case a standard case. That
3 increased efficiency across the board, Reserve
4 Component, Guard, Army Reserve Guard, and
5 regular Army.

6 I will tell you that this action
7 here, which we borrowed from the Air Force,
8 was a positive action. Two-person boards
9 allowed us to move cases through rapidly and
10 efficiently, without a loss in quality because
11 we put some restrictions on that. Example:
12 any case of a Soldier who suffered both from
13 a behavioral health and a TBI had to have
14 three members because it is just a more
15 complex case. It is harder to figure out.

16 Other key improvements and these
17 are not based on studies. These are just us
18 kind of getting through and talking to our
19 other stakeholders within the Army, putting
20 the Reserve Component Soldier Medical Support
21 Center underneath the G-1. The number of
22 cases that they produced, validated and pushed

1 up doubled when they came under the leadership
2 of the G-1.

3 Again, established standards.
4 This is what you are going to do. If you
5 can't do that, there is always Saturdays and
6 Sundays. And so, we got it done.

7 Other key improvements, training,
8 centralized training, really put under the G-1
9 in the Agency to do training across to all of
10 the MEB providers and PEBLOs, lead PEBLOs, et
11 cetera. They came to us. We trained. In
12 those training environments, what we did often
13 say they would share with us their challenges.
14 And what those training opportunities turned
15 into, actually process improvement
16 opportunities because what we would do is get
17 the feedback from them and they said well, you
18 wanted us to do it this way. It is
19 impossible. If you ask us to do that, we are
20 going to fail. So, let's do this. We take
21 that, change the process, disseminate it back
22 out and then start training the new standard

1 so we could do rapid changes.

2 We implemented a program with our
3 adjudicators so that when they first come into
4 the organization, the first thing they did was
5 they were assigned a mentor, a senior
6 adjudicator who had been there, done that.
7 Sat them down, talked them through, walked
8 them through the building, give them their
9 points of contact, all that kind of stuff.

10 They would then go through a
11 lesson outline with them. I think Colonel
12 Faris said it when she was up here. If you
13 know that the test is going to be, you
14 generally do better at it. And so, they would
15 understand what they were going to be tested
16 on to be certified as adjudicators. You then
17 stick them in that adjudicator training and
18 their mentor sits there with them.

19 Well, like I said, we were
20 identifying process improvement things,
21 pushing it right into the training. So what
22 happens? That mentor, who is a senior

1 representative in the PEB hears those process
2 improvements, hears those changes. They then
3 go back and train the rest of the adjudicators
4 back in the PEB. And so that is what the
5 model we use to get through that.

6 Information technology, you know I
7 have talked there, 31 percent standardized
8 also how adjudication was done. When you
9 standardize how adjudication is done, it is
10 easier to train it because I only have to
11 train it one way. It is easier for me to
12 check it IEDQA because if you don't follow
13 this, I know.

14 Additionally, you have visibility
15 of the leadership at both PEBs and the Agency.
16 So, I can look down and see how individual
17 adjudicators vote. And if I see that one
18 adjudicator is off the norm, I can pull them
19 out, retrain them, pull them back in, and
20 maintain momentum. And then I don't have the
21 formal percentages going up because I have
22 someone who is out of whack.

1 And then the other thing that we
2 have done is a lot of work with the MEB and
3 the Surgeon General's Office to share system
4 access, AHLTA, assorted other things. We are
5 working a lot of initiatives now to improve
6 system access for the Veterans Administration,
7 which will make us even more efficient. I
8 would expect that we could probably again
9 about 20 percent more efficiency if we can get
10 access to all their systems. And they have
11 agreed to give us those and we are working
12 those agreements right now.

13 Questions on formals. Before I go
14 there, is there any questions on where we
15 were, where we are now, and how we got there?

16 Okay. All right, we will push
17 through on formals. We are not doing well
18 recently. Well, we have been improving
19 recently but we had some problems with the
20 timeliness of our formals and we will talk
21 about why here in a moment.

22 Have we improved in most recent

1 months? Yes. I measured it again today.
2 Based on where we were today, we were at 46
3 days so far this month. That is an
4 improvement over last.

5 What have we done? One of the
6 things we did, we hired more government docs
7 because DoD policy requires three people on a
8 formal. One of those has to be a doc. Well,
9 if you have limited doctors, you can only do
10 so many formals a day. Having sat on a number
11 of formals, they will wear you out. You do
12 about three a day and then you are drooling on
13 yourself because you are listening to all of
14 the motion that that Soldier is bringing in.
15 Oh, by the way, you have already had to review
16 the case in detail with the Board before the
17 Soldier ever came in to see if there was an
18 obvious error and to help focus the
19 questioning that you are going to do during
20 the formal to try and get at the Soldier's
21 contention.

22 So, it is an intensive process.

1 So, about three a day. And when you only have
2 a couple of docs in the PEB, that limits you.

3 What have we done to further
4 improve? We are trying to recruit and retain
5 MDs. That is a challenge. That is a
6 challenge. The Army doesn't pay MDs very
7 much. MDs that work for us aren't touching
8 patients. As such, they are at a lower pay
9 scale.

10 The VA, where they are doing the
11 same job kind of in adjudication or
12 advisement, pays a lot better. So they come
13 to us, get familiar and then say hey, I have
14 got experience at an Army PEB or an Army MEB
15 and they walk across the street to VA. We are
16 kind of eating each other's young.

17 What are the factors that
18 contribute? Critical shortage of MDs at JBLM
19 first. That was the biggest challenge they
20 had. Then we had a shortage at JBSA. And
21 what that was was people walking across the
22 fence to go work somewhere else or people --

1 we had two deaths, tragically. I mean you
2 can't predict those losses of doctors and it
3 is just what happened.

4 And then just the sheer case
5 volume. The sheer case volume.

6 And then RC cases as a percentage
7 of the volume. RC Soldiers generally tend to
8 appeal more often and we will talk about why.

9 What do we do? Why do they? I
10 think these are the reasons, we believe. And
11 I talked to the Office of Soldier's Counsel
12 and a number of the Warriors there. I think
13 they agree. The biggest, probably initial
14 challenges are incomplete record. The second
15 challenge is the RC Soldier who is given the
16 same briefing as an AC Soldier as they enter
17 the process, simply just doesn't avail
18 themselves of the lawyers, who are available,
19 who are there, et cetera. So, we are taking
20 some more aggressive actions here in the near
21 future. Here is a flyer. Here is the better
22 phone number. If you can't reach them here,

1 do this. Trying to get them to reach out to
2 those lawyers earlier.

3 You asked for statistics; 47.4
4 percent of the cases that we had a formal for,
5 there was no change. The Soldier came in,
6 presented additional evidence. The PEB
7 reviewed that evidence and the formal PEB made
8 the same decision.

9 Then 38.7 percent of the cases
10 that were brought in resulted in an increased
11 rating. That goes back to, I think, some of
12 what General Mustion was asking before. How
13 does it change? Well, the Soldier comes into
14 a formal and he brings in new evidence,
15 evidence that was presented to the MEB or the
16 PEB before. So, I get a whole stack of new
17 evidence. It is going to likely change the
18 decision. And that is, generally, what
19 happens.

20 And 10.3 percent went from a
21 finding of unfit to fit. That is a good
22 thing; 10.3 percent of the formals. This

1 still translates to a number less than 3
2 percent across the Army found fit after going
3 through IDES. But this is a Soldier coming in
4 and fighting to stay in the Army. We love to
5 see those kind of Soldiers.

6 Then 2.5 percent resulted in
7 change to a combat code. For example, a
8 Soldier comes in and nowhere in his record
9 does it say that injury happened while he was
10 deployed in Kuwait, which is a combat theater.
11 He comes in and says well, here is the theater
12 treatment record I kept. Okay, you got hurt
13 there? You get 10(d).

14 And 0.71 percent resulted in a
15 decreased rating; 0.35 went from fit to unfit.
16 Because generally, a Soldier who comes in is
17 trying to be found fit, most frequently.

18 And how many resulted in appeals
19 to the our level? Well, 17 percent of all of
20 those then request another appeal to the
21 Agency; 17 percent of all of those.

22 Okay, this is designed to be busy.

1 It talks to all of those key things; what
2 happened. So, if you look at it, most of
3 these factors hit every time we had a spike.
4 It just hit somewhere else. So you had an MD
5 die here, you had one quit there, had another
6 one that was asked to leave because they
7 failed to perform, et cetera, et cetera. So,
8 it has effects at different spots.

9 As you start to come farther over
10 here, we start to do a little better. Why did
11 we have a spike here? Well, you look back, we
12 lost two MDs in this PEB for this entire
13 month. We hired two here but they are not
14 ready to execute until here because we are
15 training them.

16 So here, when I just checked their
17 data, they are down to 36 days because in
18 October all those cases that were backlogged,
19 they were doing five and six formals a day, if
20 they had to, to get caught up because they had
21 multiple boards running.

22 So, that is where we are at and

1 you can see the numbers are starting to come
2 down. JBLM, horrible; now much better. JBSA
3 got a little worse last month; that was the
4 loss of those two docs, like I said. And then
5 NCR was not doing very well; they are doing
6 better.

7 So, I would like to point out the
8 primary reason. December and January, IDES
9 cases, when did they hit? We produced more
10 cases in January 2013 than we did in some four
11 years combined, four-year periods combined
12 before in one month.

13 As the Soldier goes through the
14 election process, meets with his attorney,
15 gathers additional information, has a formal
16 schedule and then shows up, it is a month or
17 two later. So, that is where you see the
18 delay. There is a delayed impact of that
19 Soldier hitting. And so, that is going to
20 delay the sheer number of cases.

21 Your rate stayed the same but it
22 is simple mathematics. If I do five times as

1 many cases and my rate stays the same, I am
2 going to have five times as many formals.

3 So what is our average? This is
4 the other thing we look at that I worry about.
5 Across the Agency, less than 12 percent or
6 about 12 percent request a formal. So, 12
7 percent request a formal. We only execute 3.5
8 percent. So, 3.5 percent of the cases that we
9 do end up going to a formal.

10 The challenge is when a Soldier
11 requests a formal, we re-adjudicate their case
12 automatically because we assume the Soldier is
13 right. We assume that the Soldier found
14 something that we missed. And so we assume
15 the are right and start to re-adjudicate that
16 case.

17 What we have done recently is
18 start meeting with the Office of Soldier's
19 Counsel before we execute a formal to say hey,
20 what is your contention. You know, if the
21 Office of Soldier's Counsel provides evidence
22 we didn't see before, there is no sense

1 holding a formal. We will just change the
2 finding, provide an amendment to the Soldier
3 and move on.

4 What is the difference between the
5 Reserve Component and Active? If you ask me,
6 Active is here, Reserve Component here, about
7 twice as high. And the reason is down here.
8 One, they don't take advantage of the lawyers.
9 Two, many RC Soldiers, particularly RC
10 Soldiers who are not in an active duty status,
11 don't understand how we can find them unfit.
12 I can go to drill. I don't have any issues
13 going to drill. I can do two days a month.
14 That is not what we are finding them fit or
15 unfit for. We are finding them fit to be able
16 to execute their mission in a full-time
17 environment, mobilized, ready to fight. And
18 some Soldiers, particularly younger Soldiers,
19 just don't get that. And so they ask for a
20 formal and then little changes.

21 What are the rates? They are
22 about, they are fairly similar in the

1 percentages we execute between JBLM and NCR.

2 The percentage executed down in
3 San Antonio is a bit lower. We attribute that
4 to a couple of things. One, they had more
5 docs out here to look at it for a while. The
6 other thing I will tell you is they are our
7 busiest PEB. They are our highest volume PEB.
8 They have mostly the southern United States
9 that goes into there. And a lot of their
10 cases were Reserve Component cases here
11 earlier in the year where information was
12 stale. Rather than hold a formal, they would
13 send the case back to the MEB, redo, re-workup
14 the medical information, give us the most
15 updated stuff. We have the most updated stuff
16 and the Soldier would say okay, you have got
17 the most updated stuff, I am satisfied with
18 your decision. And that is what you got.

19 Army formal dispositions, you
20 asked me where formals were held, what
21 happened. Of all the formals requests we get,
22 we only actually execute about 30 percent of

1 them; 60 some-odd percent waive. And this
2 data is skewed here. September data is
3 lagging. August data is lagging. And the
4 reason it lags is because the data is not
5 measured by VTA until the case closes. Those
6 cases aren't closed yet. So, the data lags.

7 And then this is how many are
8 still pending results. Well, you look at this
9 one way back here and you say wait a minute,
10 you did a formal? Ten percent of the formals
11 you did way back in February are still
12 pending? Yes.

13 Generally, that is because the PEB
14 said you know what, we agree with you. That
15 condition should be found unfitting. The VA
16 did not provide a rating because they deferred
17 their rating. We had to send it back to the
18 VA. And the VA time line, as we showed was
19 about six or seven months. So, that is where
20 you are at.

21 Additionally, when a Soldier comes
22 through, they can get all the way through

1 their formal here and then request okay, I
2 have got my formal result and now I want the
3 VA to reconsider the percentages they gave me.
4 So they can put themselves back in that loop
5 and, again, VA is backlogged there. There is
6 another two or three months. I think they are
7 down to about a month and a half now. So,
8 they have made a significant improvement there
9 recently.

10 But there it is relative to the
11 PEBs again, fairly similar between JBLM and
12 NCR. A little bit different but not
13 alarmingly different anywhere that I saw
14 there.

15 Subject to your questions, that
16 completes what I think you asked me to talk to
17 you about.

18 MR. REHBEIN: If I may, Colonel?

19 COL JOHNSON: Sir.

20 MR. REHBEIN: When a Soldier
21 requests a formal, do they specify what part
22 of the decision they disagree with?

1 And then to follow-up with that,
2 it sounds to me like though the formal looks
3 back at everything, not just what the Soldier
4 disagrees with. Am I correct in that?

5 COL JOHNSON: Yes, sir, the
6 statute requires us to do a complete review.
7 So, when a Soldier requests a formal, and this
8 doesn't happen often, you saw the statistics,
9 but when you come in and request a formal,
10 your rating can go down, up, stay the same.

11 MR. REHBEIN: And I was just
12 thinking about the look I would have had on my
13 face when I opened that letter with the
14 results of my formal that told me that not
15 only did they disagree with me but they had
16 lowered my rating, too.

17 COL JOHNSON: Yes, sir. And the
18 thing with the formal, what we do in the Army,
19 we tell the Soldier. We do not send it to
20 them in writing. We give them the finding
21 face-to-face because that is an emotional
22 moment for them and us.

1 MR. REHBEIN: But they are aware
2 that that is a possibility when they go into
3 the formal?

4 COL JOHNSON: They are. We have a
5 standard script that we read at the start of
6 every formal that reviews that, sir. And I
7 will tell you Soldier's Counsel does a very
8 good job with their Soldiers to review that.
9 We talk to Soldier's Counsel. We make them
10 acknowledge with the Soldier there present.
11 Do you understand what can happen here, before
12 we proceed? We haven't started to proceed
13 yet. Once I pull that trigger that says the
14 formal is called to order, everything is on
15 the table.

16 But then you ask, do they tell us?
17 The Soldiers are provided in their election
18 the opportunity to provide information for the
19 PEB to consider and still request a formal.
20 If they do or whether they do that or not, the
21 PEB re-adjudicates the case.

22 If they provide us new

1 information, that is great. Because normally
2 what we will do is we will look at that new
3 information and we will contact the Office of
4 Soldier's Counsel and say hey, we agree with
5 you or Counsel, that doesn't cut it because
6 there is the evidence that is in the medical
7 file; you have got to overcome that. And what
8 it does, it provides Counsel an opportunity to
9 understand what the target is. And so, we
10 find that to be useful.

11 DR. PHILLIPS: Colonel, can non-
12 DoD medical personnel see these folks and
13 write an opinion? And if so and that
14 disagrees with the DoD medical personnel, how
15 do you resolve that?

16 COL JOHNSON: It's the weight of
17 the evidence, sir. It is the weight of the
18 evidence. So, yes.

19 Now, if you think about it, if the
20 Soldier is in DES and you heard the National
21 Guard Team talk about different methods we
22 have to pay for that Soldier to get another

1 evaluation, et cetera, if suddenly the guy
2 goes out and gets three or four other opinions
3 from an outside person when I have got a track
4 record that says this, you are going to weigh
5 those differently.

6 The other thing is you get some
7 people, some doctors in some communities where
8 you start to know what they are doing. If you
9 pay \$500, you get an opinion. Tell me what
10 your opinion is. It's sad. It's rare but it
11 does happen. But what we do is we weigh the
12 evidence and look at the totality of it.

13 EXECUTIVE DIRECTOR DAILEY:
14 Colonel Johnson, we were up at Fort Lewis and
15 did have a chance to talk to your PEB up at
16 Fort Lewis. He and the Counsel up there also
17 talked about the opportunity to engage with
18 the PEB when the formal is requested. Because
19 as you noted, if they can hand the PEB a piece
20 of paper right there and say look, this is why
21 we are requesting this formal. How about if
22 we resolve it right now and then we will pull

1 this formal out now, instead of in three
2 months when we come up on the docket.

3 COL JOHNSON: Right.

4 EXECUTIVE DIRECTOR DAILEY: So,
5 you described that process. You said some of
6 that is being done.

7 COL JOHNSON: It is being done at
8 all three PEBs. It is done less at JBLM. It
9 is done less at JBLM because, frankly, and you
10 are going to get my side of the story, and I
11 think this is partly because of the tyranny
12 of geography out West. The JBLM is
13 representing Soldiers that are up in Montana,
14 Wyoming, et cetera. That Soldier's ability to
15 go get a new test result or whatever, new
16 evidence, is limited. And so, they don't get
17 new evidence before the Board is scheduled.

18 The lawyer comes in and tells the
19 PEB, hey, believe me, this is what is
20 happening. And the PEB says okay, that is not
21 evidence. So, I can believe your client if he
22 comes and testifies at the Board but I can't

1 just have you just tell me trust me, this is
2 what is going on. I have to see evidence to
3 make a decision because we are making a
4 decision for the Service, for the Secretary of
5 the Army that has to take care of the Soldier
6 but, at the same time, we have a fiduciary
7 responsibility to the government.

8 EXECUTIVE DIRECTOR DAILEY: So,
9 that early touch with your Counsel, when the
10 formal Board is requested, can be -- it is not
11 like just walking across the street with a new
12 piece of paper to talk to the PEB guy/girl,
13 XO, deputy and saying look, we really don't
14 need to go formal, if you will address this
15 right now. It is not that easy.

16 COL JOHNSON: It is almost that
17 easy. It really is.

18 EXECUTIVE DIRECTOR DAILEY: Yes,
19 if they could come together.

20 COL JOHNSON: If they could bring
21 the information to the Soldier's Counsel. And
22 what we have done is locate Soldier's Counsel

1 right near the PEB.

2 EXECUTIVE DIRECTOR DAILEY: Right.

3 COL JOHNSON: We have done that on
4 purpose, so that it is easy to coordinate and
5 synchronize efforts. But, if it is that
6 Reserve Component Soldier in Montana, no.

7 EXECUTIVE DIRECTOR DAILEY: Okay.
8 Okay and then I do want to, as I call it,
9 connect some dots here. Mr. Tierny in San
10 Antonio's Air Force -- Tillery, excuse me.

11 COL JOHNSON: Tillery.

12 EXECUTIVE DIRECTOR DAILEY:
13 Tillery. You have both echoed one of the same
14 comments, which was the doctor situation and
15 docs for the Board, for the PE Board is very
16 difficult to manage. It takes creative hiring
17 practices, creative hours. It is tough to
18 find that balance between pay and quality of
19 life that they are looking for. It is
20 drudgery, it can be.

21 And so, I found that interesting
22 that both you and he kind of made that same

1 comment about creating an environment where
2 you are bringing in quality doctors and able
3 to help them find -- what was the word that
4 our SOCOM talked about as job satisfaction
5 yesterday? Relevance and meaning.

6 COL JOHNSON: Yes.

7 EXECUTIVE DIRECTOR DAILEY: How do
8 you find relevance and meaning for your PEB
9 doctors when they come into this job? Which
10 is very not a lot about the Soldier but more
11 about the paperwork. So, relevance and
12 meaning.

13 COL JOHNSON: Absolutely. And
14 General Mustion can tell you how many times I
15 go to him begging him, sir, I need to increase
16 bonuses. I need to increase retention. I
17 think we have got them at about as high as we
18 can reasonably do it. There is only so much
19 money.

20 Oh, one last thing, Admiral,
21 before I sit down, we did put together a
22 Dashboard info paper here. The picture on the

1 back is what it looks like. We are very proud
2 of that.

3 Yesterday, we sent an email to the
4 over 20,000 Soldiers who are in the DES
5 process and said you have access. This is how
6 you access it. Gave them a link, et cetera.
7 We have gotten hundreds and hundreds of emails
8 already back within the first 24 hours,
9 discussing it. A lot of good feedback.

10 The vast majority has been very
11 positive. Thank God, I finally know where I
12 am and I can see how I went there. We did get
13 one email, in particular, that they sent to me
14 immediately, where the Soldier says it is
15 about damn time. And why couldn't you tell me
16 this X amount of time ago. And look at my
17 time line. Look at how long I have been in
18 this process.

19 So, but that is okay because what
20 the Soldier didn't go on to say is he had
21 cancer. We delayed him on purpose so he could
22 get more treatment with the same doctor, at

1 his request. So, when we go back in and start
2 to look at it, that's okay. He is frustrated
3 and he is dealing with something that God, I
4 hope I don't ever have to deal with. So, we
5 will take that hit.

6 EXECUTIVE DIRECTOR DAILEY: So, we
7 will incorporate this into our findings. But
8 this, ladies and gentlemen, your
9 recommendations over the past year have been
10 to one of them was to increase accessibility
11 to the VTA, so that there was more visibility
12 in the DRAS and at the CBWTUS and at the
13 lawyer's offices.

14 This is the individual goes
15 online. They sign on to what you call a CMS.
16 You call it signing into a system called the
17 CMS and they can see their current status.
18 And I would be interested to see, as we go out
19 on this next round, how many more black hole
20 discussions we get. Obviously, it needs roll
21 out time. It needs time to get traction and
22 get into the lexicon. But, thank you.

1 I think this black hole discussion
2 dominated last year's Task Force discussions.
3 Before that, it had been it takes too long.
4 It takes too long. The dialogue changed last
5 year to I am moving through much faster now
6 but I have no idea where I am or how long, or
7 where I am going next or when it is going to
8 resolve itself. It is in the black hole, the
9 black hole. So there was an interesting
10 change in dialogue out there.

11 COL JOHNSON: And I think this
12 obviates the need for individual access to
13 many IDES stakeholders to VTA data because
14 that Dashboard is based on VTA data poll. It
15 is a once a week data poll, so it is a little
16 dated but it is once a week. In a 295-day
17 process, that is probably often enough.

18 CO-CHAIR NATHAN: So, Colonel let
19 me close with the last question.

20 COL JOHNSON: Sir?

21 CO-CHAIR NATHAN: So obviously, you
22 have leaned into this. You have cleared a lot

1 of the backlog out. So, now you are at the
2 point where you can sort of bail the water at
3 the same rate it is coming over the side, Navy
4 term.

5 COL JOHNSON: Yes, sir.

6 CO-CHAIR NATHAN: Now, I am going
7 to ask you a question, sort of in Army
8 metaphor. You have approached the 50-meter
9 target. You are really at the 300-meter
10 target. The 1,000 or 5,000-meter target is
11 the people coming off active duty roles over
12 the next few years. And the choke point more
13 at the VA and at the IDES system, what does
14 your gut tell you about that? Where are we
15 positioned, especially in the Army, which is
16 going to bear the brunt of people coming off
17 the roles at a faster than normal evolution?

18 COL JOHNSON: Sir, here is what I
19 told the G-1, sir, General Bromberg, my boss.
20 I said all right, sir, where is where we are
21 at now. That is one of our concerns. It is
22 an unknown target because we have looked back

1 at it historically after the second World War.
2 We looked at it after the Korean War, after
3 the Vietnam War. We looked at it during the
4 '91 draw down. We tried to see could we pull
5 lessons learned from that, the '91-'92 draw
6 down. And what we found is that there is no
7 direct correlation for the number of Soldiers
8 that are going into DES. And the DES has been
9 here for decades.

10 The most common thing, or the
11 thing that appears to be a driver is the
12 economy. So, if the economy is not good and
13 there is not an alternative for that Soldier
14 to take the skills that learned in the
15 Service, limited however much by the
16 disability they have, and then just go out,
17 they are going to seek another means.

18 They have to take care of their
19 families. They are going to have to take care
20 of themselves. If the economy stays bad, you
21 ask my personal opinion, that is my personal
22 opinion, if the economy stays bad, more and

1 more folks will go into the DES because it is
2 the only alternative they have. A former G-3
3 of the Army said, used the term, that is
4 normal economic behavior. What do you expect
5 them to do? And that is what I think. That
6 is my personal opinion. Others disagree but
7 I think it is tied to the economy.

8 What I will also tell you is that
9 the next big thing that we are after, what we
10 are trying to do within the Agency and across
11 the enterprise, is to ensure we have the
12 capacity to do upwards of 3,000 cases a month.
13 We don't expect to have, and recent data does
14 not show, 3,000 cases a month coming into
15 IDES. But what we also have to remember is we
16 have TDRL, we have non-duty-related cases, et
17 cetera.

18 When we executed all of these
19 cases, we built a backlog on TDRL. We have
20 got to get after that monster. If we don't,
21 Soldiers lose their benefits after five years.
22 So, my goal is to reduce that figure by about

1 35 percent in the next year, reduce the
2 backlog by 35 percent, and then eliminate it
3 within the next year, year and a half after
4 that. Because if we don't, that is going to
5 be our next crisis. So, rather than have a
6 crisis, let's get it after it now while we
7 have capacity in place, we have experienced
8 people in place before there is a change in
9 mobilization authorities or whatever. Get
10 after it now. Get her done and then leave the
11 system in its place in a couple of years where
12 it is a steady state and you are not having to
13 react to crisis.

14 So, that is the Army's plan within
15 the DES, larger than just the IDES. That is
16 what we are after. And so, that is what
17 MEDCOM is focused on now and that is the cases
18 they are pushing to us.

19 As you know, sir, that drill to
20 reevaluate all those troopers coming in,
21 contacting them, getting them in, getting
22 their evals done, getting it to the PEB. So,

1 that is what we are focused on now.

2 CO-CHAIR NATHAN: All right, thank
3 you. Good answer. I think that will do it.
4 Thank you, sir.

5 COL JOHNSON: All right, Admiral,
6 thank you.

7 EXECUTIVE DIRECTOR DAILEY: Ladies
8 and gentlemen, that wraps it up for today. We
9 will be heading down to -- a small group of us
10 will be heading down to Quantico tomorrow and
11 Thursday. And we will see you again then
12 possibly if you are going to Utah with us but
13 if not, our next meeting is in December. It
14 is in San Antonio.

15 So, ladies and gentlemen, thank
16 you very much for your time today.

17 (Whereupon, at 3:46 p.m., the
18 foregoing proceeding was
19 adjourned.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

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

Before: US DoD

Date: 10-29-13

Place: Arlington, VA

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



Court Reporter

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