UNITED STATES OF AMERICA

DEPARTMENT OF DEFENSE

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DEPARTMENT OF DEFENSE
RECOVERING WARRIOR TASK FORCE

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DECEMBER BUSINESS MEETING

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TUESDAY,
DECEMBER 10, 2013

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The DoD Recovering Warrior Task Force met in the Romeo & Julieta Ballroom, 110 Lexington Avenue, 3rd Floor, San Antonio, Texas, 78205, at 8:30 a.m., Suzanne Crockett-Jones, Co-Chair, Presiding.

MEMBERS PRESENT:

SUZANNE CROCKETT-JONES, Co-Chair
CSM STEVEN DeJONG, ARNG
RONALD DRACH
COL KAREN T. MALEBRANCH (Ret.), RN, MSN
DAVID K. REHBEIN, MS
COL RUSSELL A. TURNER, (Ret.) MD*
* Appearing by telephone

ALSO PRESENT:

COL DENISE DAILEY (Ret.), Executive Director, Designated Federal Officer
JOHN L. BOOTON, Director of Operations, RWTF
LAKIA BROCKENBERRY, RWTF Staff
STEPHEN LU, RWTF Staff
DAVID McKELVIN, RWTF Staff
JOSEPH NAGORKA, RWTF Staff

* Participating by telephone

C-O-N-T-E-N-T-S

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

8:30 a.m.

EXECUTIVE DIRECTOR DAILEY: We don't have any public speakers this morning, but we do have numerous written statements in Tab H from Wounded Warriors who wanted to bring situations to your attention. I do ask you to take some time and look these statements over.

The first one in there is from CW4 Zumwalt, who has sent us information in the past. He talks about and has highlighted in these three pages some very good points about what went well during the process, what went poorly, a very good, cogent presentation of the issues that service members encountered throughout the whole process.

The second one is from a Mr. Paul Rieker. And we were recruiting off the PEB forum, and I believe these come from the PEB forum. Is that correct?

Okay. Mr. Rieker -- and it's probably Dr. Rieker, is soliciting the Department of the Army and the Department of Defense for new

techniques on mental health and PTSD treatments. So he's got a list of papers and presentations that he has made to DoD to VA, talking about a better way to address PTSD.

We might get Mr. Rieker in here sometime, but he lives out on the west coast, so we've missed him as an opportunity to speak. But he sends us a lot of material.

And I do believe those are our only two. Yes, those are our only two presentations. Chief Ward Officer Zumwalt and Mr. Rieker.

DR. PHILLIPS: May I make a comment?

EXECUTIVE DIRECTOR DAILEY: Yes, please.

DR. PHILLIPS: I did read through the letters, and Dr. Rieker has many supporting letters praising his technique. I can't assess it and I'm not a psychiatrist, but the supporting letters have seemed compelling enough that if we do have some time, it might be worth our while to either have him send us a copy or do a short presentation. Because it does fit the mainstream

therapy plans that are active right now.

EXECUTIVE DIRECTOR DAILEY: Okay. Sure.

DR. PHILLIPS: And on Warrant Officer Zumwalt, to me, it's an example of someone who really wants to stay on active duty and move along in the chain of command and has a health problem and basically tries to, in some respects, hide that problem from his superiors. And I'm guessing, because the fear of him not being able to -- being told to move out, and perhaps he should have been retired earlier in the process. I mean, I don't want to make a judgment.

But it seems to resonate to me that this is sort of an issue that we see during our visits, that our service members want to stay in but are afraid to really announce or pronounce their issues and just kind of muddle along, which, in the long run, is detrimental to them and to the service.

And so I'm just wondering if we should address or discuss the issues of the fact

that if you cannot make it to the next step or if you cannot make it to a deployment, are there alternatives that the services can provide to allow you cover and then maintain active duty.

I know we try and I know this goes on every day, but his story kind of resonates to me that someone should have ...

MR. REHBEIN: If I may, for just a moment on Mr. Zumwalt's statement. And I'm not going to disagree with Steve because I'm going to focus on a different part of it.

I think we've all had a concern that he highlights here about, is there discrepancies, disparities in the treatment that's received especially in a line unit as opposed to a WTU. I think that's one of the things he's focusing on here.

I think he makes some very good points and presents some creative ideas about how that could potentially be looked at a little deeper. And the problem's maybe not totally rectified, but at least addressed.

I really wish there was a way to provide sufficient funding to get everyone that's a recovering warrior out of the line units and into a WTU because the WTU's mission aligns with the recovering warriors, whereas a line unit's mission does not align with the recovering warriors.

And when you have that kind of conflict on mission, it's going to, I think, probably act more to the detriment of the recovering warrior than it does to the unit mission because the recovering warrior is an individual and the unit mission is for the group.

So I think some of his ideas here need to be seriously considered as to whether or not there are -- maybe not as he expresses solutions, but some potential solutions to address the problems that he's pointing out to us.

CO-CHAIR CROCKETT-JONES: I want to use some clarity here. Certainly anyone in IDES -- I would hope that anyone who is injured, wounded, ill, or injured seriously enough to be

retired out needs to get care and transition completely.

And I think that we're always going to see disparity. Units that are tasked to make that recovery and transition happen are always going to be more effective and focused than a unit that has another mission and is, you know, having a correlated job of recovering some of its members.

I think he presents a lot of good ideas and things to consider. Some of the things that he has spoken about already exist, and I think that some of the things that he mentions were not a matter of policy not existing, but of policy failing him. So, yeah. I think that this is good information to mull over and it informs us. Basically, we always need to hear more realtime experience.

I'm not sure what the avenue for the other presentation would be to get -- you know, I think it highlights perhaps the difficulty of introducing new ideas within the VA Health System.

And it makes me wonder if one of the Centers of Excellence is the proper forum for his ideas to be considered.

And I'm not going to comment further on that at this time.

Is there anything else anyone wants to discuss about the PEBLO?

CSM DeJONG: Kind of going outside the public statements that are there, I want to make kind of a personal statement and something we talked about over the last couple years.

If you look at the numbers of the drawdown percentages, we look at number of wounded, one of the fears that we had was possibly wounded, ill, or injured being nonretained to meet the drawdown.

Now, this is pure speculation on my part just based off of some phone calls that I fielded over the last month, but there are organizations out there that -- it's something we may want to look at is why I'm throwing it out there. In one instance that I'm looking at right

now, it's about 90 percent of those targeted to not be retained have a medical issue.

We obviously don't have time to gather a lot of data on that, but it's just something we may want to look at going forward. And if it's something that we see in the last couple of quarters of what we have left, we could maybe formulate something to make sure that everybody's getting what they deserve instead of being targeted for number reductions.

DR. PHILLIPS: Just to follow up on that comment. I think that's an excellent point, because before we had a draft, we built up, you expected that most people would want to just leave. A few perhaps stayed on. Some that had intended to stay on didn't. But it was a natural process.

But when you have a volunteer Army, you assume most people want to do this as a career. And yet in some cases, they fall under the wheel of needing to draw down and save money. So that's an issue that has to be addressed, as

you point out. There has to be a mechanism.

EXECUTIVE DIRECTOR DAILEY: Well, ladies and gentlemen, we are spending some time at the Air Force this morning and tomorrow, so this would be the opportunity, although not on our agenda, to discuss with us. But keep in mind that they are one of the organizations that are managing the wounded, ill, and injured, and this is an opportunity to discuss with them throughout the next two days how they manage within the units. Obviously, bias here in favor of WTUs, but there are other models that are utilized. Just take the opportunity to question them about how it works also. Okay?

Turning it over to you, ma'am.

CO-CHAIR CROCKETT-JONES: Then if we are ready, we will welcome the Air Force Colonel Thomas Matschek, the Air Reserve Case Management Division Chief, will be briefing us on the continued efforts to launch the new Air Reserve Component Case Management Division within the Airmen and Family Care Directorate. We have this

information under Tab I of the binders, and I'm going to turn it over to you. Thank you.

COL MATSCHEK: Good morning, everybody. My name is Colonel Tom Matschek, and I am the Division Chief for the Air Reserve Component Case Management Division. Very excited this morning to talk to you about our organization and what we're trying to do and what we are doing to take care of wounded, ill, and injured Reserve Component Airmen who were injured specifically within the line of duty.

So this morning I'm going to talk about how we're organized, how we're built right now, basically where we've gone from the last time we talked with y'all in February, and talk about how we're moving forward. And then tie it up at the end for a few questions that aren't intrinsically built into the brief to address there towards the end as well.

So a few terms, if you will, is that MEDCON, Medical Continuation, just in a nutshell is what's given to Reserve Component Airmen. So

guard or Reserve that's injured in the line of duty while on a military status, one of the entitlements that they may be eligible for is Medical Continuation Orders, MEDCON.

And what that does is puts you in an active military status -- active duty military status, and allows you access to medical care benefits and everything else entitled with that.

And what we do is -- we do three primary functions, which is we accept all the applications for those folks who believe that they're eligible for MEDCON. We make consistent and objective determinations of that eligibility of MEDCON.

What we do is -- if you notice at some point during a break or whatever, we see a lot of people in service dress; those are care coordinators and care managers within the Case Management Division. And what they do is bring their medical expertise to bear and do actual medical case management of those folks who are on MEDCON orders.

And we're not the primary case manager, meaning we're not the ones at the MTFs. We're a level above, if you will, a tier 2 case management, to help facilitate access to care issues or whatever it may be to get our folks returned to duty or processed through the disability evaluation system to a known state as quickly and as efficiently as possible.

And the last thing that we do is, obviously, once we determine somebody is eligible for MEDCON, we've got the medical piece which is in the center, but on the outside of that is the administrative shell, if you will, the production of orders and resulting conversations with the organizations to make sure that those orders are produced effectively, efficiently, and with minimum delays.

And that's really kind of what we do as our three primary core functions, if you will.

Second to that, as we've stood on some of the things that we've really kind of brought to bear, I guess, if you will, we've got

some secondary functions, as we are the face of the Air Force MEDCON program.

Prior to this, there was a legacy system, but it was not a very well known process and there was a lot of confusion. And one of the reasons we were brought on is because of findings that said we need to have a little bit more centralized control of the process and a little bit more visibility on the process. So once again, we're the face.

And so if someone has been determined to not be eligible for MEDCON, there's a process to appeal that decision. If there's some kind of Congressional inquiry or something like that, we're going to answer those, as well as do something just like this, which is provide briefings on the program.

Second to that, we do supply statistics of our service members who are on MEDCON to the Secretary of the Air Force. We provide those to the Air Force Reserve Command SG, as well as the National Guard SG. And those are

medical folks, so once again, they have got some idea of who they've got on these orders and also maybe some of the underlying reasons why these people are brought on orders.

And then the last thing that has really happened -- and this is the thing, frankly, that I think the folks in the back, once again, feel a lot of pride in is, they've become recognized as Air Reserve Component Medical Case Management experts.

What I'm trying to say is we're not, once again, the ones who are going to walk you to the doctor, because we're here in San Antonio and our members are scattered throughout the United States. But what we're going to do is those folks who say, I'm not sure how to get this person to the doctor, to get that person to that provider, how do we make that happen. And these folks have really figured out those pieces of the puzzle and are very adept at helping facilitate that process into the care of our wounded, ill, and injured Reserve Component Airmen.

How we do that is with a relatively small organization. We're a very unique organization in the fact that we've got active duty, Reserve, and Air National Guard members all combined together within our division.

And if you look up there, what I've thrown up here, really just a breakdown, and I think some of that font may be a little bit small, but the point that I would make is that the executive management team has a reservist, a guardsman, and an active duty member up on the top three helping to facilitate this process.

And our care coordinators, case managers, medical branch, once again, all three components, Reserve, active duty, as well as National Guard; and then we've got on the right side the resources branch, which is primarily active duty. But those are folks who, once again, talk about that administrative shell to facilitate the production of the orders to get that information out there to help educate our end users on the process there. When we started this

journey, we've really had a lot of growth, and I'll go into that a little bit more so here in just a second. But that's kind of how we are laid out.

The next slide I want to show you, this is a milestone chart, which those of you who were here in February should look very familiar. One of the questions asked was: How are you progressing towards FOC, full operating capability? And what I'll tell you is we're right on glide path, right on speed, right where we're supposed to be to get to full operating capability in July of 2014.

And by FOC, what that means is that there's three different ways that a service member -- three different funding streams that a service member can be involved with when they're put on medical continuation orders. We've got Title 10 MPA, Military Personnel Appropriations. We've got Reserve funding and we've got Guard funding. So you've got active duty, Reserve, and Guard, three different types of funding.

In July of 2013, we declared ourselves IOC, Initial Operating Capability, and we've got full control of the active duty MEDCON program. We achieved that in July of '13. And if you look forward, October to January of 2014, we're actually bringing on an additional five folks to help absorb the increased workload as we bring on board the Reserve funding orders as well as the Guard funding orders. And once again, right on path in taking care of that in July of 2014.

So we'll put this slide up and get the 10-month look back so kind of what I just said, put it out there in words as well. What we've gone from four medical folks on staff in February, we're now up to all 11 of them are in place. All of them are all trained, qualified, handling cases. We've got two lead case managers who are, once again, very experienced within the MEDCON world, as well as in the reserve component medical case management world and mentoring on all the complex cases and, once again, just doing

great things.

We've got an active duty Air Force physician in place. And I'm going to brag for just a second on Doc Littenburg in that we brought him in about the same time I came on board. And his background is very unique and very uniquely suited to help our organization, a background of occupational medicine as well as preventive medicine. And before he came into the Air Force, he actually worked with the State of California workers' comp. So he got some familiarity with some pieces of this puzzle before he even showed up. And, once again, the really single person out of all of us that really helps assure our legitimacy.

Because before this, in the old model, there was not a dedicated, credentialed medical physician involved with the MEDCON process. As we look at ways to solve what's a complicated process, doc's expertise really shows up and has helped us out in spades there.

Resources branch, the less glamorous

side, if you will. The folks who are pushing, making things happen. All four of those positions are in place, filled, and we had our last person show up two weeks ago. So we've got everybody in place and, really, once again, doing the yeoman's work behind the scenes making everything happen.

And then lastly, since February, obviously, I've come on board; before that, a little bit of temporary fills waiting for my assignment process to be finalized and everything else. So that's kind of where we've changed, if you will, from the last time you were addressed in February about the ARC-CMD to where we are now.

Now, what are we doing? This is a graph showing our Title 10, which, again, is our active duty MPA MEDCON case load, for about the last seven months there. So what you'll see is a slight decreasing trend and where I think we're going to be able to stay at about 170 active cases on the books as we go month to month. Obviously, there's going to be some fluctuation up and down, but I think that's going to be a steady state

where we're at.

And if you look, I've broken that down between Reserve and Guard, and you can see that that distribution there is very level between the two, once again, equally distributed on those pieces there.

And the other piece that I broke down was DES and non-DES; so in terms you're familiar with, the Disability Evaluation System, and then those non-Disability Evaluation System. Those that are in the non-DES really is where I contend that, once again, care coordinators or medical care managers really can bring a little bit more force to bear because those are the folks that we have the best chance to return to duty, bring them back and everything else like that. And once again, you see it's relatively equally distributed between the two -- between those folks that are being processed through the evaluation system and those that have a more active medical care profile going on, if you will. So that's our case load.

And what are we managing? Out of the 170 cases, we have 324 different line-of-duty determinations, 324 different medical diagnoses, if you will. And you can break that down and see we've got primarily shoulder. PTSD is our number two type LOD. And the majority of that, almost the remaining of that top half, were all orthopedic-type issues. So that's what we are dealing with on a day-to-day basis as far as when we're doing our medical case management.

So that's where we're at now. I'm going to talk a little more about how do we move forward, how do we get to that full operating capability, that FOC.

So I talked about we have got 170 cases, and the undefined workload, if you will, is those applicants -- those folks who are looking for help from MEDCON. And we normally manage about 20 of those applications each month, so that gives us a workload of about 190 cases that we're churning through on a monthly basis. With the manning that we've got, that gives us a load of

about 40 MEDCON cases per team.

And by team, what I'm talking about is we have a medical case manager, a nurse, and then we have a care coordinator who's an enlisted medical technician, and those two work together, distribute the workload as appropriate to, once again, make sure that those folks under orders are getting the care they need.

And as we continue to move forward, our planned capacity is really 50 cases per team is what we're looking at, so we've got a little bit of headroom, which is a good thing because we've been drawing and learning and training, so that's great.

And as we go to FOC, really kind of plan our case load to almost double to the number of about 350. You can see I say MPA, if you think active duty, and we're going to have about another 70 folks who are affiliated with Guard-related funding issues and 90 within the Reserve funding issues there. And then as we bring that manpower that I kind of alluded to earlier, three more

Guardsmen, two more Reservists, that will give us the manpower to absorb that increased workload. And that's how we'll put the pieces -- the people part of this puzzle.

And then the other piece that we need to do is work a little bit of systems issues. And right now, since we're only working active duty orders, we have an active-duty-specific database that we use to keep track of what is going on with our members and determining eligibility and everything else; and working with systems experts within the Air Force Personnel Center to develop a solution within the software suite that Air Force Personnel Center already uses and works on a daily basis with all of their personnel actions, and we're bringing into a small corner of that system, right now technology's developed a universal case management suite. And the idea behind that is where we can consolidate our medical salient notes with our administrative pieces, and, therefore, we've got one view of everything that's going on. And once again, that

also gives us the ability I alluded to earlier, being MEDCON statistics one place where we can pull out how many folks do we have on this status, how do we have these different medical diagnoses, whatever the case may be, all within that one suite there.

So those are the two things that we really are working on. And the good news in both of these is the solutions are moving forward. I was hoping that I'd be able to stand up in front of you and tell you, hey, we've got the software, we're working it. No, that's just not where we're at. We're about a month behind schedule in that regard. But once again, we've seen the beta version, if you will, and are very excited at that capability.

And the National Guard as well as the Reserve Command are both working together to get to those remaining five positions. The Guard positions have been advertised, so we're just waiting to fill those here fairly quickly. And the Reserve positions will be filled here in the

spring as well. So once again, funding has been identified, so we're moving forward. Good news stories, as far as how to progress forward to fully encompass the whole mission.

Now, this is going to be another chance to brag for a little bit because what I want to talk about is two different cases. I'm going to be very generic in my description because, once again, it's kind of in a public forum, not going into much medical specifics or anything else, but talk about some of the great things that the pros in the back of this room have done, as well as take care of wounded, ill, and injured Reserve Component Airmen.

So from the Guard, what we had is, we had a service member who was on MEDCON prior to our stand-up. So, if you will, they were enrolled in MEDCON under the legacy system, and that's a good thing. But he's a Guardsman, and he's not collocated anywhere close to an active duty military treatment facility, so the treatment that he was receiving was through civilian providers.

And there was no central core, if you will, so no central person that was working. Obviously he had a primary care manager. Long story short, getting treatment from different physicians, and it wasn't one consolidated look.

Our brethren in the Wounded Warrior Division, within the AFPC, the recovering care coordinator that was dealing with this case was realizing that this person was needing a little bit more help and was languishing within the system. And as we were stood up, one of the first cases they brought to us and said, hey, this person needs a little bit more help and needs some medical case management.

And so we came on board. We gathered all the information we could. And Doc Littenberg and one of the lead case managers looked at the case and initially thought this person was a valid applicant for the Center for the Intrepid. We did a little bit more looking into it, and this member was not injured in combat so did not meet those eligibility requirements to

get to that piece. But his injuries were very significant.

What we did find is that the VA Polytrauma Center was a perfect fit for this particular guy and to get him the care -- the consolidated care, if you will, a single point of reference into how do we get this guy and how do we move him forward and everything else like that.

So Dr. Littenberg and the team presented the paperwork and got him admitted to the Polytrauma Center and worked with the unit to get him moved down to Tampa. And that in itself was, once again, a good story because there was some roadblocks to it. The member himself was initially hesitant to travel, was hesitant to leave family, and rightfully so, as he goes through some of this training.

But the unit really stood up and our team worked together, got a service dog. They helped his travel down there, traveled with him, got him settled in place. And, frankly, they're coming back every other weekend along those lines

to make sure that that member did not feel left behind, did not feel abandoned, or anything else like that.

And the good news is, about two and a half months later when he was released from his inpatient treatment back to his home unit, the unit is -- really, there are just glowing remarks about how the changes, the benefits that this guy received while he was down there. And beforehand, very withdrawn, not really involved with the unit; but since then, obviously, plugged back into the unit, being taken care of, and once again, I think, if you will, for lack of a better word, just really renewed back into life overall.

The bad news is that he's not going to be found fit for duty. He's going through the Disability Evaluation System, so that's the best part of the game. But as we move forward, the great thing is still providing this person support and still touching base with that unit and seeing if there's anything else that needs to be facilitated, as well as using some of the synergy.

Because the great thing about our current organization, if you will, is all this being within the personnel center. Earlier we talked about the Wounded Warrior Division, which is within rock-throwing distance from our office, and so there's a lot of synergy that goes back and forth between that organization between the recovery care coordinators, our medical case managers, and the nonmedical case managers, as well as the disabilities division, which is two floors above us.

So we can, once again, help facilitate that process in whatever way we can to make sure, once again, we get our guys returned back to duty or returned back to a known state through the Disability Evaluation System.

COL MALEBRANCHE: I have a question. This took place prior to 2012, this individual's injuries?

COL MATSCHEK: The injuries occurred in 2012. Yes, ma'am.

COL MALEBRANCHE: And you were

mentioning about the numerous civilian providers. Did the TRICARE contractor assist in this? Were they one of the case managers in this case if they were in the civilian community?

COL MATSCHEK: Yes, ma'am. TRICARE is obviously going to be involved. I'm not going to be able probably to tell you to what level the TRICARE folks were working this piece. But yes, obviously, because he's got his referrals and all those pieces were being coordinated through the system. Yes, ma'am.

COL MALEBRANCHE: And for one who has severe enough injuries to go to a polytrauma center, were they referred even to a Federal Recovery Coordinator?

COL MATSCHEK: Yes, ma'am.

COL MALEBRANCHE: The reason I'm asking some of these is that we've had some of these cases in the past, and currently the Army, Air Force, Navy, and VA are looking at the Center for urgency care coordination group, and you at the national level, you have a person representing

Air Force. And we were talking about some of these very issues of transfer point where we miss and lose people and what can we do to avoid that, so there's no falling between the cracks. This is good news, and I'm glad they got him to polytrauma.

Were they from this area or was the polytrauma in Tampa chosen because of locale, or why was that particular one chosen?

COL MATSCHEK: The case was on the East Coast, and so that was the closest.

MR. REHBEIN: Sir, before we go on, can we back up one slide because I need just a touch of clarification in my own mind. Up through the 20 new applicants, did I understand you to say that that's all you can handle each month, or is that all there is each month?

COL MATSCHEK: That is what we have in the queue, meaning that is all the applicants that are coming to us. It's not that we are limited by that.

MR. REHBEIN: That's the

clarification I needed. Thank you.

COL MATSCHEK: Anything else with those pieces?

So to talk about the reserve component case study. This one was a little bit closer to home. This was a service member here in San Antonio, and so we had a little bit more eyes directly on this one, which is a little bit unique from what we're used to normally dealing with. But, once again, a phenomenal good news story at the end result. Also, once again, highlighting a little bit of the synergy between the different organizations.

So, if you will, our Guard member, once again, was highlighted, if you will, at our infancy through the Wounded Warrior Division, and then this particular member came in shortly after our standup as well. And we actually got information on this particular case through the disability division.

And so what ends up is, once again, we've got a member who was on MEDCON orders and

then at this point was really off of MEDCON but having some more issues, some more problems. And the disability folks had heard about it, contacted us. Once again, the case managers got involved with this particular case, able to facilitate access to care due to a line of duty determination, and in the initial uptake, if you will, once again, to get this person access to care -- immediate access to care, because there was some concern for this member's personal health, some issues there.

And so we got her taken care of, got her initially treated. And at the point when we got hold of her, frankly, she was not on MEDCON at that particular point there. She had been determined no longer eligible for MEDCON because the treatment plan had finished at that point. And this is, once again, prior to our standup.

But then, as with some of these conditions, which again, you can have delayed onset recurrences, and so as soon as we got ahold of her, got her the treatment that she needed, we

got her on MEDCON as quickly as possible, and got help to facilitate her processing within the local clinic here to make sure that she got the treatment that she needed, as well as helped facilitate through roadblocks to get her a referral to an inpatient treatment.

And once again, the great news is that she is out of all the treatment that is going on now -- all the significant treatment, still obviously maintaining contact with the appropriate folks, reconnected, replugged back in with her unit where she's assigned. The unit that she's assigned to, once again, words coming back, this is once again, a different person, really taken over the hump. And in this case, there really was, I truly believe, potentially averted disaster there, really means that being involved in this case, getting involving with it, really helped save this particular person's life.

So once again, if we go back to talking about the synergy. Once again, a little bit of referral from within AFPC, and then, once

again, being able to bring in the expertise of the case managers as well as the physicians and administrative team to get her back on MEDCON orders and getting her processed through the system now as we speak.

So those are two case studies and two, once again, great things, I think, two examples of the great things our guys do on a daily basis.

So now kind of some of the things that we're doing well, some of the things that are going well within the ARC-CMD.

As I've already alluded to, we've got some great relationships between the Reserve and the National Guard. Once again, that was one of the reasons we were stood up, was to be a focal point, if you will, for questions regarding this process.

And what we do is, we talked about we share those monthly statistics, we teleconference as needed about big-picture things, but then we also do information sharing almost on

a daily basis. So if there's a specific case that they're hearing something about, if there's something, once again, that we're seeing that is, let's say, Reserve centric, that once again, if we can talk to the Reserve SG and say, hey, here's what we are seeing, here's the trend, once again, make sure that everybody is aware of whatever roadblocks there may be out there, whatever issues may be there, some of them perceived, some of them actual, and some of them not, once again, once we talk them out. But that relationship, that ability to communicate within those organizations really has done wonders in helping increase awareness of the program and increase, frankly, access to care for our folks who are on MEDCON orders there.

Talking about synergy between the divisions. I'm going to skip the first one, and start off with Casualty Division, because really, if you will, they're kind of the vanguard. They're the folks who are reporting on someone who has been injured with some kind of significant

injury or something like that.

So we have a heads-up on what's going to happen, and we do communicate, once again, very consistently about -- as an example, a while back, there was a Guard unit that was patrolling, and there was a few folks that were injured during some outside-the-wire activity. Once again, Casualty made sure we were aware of it and we're prepped and ready to go help those folks out. That's an example of that synergy there.

Talked about the Disabilities Division. Once again, upstairs talk with them; once again, I wouldn't go so far as to say daily, but weekly to make sure, once again, that we've got visibility on their cases and vice versa, just once again to make sure that we're doing everything we can to make sure that process continues on.

And then, really, Wounded Warrior Brethren, that division, you know, just great things, great sharing between them. We've got the recovery care coordinators, and they're, frankly,

our eyes on the ground. They're at every base, at every location. And so there have been more than once when they've called us and said, hey, we think this or that, and once again, given us a little bit of heads-up.

And at the same time, when we've been doing some case management, maybe we haven't heard something for a while from someone, or whatever the case may be, and that recovery care coordinator has gone out there and made sure that perhaps some communication links that have gotten a little frayed, a little thin, were brought back up to full robust capability there.

Wounded Warrior Division also brings into our nonmedical care managers, working basically centralized there at Randolph, benefits and entitlements. And then we've also got within that Wounded Warrior Division the SCAADL program.

And our program manager for all the Air Force, once again, is within rock-throwing distance from us. It's been a great thing. So if we find someone who thinks that they may be

eligible and if our care managers, case managers are talking to folks; and as an example, you know, my mom had to give up her job or quit her job to come help take care or do whatever it may be, that we know, hey, that's obviously a trigger point for SCAADL, and we talk with our folks and talk within the Wounded Warrior Division and make sure that kind of capability is exploited to the maximum possible.

Yes, ma'am.

CO-CHAIR CROCKETT-JONES: I want to ask a question because I'm -- I'm confused.

So if someone comes in -- a Reserve Component airman comes in to the Wounded Warrior program, what I'm trying to understand is, would someone be pulled into the Wounded Warrior program before you would be aware of them for medical case management? Wouldn't they be getting medical/clinical case management from some other source, or are they shifted to you because of their component status to get more specialized care?

I'm trying to understand how the system basically works in combination with the Wounded Warrior program. Are they not providing medical case management?

COL MATSCHEK: The Wounded Warrior program is primarily focused on recovery care coordinators and the nonmedical care managers, the medical case management for our active duty Wounded Warriors. And I'm going to step out on a limb here and get a little but uncomfortable, and if I say something wrong, you guys correct me back.

But basically, they've got a case manager at their military treatment facility which is taking care of medical-specific issues. The same thing is happening for our Reserve Component airmen, so if I'm a Reservist at MacDill Air Force base, I've got a case manager at MacDill that's taking care of the day-to-day medical case management. But what we are -- once again, you talk about this second tier Reserve centric, we help overcome some of those barriers. Well, if

it's a Reservist we're not sure what to do with them, how do we handle this, and we'll work that piece.

And really even more with significance is our Guard members who may be at Mansfield, Ohio where there is no active duty military treatment facility nearby, and that's really where we'll do a little bit more of the heavy lifting on those medical case management because there is not an active duty MTF that is within eyesight.

CO-CHAIR CROCKETT-JONES: Okay. So theoretically, some of your folks have two medical case managers?

COL MATSCHEK: For the most part, all of them should have two, yes, ma'am. Because you have your case managers that are there at the MTF working within the TRICARE system, working with all of those pieces. And then us as the Case Management Division working the liaison with that medical stuff to the AFRC HG to National Guard HG to the Disability Evaluation System, whatever the

case may be, we're the nexus, if you will, from the initial medical treatment to how that manifests itself into a Reserve centric piece. Does that make sense?

CO-CHAIR CROCKETT-JONES: Yes. I'm getting a clearer picture, and don't think that I'm not disputing that we have as a Task Force seen the Reserve component frequently is less informed about benefits and entitlements -- less informed about resources, and have much more difficulty in getting a good continuum of care. We have seen all that. I'm bobbling a little over this as a fix. I'm just trying to understand, because I just wonder, is this person seriously aware of this upper-tier case management, or is this happening more sort of hands-off? I'm trying to get a good grip.

COL MATSCHEK: What I'll tell you is if you go with the scenario that we started this in the July time frame, we're still a little bit of a work in progress. Initially, yeah. I would say you're right. We're a little bit above,

meaning that some of the strings, some of the puppetry that is going on is being done without the military member fully understanding what it is that we're doing, versus what somebody else is doing. But as we continue to solidify the program, as we continue to -- we brought our last people and got everybody fully trained and starting to go to medical case management 2.0, if you will. We're, no kidding, dealing more so directly with those military members but that's a relatively new model. Meaning that realistically within the last two to three months has it been when we're much more so apt to call and talk to that service member throughout the course of their treatment. As opposed to before, the scenario was that there's a medical PFC at every base and in every organization, and they funnel all the MEDCON paperwork to us and they work that stuff. And they were kind of that conduit for information, once again, reserve centric, but now we're taking to that next step, we've got enough folks, we've got the resources now to where we still use them

as a conduit for initial entry, but once we get to that, doing more direct one-to-one case management.

COL MALEBRANCHE: Just to follow on to that for a moment. I was kind of wondering the same thing. So when the MEDCON paperwork is started, that's how you get them, but are your airmen able to refer themselves for case management to you? I'm kind of wondering how your population gets in, other than this set number. So they know you exist, can they refer themselves?

COL MATSCHEK: Yes, ma'am. And there's no set number. Don't get me wrong. That's just where we're at right now. So I mean, what I will tell you is, we went from -- in April we had 230, 250, and just due to the drawdown, to the decreased number of people on active duty and the decreased number of Reserve Component members on active duty, our caseload has dropped as well. So it's not that we are limited to only this number of people within this program. It's whoever is eligible is eligible, and we're going

to take them.

And then, frankly, if it gets to the point where here we need more manpower, that's another discussion that we would have at that point there. But we're built at this particular point to handle our plan and known workload at that point there.

So that's a side conversation, but you asked me specifically -- ask me the question again.

COL MALEBRANCHE: I'm wondering how the airmen get to you. They're being funneled through providers?

COL MATSCHEK: Through their medical POC. So if someone is injured in the line of duty, the first thing that the Reserve component member has to do is have that line of duty determination formalized, if you will.

And there is one person within every organization that is the focal point for that process, the medical POC. And normally, they're a senior full-time Reserve component member within

the medical treatment facility, within their Reserve medical unit. And so they handle all that stuff.

And we have with our teams, and each team is regional, and they reach out and talk to and communicate with those medical POCs, some of them on a daily basis and some of them just as needed.

But those folks, if you will, everybody who is affected at a Reserve organization has that medical POC, and those medical POCs know that we exist. So that's how that initial connection is made, combined with the fact that there were some public affairs releases that were out there about here's where we are at. They released stuff to both AFRC leadership as well as the National Guard leadership once again saying, hey, we've received IOC, we're doing great things, we're here for you, let us know.

And as an example, I actually got two phone calls yesterday evening from folks who say, hey, I saw your name in this or that, or

whatever it is, and I have some questions. One of them we were able to help and another one, you know, kind of point them in the correct direction; because, frankly, they need a line of duty determination first before we can get involved with it.

EXECUTIVE DIRECTOR DAILEY: So let me ask a question real quick. You have nurse case managers and care coordinators in your cells, and they're regional aligned.

COL MATSCHEK: Yes, ma'am.

EXECUTIVE DIRECTOR DAILEY: We got that. Good.

Would someone have an RCC or a nonmedical case management -- or a nonmedical case manager from your Wounded Warrior Division also?

COL MATSCHEK: Yes, ma'am. If we go back to kind of the LODs and some of those LODs were more orthopedic, let's say, an elbow, you know, a busted knee, something like that, that probably won't meet the criteria for Wounded Warrior or recovery care coordinator, but our more

significant folks or folks who have PTSD that meet this significantly injured or very significantly injured criteria will get subsumed both within our organization as well as within the Wounded Warrior Division.

COL MALEBRANCHE: Okay. So then your function is going to be focused a lot on making sure that their orders are staying current and they're not dropping off orders. I'm assuming that's kind of one of the things you want to make sure. Right?

COL MATSCHEK: Yes, ma'am. True statement.

COL MALEBRANCHE: That's solely going to fall under your purview. Right?

COL MATSCHEK: Yes, ma'am.

COL MALEBRANCHE: And we're very concerned about that. We've been concerned about that for the last three years because we see this a lot. And so that's one of your metrics, so to speak?

COL MATSCHEK: It is. Yes, ma'am.

COL MALEBRANCHE: Good. And outreach education, you mentioned those types of functions.

COL MATSCHEK: Right.

COL MALEBRANCHE: So we're just a little concerned here, we think maybe a little bit about overlap for more seriously wounded, between your functions, your case managers, and care coordinators, and the Wounded Warrior Division's functions. How are you eliminating overlap in the more seriously wounded for your Reserve component between you and the Wounded Warrior Division?

COL MATSCHEK: I would say that, first off, a little bit of overlap is a good thing because one of the stories that we are talking about is, hey, we've got some people who are falling through the cracks -- or potentially falling through the cracks, so a little bit of overlap is a great thing because we've got a little bit of backup on each other.

But what I would say is that kind of by definition, we're doing two different things.

Meaning the Wounded Warrior are doing the nonmedical case management, determination of benefits, entitlements, the GI Bill, all those pieces like that.

Recovery care coordinator is doing a little bit of facilitating within this whole arena, and our teams talk to our recovery care coordinators. Specifically, once again, our lead case managers are on the phone with recovery care coordinators almost on a daily basis working to make sure that if there is something that needs to be handled within one arena or the other, that that communication is flowing on both sides.

COL MALEBRANCHE: And then the last question. You have a medical component, it sounds like; you've got a doc on board.

COL MATSCHEK: Yes, ma'am.

COL MALEBRANCHE: And there's a nurse case manager at the hospital in the local area.

COL MATSCHEK: Yes, ma'am. Right.

COL MALEBRANCHE: How are you

preventing overlap between your medical -- do you have a nurse case manager at your location?

COL MATSCHEK: Yes, ma'am.

COL MALEBRANCHE: And a nurse case manager at the MTF. How are you preventing overlap between those two nurse case managers?

COL MATSCHEK: Once again, if you think that -- the ones at the military treatment facility, our people on the ground are, no kidding, the ones, once again, doing the moving. You know, here's your appointments, here's where you're at, here's where you're doing all those things.

If we're a tier 2 case management kind of organization, what we're doing is, if that case manager says, I can't figure out how to get this person this referral, I'm not sure how to make something happen, that's when we get involved with it. Does that make sense?

Our team that is there at the MTF is doing the physical care, and then we're once again facilitating from above any kind of Reserve

centric issues.

MR. GONZALES: I went to visit Jersey, and I was there when we were dealing with one of these cases; the individual had a latent reaction after they had gone back into the community. They walked into the unit and asked the unit medical, "I need assistance, I need help." She, quite frankly, was pretty much overwhelmed with trying to figure out, first of all, was this a line of duty determination. That's a tough evidentiary determination.

The second thing that came about that I observed was that the unit commander was sitting there thinking, oh, man, this is going to affect my money. I mean, I have training money, and if I put this person on orders, guess what happens? That training money gets affected. They did not know that there was another sideline process, that was to go to great lengths to get approval for immediate medical care during the pendency of the final duty determination. Because you just need to take care of the person first.

We started to look at this, and then when you overlaid that with the fact that we had a lot of people on orders -- temporary orders, and they lapsed, and then all of a sudden, their care stops immediately in the middle. As all of you know, then to try and regenerate those orders is really a tricky, tough issue because you had to go through the whole process once more.

So with that in mind, our folks came together and decided that the only way to handle the severity of this -- and this is a very significantly complex situation as far as the line of duty determination, making sure the person is covered temporarily for the acute situation.

So we came together and put together the cell -- the MEDCON cell to see if this would bring the kind of specialized knowledge to a centralized location close to the people who actually manage the comprehensive care plan, both from the medical and nonmedical point of view so that they could coordinate. That's the idea that started it.

And most importantly, they're the ones who make the determination on the orders. And the orders are very important because that's where the money is. We account for the money, we understand if this is a major -- an exception situation where it becomes systemic, something we're going to have to address as time goes on.

So this kind of is a management of the 20 percent, hoping that the 80 percent always works. And so it's been a blessing for us because of the complexity, again. I hope that helps.

CO-CHAIR CROCKETT-JONES: That definitely helps me. I think now I understand what my questioning is. It seems that your case managers, you present them as medical case managers, and I get that that is a component of what they need to do. But really, they seem to be a broader kind of case management in that this seems to be targeting administrative plus nonmedical plus medical.

COL MATSCHEK: True statement.

CO-CHAIR CROCKETT-JONES: And sort

of an overall case management in its most broadest sense. And so I think that's why it's created some confusion in looking at this program is that they're really more than just medical case managers.

I think my only concern in all this, the only thing I don't necessarily understand is, do you feel that the service member who is receiving the benefits of all this case management, do they have a clear understanding of who they call when they have a problem?

COL MATSCHEK: Yes, ma'am.

CO-CHAIR CROCKETT-JONES: I mean, I think that's one of our main concerns.

COL MATSCHEK: Yes. If you think of the help desks, and that's a bad scenario because that gives a bad taste in their mouth. But what they are going to initially do is, they're going to talk to the folks there wherever they're at locally. And as soon as that does not work, does not get their resolution that is needed either A, the person that was asked is going to be

contacting us. And it's kind of why I went back to this slide here where we talked about the face of the MEDCON program and also the last bullet down at the ARC, medical case management experts, once again, focus on ARC, the Reserve component.

So either: A, the person that was asked the question is going to come to us through that communication chain that I talked about where all our med POCs know that we exist, or the members themselves, if they're not satisfied or can't get the answer, they know to contact us because, once again, our case managers are making contact with all the service members that we have on orders both sides, if you will.

So the medical side, if they're not sure, they know how to get ahold of us, as well as the service member. If they're not sure what to do, they know that, once again, the safety net exists, that we're still there to facilitate where we can.

COL MALEBRANCHE: So then also you are the safety net then, kind of referring back

here, for those that the line of duty has not yet been determined. You obviously don't have continuation orders. I'm worried about those. And we've talked to folks that have this line of duty determination hanging; and in the meantime they need care.

So how is it that they get care? They're not locked out from you yet until they have a determination. That's not -- just so they aren't left hanging, where they can get ahold of MMSO to get the care. I mean, that's -- I'm a little worried about that.

COL MATSCHEK: That's a very valid concern. I'm going to flip a slide or two and come back to this. But one of the things you can talk about is some of our things that we're still trying to work is ARC access to care with line of duties. And a kind of theme is that if I'm either in the process of the line of duty and not MEDCON -- and it's really folks who are not in a MEDCON status. Because once you're there, then you're going to have access to care, obviously,

because you're in a military status. But that is something that we're working.

Really, once again, I think our case managers talked about that idea of not just medical expertise, but the Reserve component expertise; they've gotten much smarter on how to facilitate that access to care for those folks who have a line of duty.

One of the things that we're not involved with is the processing of the line of duty. If you will, we're an end user of that process. But once again, everyone knows that we are out here and we help to facilitate that; and have more than once said, look, you know, this person's going to have problems X,Y, and Z if this line of duty is not taken care of, not really within our purview yet because they're not on orders. But because of the communication, because of the change that exists, once again, add a little bit of legitimacy to that service member's concern.

And we've seen on more than one

occasion that line of duty expedited up to the proper level where it needs to be as quickly as possible so that person does have a finalized line of duty to remove some of their questions.

COL MALEBRANCHE: And I think part of this line of duty piece is that when somebody's physically injured, we can see them and know we're going to get them care.

COL MATSCHEK: Yes.

COL MALEBRANCHE: But sometimes they have, you know, a behavioral health, a mental health issue where that is not readily seen, so it's the verifying. That might be a very valid thing, when they're kind of just hanging there during that process. And that's what I was wondering is, how are we taking care of those folks. Because, again, we've talked to some people with those issues, and "They don't believe me, and I'm trying to get this figured out, and my whole family is suffering because of this."

COL MATSCHEK: And I would say that if they are not on medical continuation orders,

we're not going to have necessarily a complete viz or any viz on those.

But what has happened over our life cycle so far is that people do know that we're available and do know we're the Shell Answer people, if you will, for some of these questions. And so we get brought in on some of these cases and can kind of help facilitate.

Going back to discussions with the Reserve component medical folks as well as National Guard medical folks, we can make sure that they're aware, we heard about a case in wherever, that they've got some issues there. Yeah, we're tracking it, we're good. Or, you know what? We hadn't heard anything. Okay, here's who we talked to, once again, to facilitate that process to get those folks taken care of.

All right. Ms. Daily, one of the questions you asked and alluded to that we talked about is the significance of those orders. And one of the things we're asking is -- the concern is, is anyone being taken off orders in mid

treatment, or something along those lines like that.

What I'm here to tell you is that that is not happening under our purview. Okay? Since April of 2013, we've had almost 380 cases, folks who've been on MEDCON one way or the other. The majority -- or you can see, 200 of those cases have been released, meaning they've either been returned to duty, processed through the Disability Evaluation System.

Then you've also got some administrative releases. So by administrative release, what I'm talking about is this: There's still an administrative process that you have to meet to be eligible for MEDCON. And the two pieces that changed throughout the process is treatment. Am I still requiring treatment, am I finished with my treatment, and do I have a 469 mobility restriction; has a doctor determined that I'm still unable to perform military duties. So without one of those two pieces, then that can be one of the reasons why somebody could be

administratively released.

So the majority of these are released because of return to duty or Disability Evaluation System, and we have a small number are released to administrative. And since April of 2013, we've had five cases that actually met eligibility but were terminated due to administrative deficiencies.

All five of those cases happened during the furlough or the government shutdown. And the great thing is, we were not affected by the furlough or the shutdown. We were in place. We were able to talk to the service member.

And what we were able to do is -- unfortunately, the nature of the game is that they did come off orders, but we tracked those five people specifically. And as soon as the right people were brought back in to whatever status they needed to be to get that paperwork re-facilitated to get that 469 completed, to get whatever it was, we were able to very quickly get that person put back on orders. So yeah, someone

did come off, but what I'll tell you, the great thing about our organization, about our workload, about the relationships that we have is we're able to basically, put eyes on every case on a daily basis, and as we work and see our progression, or queue, if you well, as we see orders progressing, we know where to bring our efforts to focus to bring those folks there. So that's kind of what has happened. And once again, I think, a successful proven concept that there are conditions that we can't control that are going to affect part of this.

But we are aware of those pieces and stand by running in place, if you will, waiting for us to get the paperwork to flip the switch to get that person put back into the right status to get their care as quickly as possible.

So last two or three things I want to talk about real quickly is some things that we're still working on, some room for improvement, and everything else like that. You already heard it alluded to more than once that geographically

separated units specifically more often than not are Guard organizations where there is not an active duty military treatment facility. Again, there's some Reserve organizations that may not have an active duty military treatment facility there. And that's really where our teams have sharpened their tools, if you will. That's where they've learned how to work and overcome some obstacles that come there.

I've got TRICARE Limitations. And really what we're talking about there is, we've had on more than one occasion where a member is assigned to an organization in one region of TRICARE, TRICARE North, but where they live is in TRICARE South. So we've had some trouble with perhaps getting a panel from one place to another. Initially that was a problem.

But what I will tell you, the great thing is, once again, established relationships with the proper folks there at Wilford Hall, at AFMOA, Air Force Medical Operations Agency, the case managers there, to work those specific cases

one by one and make sure that we get them, you know, the access that they need between the two systems there and overcome that shortcoming.

Once again, I didn't know much about some of these pieces, but that was one that I never really envisioned at all being an issue and found out that it was, but we have been able to overcome that one as well.

We talked about access to care with the LODs. Still working that. Boy, I tell you what. If we had a silver bullet on that, I'd be shooting that. Because that's -- like I said, that's something that just has been a consistent ring. It's getting better. We've got our people who are smarter on it. We're able to articulate better how to present your case when you go to a military treatment facility. You know, what documents to have and everything else, and so even though it is still an issue, once again, the magnitude is markedly smaller there.

And then still increasing awareness and education. As within this briefing here, you

can see a lot of those cartoon question marks over your heads about who are we and what do we do, which tells me that we still have to continue to go out there and tell our story better, more succinctly and clearer so therefore we can really continue to bring these great resources out there to the field to take care of our airmen there.

But I'm going to close up obviously with the good things. And these are good things that we already talked about more than once. The synergy, both within Personnel Center, within the Wounded Warrior Disabilities Division and Casualty Divisions and ourselves, as well as working with our Centers of Excellence. Once again, communications, really, relationships are very strong there.

And even though I said awareness and education is something that we've got to work on, the good news is we are already making roads in awareness and education and we're seeing things, once again, as presented by the multiple phone calls that we've received within the last three to

four months as we made ourselves more visible, and people are more aware of us. And we're trying to facilitate issues.

Once again, it's surprising how many of the cases we can't help because they don't fit within our purview, but everybody knows that we answer our phone and everybody knows that even if we can't fix the problem, we probably can at least get them a really decent turn in the right direction to get them access to whatever it is they need to do there.

And so really, in a nutshell, what we are doing: Consistently and objectively determining MEDCON eligibility, which is once again the key. We've got to get our folks in the right status before we do anything else. We provide that medical case management. And maybe after today's briefing, we say we provide overall reserve component medical case management.

And then the last thing we do is really work with our brethren in the Wounded Warriors recovery teams to make sure that our

wounded, ill, and injured Air Reserve component members get the treatment that they so desperately need.

COL MALEBRANCHE: Okay. One more question.

COL MATSCHEK: Yes, ma'am.

COL MALEBRANCHE: The Air Force person that we've been working with in Washington on the Care Coordination Contingent Group is Tim McTownes. Are you familiar or have you been involved with the big working group on this care coordination -- on this interagency care coordination?

COL MATSCHEK: I have not.

COL MALEBRANCHE: So we probably need to get you some information about that. Because one of the things that we're looking at is was this model of case management across the time of different transitions. And Reserve and Guard are very much a part of this, because that's one of the groups that we find oftentimes is often falling through.

So with your agency and your existence, it would probably be good for you to take a look to make sure that we're covering those things and that they're included; it's going to be part of the DoDI and VA directive.

COL MATSCHEK: Okay. Yes, ma'am.

MR. REHBEIN: If I may, sir, and I apologize, I had to step out. If you addressed some of this and I'm duplicating things, again, my apologies.

But let's hypothetically talk about a situation of an Air Guard soldier in, say, Sioux City, Iowa, geographically remote from an MTF, geographically remote from a VA Medical Center.

Couple of questions: That person's nonmedical case management, is that being handled by you or by his unit?

COL MATSCHEK: Nonmedical --

MR. REHBEIN: Pay issues, things along that line.

COL MATSCHEK: That's going to primarily be handled by the unit, as far as if

there's a pay issue. What I'll tell you is if there's an issue with getting the person on orders, getting that person in the proper military status, we're going be involved with that.

But what we do is we provide the authorization for the orders, but every organization that a service member is assigned to, actually, they're the ones who turn the crank, if you will, to produce an order on the backside of that.

MR. REHBEIN: One of the things that the Task Force talks about every time we make a facility visit is how those squad leaders -- how the people administering that recovering warrior are selected and trained. Obviously, selection is already accomplished because that's their -- that's their supervisor in their unit.

Does that person receive any extra information on how to go about handling this rather unique case that they have not been exposed to in the past? Because it really creates some challenges for that unit on how to handle this

person.

EXECUTIVE DIRECTOR DAILEY: If he's serious enough and all these entitlements are starting to kick in, Mr. Rehbein, he's also going to be a client of the Wounded Warrior Division. Correct? An RCC and the nonmedical case manager from the Wounded Warrior Division would also be assigned if it's serious enough and his eligibility for these programs are starting to kick in.

I think this is one of the things the Task Force is the most concerned about. Somehow this individual has to get on the Wounded Warrior Division's radar. And who, if it does get to your radar, or through the medical system, gets a nurse case manager which might also trigger your involvement and which, if gotten into the Wounded Warrior Division, would also say, oh, he's a Reservist, we need to talk to Colonel Matschek about orders, about line of duty, what status in the line of duty. That would be how it would all be triggering.

You're correct. The medical technicians, medical NCOs at Wings and in the medical squadrons, generally as we've found -- and you all are going to fix this -- right? -- or not. All well versed on SCAADL, TSGLI, getting social security benefits for them. And the expertise resides here in the Warrior Division, and it resides with Colonel Matschek's team now, and the issue is getting your clients up to these resources.

Does that help?

MR. REHBEIN: Yes. And then the other part of what I wanted to address for just a second. As we travel to some of the Army Community-Based Warrior Transition Units where a lot of their folks are receiving their care through TRICARE providers, one of the challenges they have is getting the records back from those TRICARE providers back into the service member's military health record.

Is that a challenge that you folks also have, and have you been able to crack that

nut?

COL MATSCHEK: We're coming close to exceeding my level of expertise in this particular question. What I will tell you is that there are that kind of scenario where we work to try to get those medical records from our civilian providers. And by having a physician on staff, there are times when we may go physician to physician to help facilitate that process, if there's some kind of specific information that we're missing.

But what I'll tell you is that I am not aware, first off, of an elegant solution that exists to get that information; that it is a paper shuffle back and forth via fax machines, via secure file transfers, whatever it may be to get that information to us. But I do believe, once again, that AHLTA has a tab on there where you can embed some level of outside provider notes. Once again, we've exceeded my --

MR. REHBEIN: It's something you've got awareness of and you've got eyes on?

COL MATSCHEK: Yes, sir.

CO-CHAIR CROCKETT-JONES: Can I ask -- if some of your case managers are here that might want to comment, what is the top intervention issues that they're being asked? You know, on a day-to-day basis, what's the call? If the phone rings, what would they predict the call's going to be, or has it been too scattershot somehow to try to --

COL MATSCHEK: No, I wouldn't say scattershot. I would say kind of by looking at what we saw up there with our LOD charts and everything else like that on what our line of duties are, is that the preponderance of folks who are hurt, knee or shoulder or back in theater, what happens is they tough out that tour, if you will; and, you know what? I've got a brace, I'm limping along, I'm doing whatever the case may be, I'm coming home, and, you know what, I now need some help and I need some work, and that's where we get involved with that.

It's not the majority of our cases, but obviously, the higher acuity cases, multiple

folks, you know, either both currently caused or more so than that, a lot of latent exhibition of PTSD and finding out about those, once again, either through the service member, but more often than not through the organization because they've worked with us on another case or something like that. And we've been able to facilitate, once again, access to care for those kind of folks.

Those are our two primary things. I don't know if anybody would argue otherwise.

COL MALEBRANCHE: So your case managers -- when they're going to, let's say, transition out, do your case managers then do a handoff with the VA, and for those on SCAADL to the caregiver program? Is that all part of what your organization does too?

COL MATSCHEK: Ask it again, please.

COL MALEBRANCHE: If someone is getting out of Guard or Reserve and they need to go to the VA, do they get a warm handoff to the VA case manager because they're no longer in the Air Force, and is it looked at then so their potential

caregiver support is able to be done?

COL MATSCHEK: For those that meet the Wounded Warrior criteria, one of the things they definitely have is continuum of service. So they definitely work those warm handoffs, if you will, to transition them from place to place to include ones that have been separated, how do I continue on and do those things like that.

For our other cases, more so orthopedic, knees and things like that that are not, once again, as high of acuity cases, I would say that there's not as much -- emphasis is not the right word, but we don't have a specific handoff, let's say, to the VA for somebody who's coming off MEDCON orders who have been found not fit for duty because of an orthopedic issue.

COL MALEBRANCHE: So they are referred then to the VA?

COL MATSCHEK: Yes, ma'am.

CSM DeJONG: You made mention, sir, about no one has fallen off orders up to this point, so I'm interested in what you do to ensure

that no one falls off of orders and what process you use. Over the last several years, we bounced different courses of action and ideas around about how to best prevent this because it is one of the things that we hear routinely for Guard and Reserve soldiers falling off of orders. We have presented ideas out there, but I'm just wondering what you do to prevent this.

COL MATSCHEK: Obviously, the workload we're talking about is 200 cases. And in the database that we have right now, first thing I do, come in in the morning, sit down, log in, and here's my queue. Here's all our folks, and here's when their orders expire. And basically, we start chopping from top to bottom. And as folks get closer, we start looking at them closer, if that makes sense.

And then, really, I would say that that executive team is really watching those cases that are going to be in an unknown state. Because there are plenty of folks that come off of orders, but it's once again, "hey, no more physical

therapy required, I'm ready to come off orders now," those things like that. But it's an example of, once again, those five cases.

Or if we have other cases of somebody who has got something significant going on but we haven't gotten the paperwork that we need to continue that order, that we're going to because of our workload, because of the fact that we have dedicated folks, I guess, here, meaning manpower dedicated here, to watch these cases, that we do have the ability to reach out onesies, twosies, and all of our application process, which you know, is contact information, e-mail, phone numbers, and everything else. And our case managers and care coordinators will reach out to our folks and, hey, are you coming close, what's the deal, where are we at. And, you know, we'll facilitate that however we need to.

But I would argue that some of that is a function of both manpower as well as case load. If you were to ask me that question a year and a half ago, I think I would have given you a

little bit more of a tapdance of an answer because there was more work load at that point.

EXECUTIVE DIRECTOR DAILEY: For your PTSD latent issues, line of duties are required. Are you able to get them orders or get them on orders based on intra-line of duties? Are you using the intra-line of duty option in the policy?

COL MATSCHEK: Yes, ma'am. If there's no break in service between orders. And I know what you're talking about, yes. Yes. Yes. I'll tell you that the cases that we have brought up to this point here, we have not run across somebody that I'm aware of, PTSD, who did not have that LOD complete when they've come to us in this latent condition.

So as an example, we had somebody up in Montana not too long ago, once again, PTSD. He was being treated by the VA, you know, kind of working it on the side. Once again, gets a little bit of a flare-up. The unit gets involved. In that particular case, he already had his line of duty completed, so we were ahead of the game. But

that was one of those kind of scenarios where we would have been able to invoke that piece of the policy if we needed to.

EXECUTIVE DIRECTOR DAILEY: Okay.

CO-CHAIR CROCKETT-JONES: I'm going to thank you for your briefing. It took us a bit to get some clarity on it, but I know that we are at least very happy to see an effort to get some parity of outcomes for Reserve component folks. And thank you very much.

And we have now a break until 10:15. I want everybody sitting back here ready to start then.

(Whereupon, the foregoing matter went off the record at 9:56 a.m. and back on the record at 10:18 a.m.)

EXECUTIVE DIRECTOR DAILEY: Ladies and gentlemen, can I get the Task Force members to return to their seats, please.

CO-CHAIR CROCKETT-JONES: At this time we welcome Air Force Lieutenant Colonel Joseph Villacis.

MR. ISHEE: No. It's Calvin Ishee.

CO-CHAIR CROCKETT-JONES: And we also have Calvin Ishee to discuss the current performance of the Air Force Formal Physical Evaluation Board. We have information on Tab J.

I'm going to turn it over to you. You can do better introductions, obviously, and give us some background. Thank you.

MR. ISHEE: Good morning. I'm Calvin Ishee. I'm Chief of the Air Force Disability Program. I've been in the job a little over a year, and it's my pleasure to be able to talk to you today about our PEB process, specifically the formal board. We're going to try to address all the issues that you brought to our attention, and I will answer any question to the best of my ability.

A year ago, or whenever it was that you visited last, a lot has changed. When I first got this job, I walked in and there's a hundred-plus boxes of cases. Everything was paper. Over the last year, we were able to go

end-to-end electronic management, and you can see how we've been able to do that.

From the military treatment facility-PEBLO to the informal board, the formal board, the SAFPC, instead of having to mail everything, we can ship them electronically.

We use a system called Right Now Technology, RNT. RNT allows us visibility on things that we didn't have visibility on before. A person might call us up and ask the status of a case and we'd have to look through a hundred boxes of cases. It gives us production capability, case movement. A person calls, we can tell you exactly where the case resides. Communication tracking, quality assurance, work list notification. What's great about it is an open architecture whereby we can make realtime changes.

When we developed this program, we got the internal customers involved, the IPEB and the FPEB and the case managers, and they helped us develop the tabs, what do you need to know, when you need to know it. So we own it. It hasn't

cost us anything.

I will tell you at this time DoD is looking at a joint IDES enterprise-wide IT solution. They're meeting regularly, and the hope is that somewhere down the road, we'll have one system for all services. But we're not near that point at this point.

Okay. We also use what's called an Electric Case File Transfer, ECFT. That was part of a DoD pilot system. We've been doing it at two bases; Robbins and Tinker. So only two bases.

We had some challenges early on with the VA. We still have some challenges with the VA with the interface. But what we've been able to do is by using ECFT, we can transfer files that are four and five hundred pages, full medical records. Before, we would have to mail them. You'd have to scan them, you'd have to print them out. Now we're able to take those large files and use eCFT to transfer them. And so everyone's able to see those.

Now, when you combine RNT with eCFT,

we've eliminated mail costs. We used to have to mail the packages from the base, the military treatment facility, to the Informal Board, to the Formal Board which used to be located at Lackland, back to the Informal Board, up to SAFPC. So by flowing the documents electronically, we have been able to eliminate a lot of unnecessary mail costs and mail time. So we've taken a lot of that out of the system.

It's also decreased production time or process time. Again, when we didn't have to wait on the mail time -- I mean, when I first got this job, I thought it was interesting that we had to mail it from Randolph to Lackland and back. So we've been able to work out that issue.

And again, we get phone calls all the time from the commanders, where is this case. We can tell you exactly where it resides right now, whereas before, we would have to go check a hundred boxes.

A lot of good things have happened in the Formal Board. We'll talk more about

timelines because we're all concerned about timelines. But because we've been able to automate the system throughout the entire process -- of course, it's new to everyone. There are some of those people who like that old looking through the hard copies. However, by allowing us to transfer these records electronically, it has saved us a lot of time and effort. Many of the physicians like it because they have access to the full record. They don't have to go in asking for more information.

The other thing that we did is, since your last visit, I just said that the Formal Board used to be located at Lackland. No synergies. If a doctor or physician called in sick that day, we would have to send someone over. That's a 45-minute drive. If they got sick during the day, we'd have to cancel hearings for that day. We've been trying for years to get them moved over here. And this happened this last year. The lawyers came with them. And so we brought the entire complex from Lackland to here.

And a lot of great things came out of that that were very good for us, a lot of synergies. If a person is out, we simply send a person two buildings over instead of a 45-minute drive. It allows greater flexibilities for our manpower as well.

We have implemented advance adjudication. With our lawyers, we sat down, we came up with a way for the member to come in, in between the IPEB, the Informal Board, the Formal Board, to present new information. I'll talk about that later.

We've implemented a quality review. We want standardization. We want consistency of decisions. DoD is implementing a program DoD-wide where there's going to be a quality review. We've already started that process. Our board process is to look at the different cases, make sure that they're accurate, make sure the decisions are consistent.

And we've increased and enhanced our communication with our strategic partners. The VA

actually came in from Providence and spent a few days with us looking at our processes. We sat down with them and we made progress on the DD-214s, which we resolved this last time. SAFPC, I call them on a weekly basis; what are your trends, what can we do better.

The trend line for the FPEB was down-trending in the summer -- prior to this summer. This month, we're going to do better.

But I will tell you this last year has been full of challenges for us. Any time you implement new fixes, it's going to create issues. For example, when we went from total paper to the automated system, some of the case managers or some of the board presidents are saying, "I was faster with the paper because they have these little tabs on here, I can move faster." Now that they're getting used to the electronic case transfer system, they're getting faster. But any time you implement a new fix, it takes time to implement and time to work out the bugs.

Hiring. Thanks to my boss and our

AFPC commander, we were able to get eight new positions. And any time you hire new positions -- it took us time to get new people. And then once they get here, you have to train them. The learning curve for a person who comes to work for us is four to six months, depending. You can't start work on Monday and then Tuesday start adjudicating cases.

And we had two doctors training four doctors, and so the two doctors that were adjudicating cases and doing 12 cases a day, they were down to four and six cases a day because they were training the new people. They had to review a hundred percent of their cases, and they had to continue doing their own.

Also, when we relocated the Formal Board, we were closed for a week plus because we had to geographically move all of that stuff. So that impacted us.

What happened last summer around the May-June time frame, we lost 50 percent of our staff at the Formal Board through retirements. We

had a doctor who was awesome; he retired. We had a case manager who had been there for years; she was gone. And then when you only have six people working there and you have those people retire, you start over. And so we had to train new doctors to go over there and new case managers as well.

And, of course, the budget impact, the furlough. You know, one of the things my boss has challenged me to do is to look at what is our production requirement? Say 5000 cases a day. What is our production capability?

And each facet of our operation, that's different. You have case managers who look at cases every day, and they may be based on transactions versus cases. You may have the IPEB that does eight cases a day. You have the Formal Board that does four cases a day. But every time someone's off work, the production stops. And when we had the furlough, the case managers were civilians. They are there from the start to the finish.

So we processed what cases we could on the Informal Board side. We were able to conduct some hearings on the Formal Board side if it's military personnel, but the civilians, we weren't able to use them.

Also, the VA laid off 7000 people. The base personnel were laid off since the cases were stopped right there. And the mail stoppage for our TDRL shop. We still used mail for TDRL. It's for retirement certificates, those types of things.

All right. This is our report card. We look at this every month. In fact, we are looking at this daily.

With the new RNT capability, we can look in and I can tell you where we are every day. For example, six weeks ago, our medical queue was almost at 500. Two weeks ago, we had gotten down to zero. But if you look at the bottom two, the red, our goal is 30 days. We are up to 47 days. And if you look, for a while there, we were doing great, and then we had a change in staff, and now

you can see the days have increased. And plus we had the furlough, and we also had the move from Lackland to Randolph.

EXECUTIVE DIRECTOR DAILEY: Excuse me. You mentioned a bit ago when you talked about the furlough and the VA that the VA laid off 700 people?

MR. ISHEE: 7000.

EXECUTIVE DIRECTOR DAILEY: I'm not aware of that. When was this?

MR. ISHEE: When we were talking to -- I'm sorry?

(Inaudible dialogue.)

UNIDENTIFIED FEMALE: They were furloughed, not layed off.

MR. ISHEE: Furloughed, not layed off.

There was a person at every base that represented the VA. They did not work. What they did was they counseled the member on their benefits. They had no one to do that during that two-week period of time.

Now, I will tell you that working with our counterpart at the VA, some of those offices were given overtime, and they were able to continue working processing some of the cases.

Again, this is our report card. We're not where we want to be. We're certainly working hard to get where we're want to be. I think we're going to see some improvements in November, and I'll give you an update on some things that we're going to do there as well.

Okay. Process improvements. For the last year, we have looked at every single process that we can. I came from a different career field, which for me I enjoy because I break pieces of a process down. And anytime we found redundancy or duplication or something that we just didn't need to do, steps, we started taking them out.

Again, the relocation has been big for us, and I think our lawyers here will attest to that.

We added an additional board

president, a Reserve president. We have four people over there instead of three. When three of them are adjudicating a case, that fourth person is either preparing for the next case or doing a writeup from one that's already been heard. We have six total people that are assigned to the Formal Board. That's what has been allocated.

Now, we have a new process which we actually learned from the Navy, I believe. It's an advanced adjudication in between the window of an Informal Board and a Formal Board, that ten days, we give the member an opportunity to come back to offer up any new information.

And we discovered that the Navy has been able to resolve many cases before having to fly them in, bring them in TDY for a Formal Board. Some of the members enjoyed that because they didn't want to come back here. If they liked the decision, they would sign off on it, and it saves time, energy, and money.

For example, we're at about 11 percent adjudication. And, you know, when you

look at a large number over the year, you're talking a couple of hundred thousand dollars in TDY costs easily.

Now, I will also tell you that one of the things that we've discovered is that our bench was shallow. Those two people I talked about over on the Formal Board, they have leaves, they had issues when they're gone. And so what we tried to do is take advantage of the synergies over here on the IPEB side and the case manager side. We started training them to go over and support them because they have to do VTA updates and all these other things that some of them were already doing, but just in a different capacity.

We also created a hot team where we send over a lot of our people that we trained from the Informal Board, the case managers, to help them get caught up.

I gave the example of the medical queue where it was up to almost 500 and we brought it down to zero. It's like a production line. Like that Lucy show where she's making the candy

and all of a sudden, it gets too much. Well, guess what? As it goes down the processes when we released all those cases through the medical queue, it now bumps up on the Formal Board.

On 3rd September, we started doing what we call a surge. Instead of four cases a day, we're doing eight cases a day. What that involves is robbing Peter basically to pay Paul. We've taken people from the Informal Board and moved them over to the Formal Board to try to double up on the cases. So we're hearing in eight instead of four. In fact, we're looking at the possibility of doing another surge in January as well.

And I have to tell you, the legal folks over there, they have been awesome working with us on this whole process. I mean, they could easily say that they can't have that capability, but they've worked with us greatly.

We've also refined the advance process. Because we normally would have a ten-day window. And I was just talking to the Lieutenant

Colonel who runs it over there. And what it is, is in that ten-day window, they know kind of -- and the member knows if they really have a chance of getting it overturned or not. Again, that's 11 percent, and I showed you on the slide a minute ago. So we've kind of learned the process as it goes.

In the last year, every time we've formed a rapid process team, which we've done about ten, as we go through the process, we learn they may implement something; but as we go along, we tweak it, because perfection is not going to come out the first time around.

Maximize the manpower. What we've tried to do is to broaden our base. We want utility players. We want them to be able to work wherever we need them because we have a finite workforce. And so, you know, if the doctors get caught up on the Informal Board, we move them over to help on the Formal Board to do adjudication reviews, which is an extra duty for the physician that's already over there.

CO-CHAIR CROCKETT-JONES: I have a question for you. Is there any concern that moving folks from Informal to the Formal means that they're just re-reviewing their own work?

MR. ISHEE: That could be a concern, but so far, we have enough doctors that that's not the case. I will tell you when I first got here, I remember my second or third day on the job. I came from the services MWR community, and I was sitting here listening -- you know, do we have a doctor in the house today? Well, no doctor, you can't produce cases. We've been blessed now with two civilian doctors full-time; that's not an issue. Whereas before, we only had three doctors that did everything. So now we've got like six-plus assigned, some Reserve, but one's an overage. But that's not a worry.

CO-CHAIR CROCKETT-JONES: Okay.

MR. ISHEE: Again, we're trying to broaden our bench. We are looking at a rotation program between the Informal Board and the Formal Board. I sit on Formal Board cases, and you do

have to have an expertise in hearing the cases. And those people are very passionate about what they do. And you have to be trained to do that. So we're trying to broaden our bench so that if people are on leave on the Formal Board, we can continue having hearings.

We are going to go dark between the 18th through the 3rd or 4th of January. Typically we don't do cases during the holidays. The members don't want to do it. We do other things during that time frame.

Now, I will tell you, we brief the Secretary of the Air Force every quarter. This is on the front burner with the Secretary.

And we have implemented tons of fixes. We've got additional manpower; we've automated the system; we've made a lot of internal improvements and corrections. By March of next year, if we can't get closer to the timelines or if we don't meet them, we've briefed that we may go back and say, we need more manpower.

I wish I could tell you today the

right size. I don't know if we're right-sized or not. There are too many variables in here that I just can't control and don't understand yet, to be quite honest. But in March, if we're not there, we will go back and ask for resources.

The Air National Guard and Reserve versus active duty is definitely different. Active duty, of course, we can schedule appointments whenever we want.

The challenge for the Guard Reserve is getting the service members to their appointment, getting the civilian doctors' support. And they have civilian jobs and some say, "I can't get off to go."

Also, the service members' medical records, many of them got them through a civilian doctor. And, to be honest, it's very hard to get those records. And when we do get those records, sometimes they're outdated. The information is stale. It could be 12 months old. We continue to work with them all the time to get the current information.

Also, we discovered that in talking to Reserve commanders is that they're there once a month for the weekend, they may have 260 people working for them, and sometimes they admit they lose visibility of a person. We're trying to work with them to make sure that the service member is taken care of. And we have three people assigned to the Guard and Reserve cases.

The other issue is line of duty. Getting the line of duty from them, it's very challenging. Sometimes it takes 60 days, 90 days. And we're working hard with the command as well as the units to get those determinations.

And also something that I didn't know until recently was point issues. For the Guard and Reserve, the more you work, the more points you get, and somehow that's factored into these cases. And that adds on us waiting to get the points from the unit, adds to the time -- five days to the time average.

All right. Here's the slide that you asked about overturning of cases. If you look

to the chart on the left. Out of, say, 5000 cases we had last year through the Air Force DS program, 684 of them, hearings were held at the Formal Board. Of those, 74 cases, or 11 percent, the decisions were either overturned or changed. That could have been through the adjudication process. The board itself could have overturned it. So that's the frame of reference that we have for overturned cases.

Now, if you look to your right, you ask the question, of those cases, how many were appealed to the staff PC, Personnel Council. Of these cases, you can see that 354 cases were, in fact, appealed. 330 cases, the member agreed and they moved on. But you can see the number of cases that went to SAFPC.

EXECUTIVE DIRECTOR DAILEY: Hold on. My math doesn't work here, as usual. The 354 and the 333 equal the 684. Okay. So 354 cases went to -- was that our intent, or are we only trying to look at 11 percent, of the 11 percent that had changes? Of those 74 cases, how many of them went

to staff, how many were appealed? You broke down the whole number. Okay.

CO-CHAIR CROCKETT-JONES: We want to know what happened, I guess.

MR. ISHEE: I'm sorry?

CO-CHAIR CROCKETT-JONES: We're trying to get an understanding of what happened to that 11 percent.

MR. ISHEE: The 11 percent of those cases, those are the cases where I talked about the adjudication process. The service member agreed with whatever. They came up with new information, so we changed the decision based on their information. Or the Board overrode the IPEB.

One of the things that I really wanted to look at was how many were turned over, why were they turned over. But there's no mechanism to do that.

For example, as a follow-up to your question on the slide on the right, I called SAFPC. I said, of our decision -- of our cases

that are appealed to you, how many are turned over; why, because I want to know if there's any trends; are we doing the right thing or the wrong. They don't track any of that. The system doesn't track.

So we had to go manually in here to try to figure out the caseloads of the ones that were turned over. Again, prior to six months ago, a year ago, everything was manual. As we go along and we're automating everything, we're still trying to determine what we should track and why. If it adds value, then we want to do that. And so in this case, I will tell you we struggled with this because having to go back into the system, you just can't mash a button. It took hours and hours and hours to try to find. And like I said, when I called SAFPC and they told me we don't track it, we're not going to track it, so I don't have a frame of reference of those that were appealed to SAFPC, what was changed.

Now, you asked an interesting question; holistic reform for DES. It's pretty

simple for me. I didn't go into detail that even though we've automated our system, our case managers have to update five-plus systems. For example, the case managers, when they get them, they have to update VTA, MilPDS. They have a whole range -- RNT. They have a whole range of things that they have to update for every transaction. That's time consuming. And if you've ever sat there with that circle of death on your computer, you understand.

In fact, we created what I call an interruption log. This is a production capability. Every time we pull a person off or every time we have computer issues, the production line stops in their particular area. I want to be able to quantify that to tell you or tell whoever, here's the challenges that we have.

Now, I don't want to become a bureaucrat about it. However, my boss tells me, "Calvin, don't give me anecdotes, give me facts," so that's what we're trying to do.

If I were a king for a day, we would

have one system DoD-wide with reporting capability that when you ask me that question, I can say of those 11 percent, 10 percent of those were because of advance adjudication, the rest were because the board overturned them, and these are the reasons why. I don't have that capability.

So I do know that DoD has developed a joint IDES working group. They're meeting weekly. The eventual goal is to have one system, but you can imagine working with three sister services with three different systems. Everyone has their own interests. And so trying to herd the cats, if you will, has been challenging. I'm seeing more action now than I've ever heard, so God willing, that will happen.

Here's my last slide. This was an interesting question for me. Let me just say that the VA provides compensation. I feel uncomfortable answering this question because my job is to determine whether they're fit or unfit. I have nothing to do with compensation. I feel uncomfortable offering an opinion that the Air

Force should provide compensation for this. So I'm sorry that I'm not more forthright, but my job and my mission, you're either fit or you're unfit. I don't deal with the specifics of compensation. I do feel uncomfortable talking or representing the Air Force on a question that's not in my bucket, so to speak.

Any questions?

I would like to turn it over to Colonel Villacis to make his presentation.

COLONEL VILLACIS: Thank you very much, ladies and gentlemen of the Task Force, for the opportunity to brief today. I actually do not work for the Physical Evaluation Board, I work at the Air Force Personnel Center. The branch that I represent is the Medical Retention Standards Branch. We have a long and important relationship with both the Medical Evaluation Boards out in the field as well as the Physical Evaluation Board, both the formal and the informal.

Our role in the past had really been when there was a return to duty finding, to

standardize the decision-making about assignment limitation. For example, the service member has been returned to duty, and are there any requirements that would limit their assignability worldwide. So they're retained on active duty, but the Surgeon General recognized that there's a need to standardize the process of limiting assignments and potentially deployments. People that are returned to duty can deploy and often do with a waiver. They can serve worldwide, again with a waiver to ensure that the appropriate medical resources are available.

As the Air Force began to see the importance and value to our recovering wounded airmen of an integrated process with the VA, we were looking for areas that could represent potential delays. And Mr. Ishee and his predecessor informed us that about 20 percent of the time, cases that were reviewed that came directly from the Medical Board at the treatment facility to the Formal Board were found fit for duty and returned to duty.

Now, when you're dealing with a process that you own from start to finish, there are many opportunities to do that efficiently. When you add a partner like the VA for an integrated process, we wanted to ensure that our recovering wounded would get through that process as quickly and efficiently as possible. The Surgeon General -- it's really a work in progress, it started in 2010, but came into effect in 2012 -- implemented a two-step pre-disability evaluation system screening. The first step takes place at the local treatment facility through a body that's established there.

And their decision comes to my branch, the Medical Retention Standards Branch. And we are able to review cases and make a determination as to whether medical retention standards are met and whether there is a high likelihood that that case would be returned to duty.

Since the prescreen in March 2012 and actually up to October, because that's the

latest information that we have, there have been about 7600 cases that have been handled through the prescreening process. And as opposed to 20 percent of its cases being found fit for duty and returned to duty, only 2.5 percent of cases under the integrated process are found fit for duty and returned to duty by the IPEB.

You know, there's an advantage both for the people that are returning to duty as well as for the recovering wounded who need to continue the process.

The advantage for the airmen who are returned to duty is they can get back to duty more quickly. As you know, there's been a lot of discussion today and so forth about timelines. Provided that the treatment facility has given us all the relevant data that we require, we can make a decision really quickly and that service member can continue to serve and, in fact, sometimes don't need any assignment limitations. If an assignment limitation is needed, that can be placed, and they can carry on with their military

career.

For the recovering wounded, it keeps cases out of the queue that don't belong there. So the recovering wounded have the opportunity to move through the system more quickly.

So from our standpoint, the prescreen enhances the readiness as well as speeding the recovering wounded to the higher levels of the Disability Evaluation System.

So next slide.

Do you have any questions?

CO-CHAIR CROCKETT-JONES: Okay. With the prescreening, you've reduced the number of folks going back to duty from PD.

COLONEL VILLACIS: Yes.

CO-CHAIR CROCKETT-JONES: How much delay in that prescreening process before a person, in general, is then prescreened and moved on -- does that prescreen for the MEB?

COLONEL VILLACIS: Yes, ma'am. The question was -- so we are pre-DES, which means that we would be before the Medical Evaluation

Board and before the Physical Evaluation Board or the Formal Board. In fact, my office, after reviewing the case, will make a decision and communicate that back to the treatment facility.

We direct that they conduct a full medical board. And in practical terms, what that means is that the case gets entered into the veteran's tracking application. So the composition of pension exams are scheduled, and the medical services coordinator discusses everything with the service member. So that process kicks off as quickly as we make our decision.

CO-CHAIR CROCKETT-JONES: What's the average timeline for your decision-making?

COLONEL VILLACIS: The average decision time for a case review is generally one day if we have all the information. Sometimes there's a delay if the case isn't complete or we need additional evaluations or components, such as a commander's impact statement. We will look at that.

There is, as Mr. Ishee mentioned, multiple personnel systems that have to be updated. And what is unfortunate is that those processes, depending on the disposition, is the same data that has to get entered on a case. And, in fact, if it could be automated by pressing a button, it would save a vast amount of processing and administrative cost and time. At this point, we're doing these updates manually.

So that component, even if we make our decision quickly, there may be a one to two-day processing time after that just to get the personnel systems and other systems updated before it gets sent back to the base electronically.

CO-CHAIR CROCKETT-JONES: Your workload isn't waiting for your case determination over a period of time. You get it to your office. The decision is made, and then the updates happen within a week or less is what I'm hearing.

I sort of want to have a sight of if this doesn't create a delay, you know, in moving from MRDP to MBP. Do you see what I'm saying? A

week is not significant, but do you see --

COLONEL VILLACIS: Yes, ma'am. And I think that's an excellent question. Even if the process resulted in fewer cases that would be returned to duty getting in, you'd have to ask yourself is it worth it if we're delaying everybody by a month or two.

CO-CHAIR CROCKETT-JONES: Yes.

COLONEL VILLACIS: That's an excellent question.

The only delays right now that we're experiencing are if we don't have a complete case -- adequate, complete case to review. And we work closely with the Physical Evaluation Board, liaison officers at the MTF to get that information.

We are a resource and have always been a resource for the chief of medical staff and the chief of aerospace medicine. Those are the two important -- along with the treatment facility commander and the important people that we'll liaison with. We're generally able to get those

back quickly, so our decision is quick.

And if you're asking how it may be compared to how it was before, that's an excellent question too. And I think the same struggles that we face, the medical board faces. So a case that was being conducted locally prior to our prescreening, if the medical board met and did not have all the documents, they would be asking for those documents.

So whatever delay -- from my experience, I worked for seven years in the field and sat on hundreds of local boards -- that was a factor, and it depended on how good your PEBLO was, just local factors. But what I think is value added to this process, is we've standardized and have a good relationship.

We actually utilize an electronic case system that Mr. Ishee didn't reference, but it's Air Force owned and it's as easy as moving something from a desktop into a folder on a server to get the case to us.

EXECUTIVE DIRECTOR DAILEY: Can I

get Mr. Ishee to come back and talk to us a little bit about slide 10 again?

So out of your IPEB, you had about 5000 cases last year that you worked. And do I have it right, 684 decided to go to the Formal Board?

MR. ISHEE: Yes, ma'am.

EXECUTIVE DIRECTOR DAILEY: Okay. So this is the reason we like to look at it is to see, just kind of a feel for how satisfied your service members are with their IPEB. Obviously, if they're not, they're going to want to push it up to the FPEB. And then if they're really not satisfied yet, they want to push it their final opportunity for adjudication.

Any idea for this number being up or down over the years?

MR. ISHEE: No, ma'am. And I'll tell you why. Because, one, I've worked here a year; and two, this hasn't been tracked. This may be something that we may want to add to that capability so we can have fidelity on it.

But, I mean, there's some anecdotes that -- anecdotally that I've seen in the last year and a half that sometimes the Formal Board cases, the hearings will last longer than they were when I first got here. It seems to me that -- anecdotally now, I don't know if it's the economy or what -- but people want to stay or they're just not happy with the decision.

Anecdotally, it's -- you know, it's like a football game. Half the people like your decision and half don't. It's interesting because some people who are found fit don't want to be found fit, and those who are found unfit, vice versa.

Unfortunately, we don't have a mechanism to dig deeper. Right now our goal is just processing the cases.

CO-CHAIR CROCKETT-JONES: But you see the value of why it would be good to know, for instance, where that 11 percent that you changed, if they were -- where they are in the next line of appeal. I mean, do you see that --

MR. ISHEE: When you asked the question, that's when I also called SAFPC to see, okay, this is an interesting question for us, what are you doing? And they're not doing anything. But I do find value in it.

But my challenge as I go forward in this job, is again without taking away from production, what do we need to track, what's the value to it, and how do we use that information.

EXECUTIVE DIRECTOR DAILEY: Okay. So my real quick math was 13 percent of your IPEB cases are going up to your FPEB. And we found over time that also making sure the lawyers are getting hold of your IPEB clients very early in the process, manages expectations, and it's helpful in bringing that FPEB number down. We can keep throwing people at it, but the other way to manage it is to have less going to the FPEB.

MR. ISHEE: Right. What I will tell you -- and we've got a great relationship with the IOC; we continually meet with them -- they are very amenable to suggestions and improvements.

There isn't a day that goes by that we don't look internally to see how we can improve. Just last week one of our case managers came to me and said, "Look, Mr. Ishee, you're the LAS, Limited Assignment Status, appeal authority. Why are we printing the case file for you to look at?"

It's a great question. Well, as of today they don't print; them they send them electronically. The only thing that we have to have a hard copy of is the form. So I said, well, our next to-do is to automate that form.

So any time we can make an improvement, we look at every single process. If you were to come by our office, you'd see a big diagram on the wall, you can see process fixes for every part of it.

Anyway, any other questions?

CO-CHAIR CROCKETT-JONES: Yeah. Actually, I have one question. So when someone decides to go through the informal, they decide they want to bring you some more information, do

they come to you as an individual or do they get legal representative ahead --

MR. ISHEE: They go through their lawyer.

CO-CHAIR CROCKETT-JONES: Okay.

MR. ISHEE: What it is, is when the package leaves the Informal Board, it goes to the Formal Board because they've appealed. During that ten-day window, the attorney will get with the member and if they have new information, they will ask for this adjudication process. If not -- I mean, as time goes on, we're starting to learn, they're starting to learn. In fact, she told me just before the briefing, the lawyers and the services members are starting to learn if they have a chance or not. If not, then they'll go ahead and send a report in scheduling them to come for the formal hearing, and if it works out for them, fine. If it doesn't, then they come to the formal hearing.

CO-CHAIR CROCKETT-JONES: Thank you.

MR. ISHEE: Any other questions?

Thank you.

CO-CHAIR CROCKETT-JONES: Thank you very much. And we've got just a few minutes. Are our next presenters ready? Are we going to give them a few minutes? Want to give them 15 minutes?

EXECUTIVE DIRECTOR DAILEY: Let's take a quick break, and we can start with Colonel Edwards and his team. I'm pretty sure they will all be here. Right?

CO-CHAIR CROCKETT-JONES: Yes.

(Whereupon, the foregoing matter went off the record at 11:01 a.m. and back on the record at 11:13 a.m.)

CO-CHAIR CROCKETT-JONES: Okay. From the Brooke Army Medical Center Warrior Transition Battalion, we welcome Army Lieutenant Colonel Eric Edwards, the Battalion Commander. Lieutenant Colonel Edwards will discuss his wounded, ill, and injured population, family assistance, and unit staffing.

We have our supporting information

under Tab K of our binders. I'm going to turn it over to you and ask you to introduce your folks and start us down this lane. I'm sure we are going to pepper you with questions.

LT COL EDWARDS: Yes, ma'am. First, before I do the introductions, just real quick, on behalf of all of us at Brooke Army Medical Center Warrior Transition Battalion, I wanted to thank you for your support and safeguard of our warrior care programs. At the same time, just by you being here in San Antonio today and yesterday speaks volumes as to the commitment that we've got for our service members. So thank you in advance.

Quick introduction of my expertise here joining me in the front of the room. Command Sergeant Major Ridings, is the Battalion Command Sergeant Major. Major Josh Daily, Battalion XO. Major Sean Hipp, he's our Battalion Surgeon. We have Captain Williams, she's our S1, or Personnel Officer. And then finally, Captain Lozano is our senior interstates manager today. So, again, thank you all for allowing us to be here.

The overview of I'm providing you, again, was scaled for the agenda, some of the targeted questions. Certainly I hope to hear some of your questions and have some answers for what you have for us.

Real quick orientation to our organization. I feel this is necessary. It may be a slide that you've seen before. It's a slide carried throughout Warrior Transition Command, but everybody has got their unique spin on their command relationships here in San Antonio, and certainly we are very proud of the relationships we've got now.

Quick orientation. The blue beaten box at the bottom of the slide is the coveted Triad of Leadership, which many of you may be familiar, was established in accordance with EXORD 118-07, the Healing Warrior FRAGO that has been modified over time establishing the Triad of Leadership relationship.

In this case, our senior commander is a member of that. That is Lieutenant General

Perry Wiggins. He's also Commanding General of the U.S. Army North Fifth Army. Colonel Kyle Campbell, the Brooke Army Medical Center Commander and, of course, the Warrior Transition Battalion.

But what you need, of course, is a joint base environment. And so we are very proud to say that we work in great collaboration with the 502nd Air Wing when it comes to maintaining the status of our facilities and programs in support of soldiers and families. And then, of course, we have our higher headquarters, seven Regional Medical Command, Mission Command for the Southern Region, Warrior Transition Command; of course, the policy arm for Army. And then, of course, IMCOM support as well, and direct line communication with the Office of the Surgeon General for inquiries that go up routinely.

The next three slides speak primarily to the composition and demographics of our current population. Our Battalion is missioned to support a capacity of 670 and serve as a strategic reserve for Southern Region. And

many would argue that we also serve as the strategic reserve for the U.S. Army. And I say that because the most recent start seek guidance and reports, certainly have some of the restrictions in their MTFs as to what they may or may not be able to receive.

And the very popular examples would be OCONUS, IDES, as well as new behavior health patients, some of our COMPO 2, COMPO 3, MRPE/ADME folks coming from large mobilization platforms; for example, that being Camp Shelby, Mississippi.

So based on the levy of some of those restrictions, we certainly have a population that could surge any moment, based on the needs of the Army.

At this point in time in which we pulled this data for you, we had 488 soldiers in transition, 26 percent of those being wounded, 24 percent ill, and approximately 50 percent injured. That split on the injured is in front of you, comprised both those into the deployed and non-deployed environs.

And then the supporting staff of Cadre. These soldiers comprised of 352 military, civilian, and contract employees. Again, this information was pulled, is a few weeks old. We have a little less than that now.

But more importantly to take away on the slide is the caseload as we look at how well we're utilizing the staff that we've got. So based on the scope of our being the strategic reserve for Southern Region in the Army, we have the luxury over these past 12 months to have a steady decline in our population. Our high point last year, we had 782 soldiers in transition, and, of course, today 488. So I think that speaks highly as to some of the processes that are being improved along the lines as well as perhaps the operations downrange.

For GS hires. GS hires have not been problematic as of recent. I state that only because in lieu of the former sequestration, the civilian freeze earlier this year, then, of course, the government shutdown, all those were

problematic. Again, we had the luxury of a low population, so we did not get tested too, too much.

And with these excess personnel we do a pretty good job of supporting our fellow WTUs across CONUS. So while you might look at this and think we have a little bit of excess capacity, I'd also say that we have a number of folks that are on TDY day in and day out supporting some of our fellow WTUs who need it.

I wanted to tell you a little about the incredible men and women we have in our organization today because we do take pride in being the most diverse unit in the United States Army.

Of the 488 wounded, ill, and injured, we're comprised of all COMPOs; 308 active component, 123 National Guard, 57 Reserve component, with a split of 89 percent male, 11 percent female. The ages range you can see on the slide, 18 to 60, but more importantly, the average age being 34 and the grade range E-1 to E-9, W2 to

O6. The average being the E-3 and O3 on the enlisted and officer side. 61 percent married; 39 percent single.

What's not depicted on the slide is the added element that we have an average of 2.1 family members per soldier in the battalion. So we have a tremendous need to ensure that our family members remain informed, and we'll talk later in the slide deck as to how we do that.

Top five specialties. I realize that our LOS is depicted on the slide. To break it up, though, is infantry, engineers, transporters, medics, and military police. And what is nice about that is that our Cadre and supporting staff that support these fine men and women in their time of need have about the same composition, which is great for our soldiers and families to be able to relate to.

Like most WTUs, the primary and secondary diagnoses are that of orthopedic and behavioral. However, we have something unique in San Antonio which I think you heard yesterday

morning by the Commanding General of the Southern Region, Major General Keenan, when she talked about our Centers of Excellence. So we're very familiar with the Center for the Intrepid. Monumental structure there on the BAMC campus.

You've got the Institute of Surgical Research being really the lead DoD facility when it comes to caring for our burn patients, and additionally, I believe we are the lead in regards to the DoD when it comes to bone marrow transplant. And we have our own Army Centers of Excellence, TDI, and other great luxuries here.

MR. DRACH: Your average length of stay is 364 days. Do you know what the shortest and the longest is?

CPT WILLIAMS: Hi, I'm Captain Williams. The shortest length of stay is approximately 72 days. That's the shortest length. It just depends on, you know, what they actually have to do to make it here. We have different kinds of soldiers that come; we have SOCOM soldiers that can come in, and we have 24

hours to actually get them taken care of as far as their medical appointments and, you know, their nurse case manager, we have to look at their profile. It actually depends on actually the causes that they're on the WTB.

LT COL EDWARDS: So again, the average length of stay being 364. What we added to this slide for those that may be interested is what our headquarters really focuses in on, and that being the Army methodology for length of stay, which does not take into account the date of arrival to the date of exit. It really focuses on IDES. So broken down categorically for you by the breakouts of greater than 365, 540, and 730, it shows you the stages in which our soldiers are in right now. So roughly 209 soldiers are in the IDES process as of today.

Soldier population: I spoke briefly about the trend over the past 12 months. Really what you're seeing now is the span of April 2013 through April of 2014. But, again, it reveals both the actual and projected soldiers that we've

had with us or we project in the future.

The future projection is something we've struggled with in the past, but I think we've got it down to about an 80 percent solution over the past three or four months.

There's a gentleman by the name of Dr. Mike Carino, who works out of the office of the Surgeon General. He's part of the program and analysis division. And essentially, he has come up with a fairly complex algorithm that accounts for active component deployment, redeployments, RC mobilization, demobilization, based population, historic MEB throughput, as well as evacuation throughput and WT throughput. And so it's been nice to see that over the past two months, we've seen fairly great accuracy with regard to his numbers.

But the future projections that you're not seeing on the slide right now is that by FY15, we approximately will be down to a relatively flat number of 400 soldiers in transition on a continuous basis which is pretty

remarkable. And when you look at his FY17 projections, he has it down to the range of 300 to 340. So, again, I think it's a testament as to the great improvements we've had as well as to the impact of operations down the range.

The entrance into the WTB is really by way of three different modalities; one being command referral. This is inclusive of our warrior in transition unit transfers throughout CONUS and OCONUS as well the COMPO 2, COMPO 3 related MRP and ADME and Medevac. And essentially, the Triad of Leadership is the governance that we got in place by way of our consolidated guidance from Warrior Transition Command that accounts for the eligibility criteria of our service members. They take into account of course those that have temporary profiles in excess of six months, the acuity that it requires, that intense or very complex case management to ensure appropriate, timely, and effective access to care, as well as soldiers whose permanent profiles require boarding or those soldiers that

are trained by way of being in TDRL status.

But the most complex component may very well be our COMPO 2 and COMPO 3. And by way of looking at your annual report that you distribute here at registration, I know that line of duties is something we're working with. I think it was recommendation No. 7 in your annual report. So I know it's not a stranger to other WTUs, and we'd certainly like to be able to see some improvements in that regard, but that has much to do with just how effectively we care for our COMPO 2 and COMPO 3.

And then direct evacuations, of course, are automatic. As the OCONUS arrivals come into Walter Reed or San Antonio, COMPO 1, they may be assigned right away or if a plan exists, but not to exceed 179 days of attachment orders. So we've got a great mix of individuals, but these are the three primary facets which you bring in here.

But if you were to reference the warrior transition command consolidated guidance,

it goes to a great level of detail. We talk about initial entry soldiers, advanced individual training soldiers, recruiters, and the like.

CO-CHAIR CROCKETT-JONES: So can I ask you a question?

You have 44 folks who have been here for longer than two years. Nine percent of your current population have been here for a pretty long time. Is there any fidelity on how many of those are in active recovery process and how many of those are sort of in an elongated IDES process? What's the outline of that population?

LT COL EDWARDS: Yes, ma'am. And they are predominately still residing because they've been in the DRES system and they're currently awaiting their ratings. That is the commonality among those 44.

Battalion Surgeon, do you have anything to add, Major Hipp?

MAJ HIPP: I'm Major Hipp, trauma surgeon. Some of our most complex patients are the limb salvage patients, for example. And we

need to spend a good bit of time during healing to try and determine whether we need to amputate or are going to be able to keep that. Some of the patients that are here longer are those patients, because we can't start the MEB process until we can make that decision. So that's the bulk of the patients that are here the longest period of time are patients that are the CFI and are the limb salvage patients.

LT COL EDWARDS: Okay. So the next couple slides focus obviously on a very integral part of the soldier's healing and transition, and that is the family unit. Needless to say, the arrival of a soldier through the exit, whether they're transitioning from the service or back into the force, we immediately introduce the family members to the key components during the process and encourage their full participation and more or less understanding that any decisions that are made in their absence, of course, may impact or greatly impact their lives down the road.

So orienting family members to the

comprehensive transition plan, the IDES process, sharing soldiers' medical and nonmedical appointments and schedules, and simply providing expectation management is absolutely key. And I think despite the challenge of outreach to our COMPO 2 and COMPO 3 family members, I think they're making great strides in building relationships with the state TAG offices and other.

But the communication really starts with frontline leaders and in command teams remaining apprized of the needs of families from day-to-day activities. And we do this through a number of other venues. I know that you've heard of town halls. I've been to those at Walter Reed as well when I was stationed on the East Coast. Newcomers orientations, these are mandatory briefings for the soldiers, highly encouraged for the family members.

Family readiness events. I'll toot the horn of what we have here in San Antonio shortly. Sensing Sessions and then the focused

Transition Reviews, which are, of course, comprised of that interdisciplinary team, a number of folks both within the battalion and surrounding the battalion to make sure they talk about all the services and benefits as they transition.

CO-CHAIR CROCKETT-JONES: I'm going to jump in here. I'm having some confusion on the map.

LT COL EDWARDS: Okay.

CO-CHAIR CROCKETT-JONES: 38 percent are accompanied by family members, but 47 percent accompanied by family members during IDES. Is that 47 percent of those who are accompanied?

LT COL EDWARDS: Yes, ma'am. Yes, ma'am.

CO-CHAIR CROCKETT-JONES: Okay. What is the attendance of the sensing sessions with the FTRs? How many people do you get to those events? Anybody got numbers?

LT COL EDWARDS: Captain Lozano, do you have attendance of family members at some of our sessions?

CPT LOZANO: No, sir.

LT COL EDWARDS: I'm going to speculate less than 5 percent, 10 percent. But do you have any fidelity on that?

CPT LOZANO: No, sir.

LT COL EDWARDS: Although encouraged, ma'am, I don't think we've been tracking those numbers as well as we could, but it's always open.

CO-CHAIR CROCKETT-JONES: We know that this is really tough. Getting people in is always tough. These are basically efforts that require family members to come to you-all. Do you have any efforts, squad leaders who are required to contact family members, some units ought to have squad leaders make a home or a visit where they get an eye to eye? Does any of that happen in the battalion that you know of?

LT COL EDWARDS: It does, ma'am. I would say that it's not a 100 percent solution, but I'll tell you that during the initial assessment and self-assessment of the soldiers,

that is communicated. Where the family members are, how to reach to them, and a follow-up plan to make sure that they're a part of the comprehensive transition plan.

We, throughout the city of San Antonio, despite location, those that are residing on post, there were 88 compliant homes on and off post.

The relationships we have with some of our nonprofits. We have a great complex here called Operation Homefront, a great organization off of I-35. We do rotations out there weekly to meet with family members. And that composition of the team that goes out there -- it's headed by our outreach program chaplain who initiated this to begin with, followed by squad leaders and duty sergeants, if they want to go out there to actively engage with these family members. So we do go there as well as rotate to the VA and some of our other inpatient facilities throughout San Antonio. I would say that in the extreme case, once a week, but they always know how to reach us

if they need to.

CO-CHAIR CROCKETT-JONES: What kind of population -- what kind of numbers do you get on those remote meetings? I mean, is it that onesies and twosies?

LT COL EDWARDS: No. We have found the secret to success, ma'am, is if you bring food, they will come. And I say that jokingly and hear the laughter in the back, but if you throw some of those out there, you get attendance. And if you want a little more of their attention span while you've got those engagements, you pronounce our Child Youth Services. And we've got some of those modalities on post for our Soldier Family Assistance Center.

So we've done a great job of taking those lessons learned, what has been successful or not, to pronounce or amplify their attendance, and it's worked incredible in the past.

Surround it around an event, we use some of the forums that may be completely thinking outside the box. Yesterday we had an operation

that happens annually called the Free PX Session. A bunch of nonprofits come here, they've invested $250,000 worth of toys, household items, and the works. We used a warehouse, in conjunction with our sister service being the Marines, and the attendance, I'm going to share right now, is we had well over 700 folks rotate through there. And we used every opportunity to engage family members on the site by having a social worker on site, some of our squad leaders and other staff were a part of the setup and execution. So we got some pretty good forums out there.

CO-CHAIR CROCKETT-JONES: And I might have jumped in here before you. Explain to me who the position of soldier family liaison, is that a dedicated position or is that --

LT COL EDWARDS: We have a GS term employee. Some of the folks in the committee have reached to her for her expertise outside of the warrior transition battalion. She is a full-time employee. She has an assistant that assists her, but more than just a family assistant's role,

which is just really getting into the part of the nonprofit business, as well as the governance in regards to Traumatic Soldier Group Life Insurance, TSGLI, some of those other benefits that may not be spoken to as well from our Soldier Family Assistance Center.

So it's another resource, the competence of our internal organization other than going outside. But a tremendous asset to our battalion. And I've heard comments from family members that have met her over and over again saying, can I clone you and take you back to our home station. She is that good.

I wish we had increased depth, but one has worked fabulously, given the low population we've got right now.

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

LT COL EDWARDS: Other venues that I would like to get on the slide that are not depicted on this slide, but I'll tell you that we just initiated in November a WTB spouse forum.

And my wife has taken a very proactive role in bringing folks together. We will talk about some of their needed programs.

Our first test of this in November was establishing a PTSD spouse forum, which kind of went into some of the psycho-educational skill sets to ensure that, more importantly -- well, the family members, more importantly those caregivers, have a better understanding as to what PTSD is and some of the coping mechanisms to do that.

So it was a six-part series. Again, due to some of the great relationships we have here in the San Antonio community, we brought in the VA, as well as our own social worker in behavioral health expertise. And I will tell you that we completed the last session last Friday, they are already yelling for more. And they've given us a list of topics that we're going to start unveiling in the new year. I know that the caregiver program is in demand, they want a little more than what's being provided in the inpatient setting or some of our rehab scenarios. So we're

going to expand on that quite a bit.

If I could, as it dips into the next slide --

EXECUTIVE DIRECTOR DAILEY: The name of the program again, and it's not in any of your slides. Is that correct? What you just described is not listed anywhere in your deck?

LT COL EDWARDS: Correct, ma'am. I would relate that as close as you could to a family readiness-type venue, but the name of the program was the WTB Spouse Forum.

EXECUTIVE DIRECTOR DAILEY: So it's tough for us to catch this if it's not in the slide, so I'm just highlighting it for my staff over here. The WTB Spouse Forum. And your attendance? What did you get for attendance?

LT COL EDWARDS: We started with about two dozen, ma'am. Some of those service members had transitioned out by the sixth session. We had them once a week. I would say that we ended with about 15 on the final day, so not bad for a first effort.

But I can tell you that more importantly, it's by word of mouth, because a lot of these folks were brought in -- as we talked about earlier -- in the outreach program. We provided transportation to go pick up folks from the VA, from their apartment complexes, to encourage them to come our way. And I really think we're going to at least double the population with some of these upcoming forums we'll have. It was a great test. It was a successful exercise.

EXECUTIVE DIRECTOR DAILEY: so you started in November and you've had it every week for six weeks, different topics each week?

LT COL EDWARDS: No, ma'am. That was really around PTSD. We found a time that was most conducive for our family members to attend. We allowed them to pick the date and time; we provided the setting. And so one day a week in the session was about three hours.

EXECUTIVE DIRECTOR DAILEY: So we're talking about two programs, one the spouse forum

and one the PTSD?

LT COL EDWARDS: No. It's the same program. It's the WTB Spouse Forum. It's literally that; it's a forum. We introduce topics of interest for our family members. It just happened that PTSD was our first.

EXECUTIVE DIRECTOR DAILEY: So it started in November, and you've been doing one session per week?

LT COL EDWARDS: Yes, ma'am.

EXECUTIVE DIRECTOR DAILEY: One session per week for the last six weeks?

LT COL EDWARDS: Yes.

EXECUTIVE DIRECTOR DAILEY: And your first six-week sessions have been on PTSD?

LT COL EDWARDS: Yes, ma'am.

EXECUTIVE DIRECTOR DAILEY: It's helpful when you put in a slide, but we're trying to pick it up as you talk.

Any other real best practices? That's probably one of the top ones we've heard so far. And the attendance sounds pretty darn good

too. Starting out with two dozen in November and you kind of ended up with a dozen and a half at the end.

LT COL EDWARDS: Yes, ma'am. Very proud of it. And I'll tell you, at the time that I was submitting my slides for this conference, we were just entering the fifth of the sixth week of that program, so I wasn't going to toot my horn until I saw the end product, and that finished last week. So that's why it was not in the slide deck. But certainly hope to have some more fidelity on that soon.

DR. PHILLIPS: In between the sessions, are you aware of or do you know whether or not folks who attend are communicating with each other? I know social media is a huge utilization related for caregivers exchanging information. I'm just curious if you have any information on that or anybody has made any comments about that.

LT COL EDWARDS: By using the virtual FRG site and other social media?

DR. PHILLIPS: In between your official sessions, whether they're actually communicating with each other and is there a robust activity associated with what you're providing.

LT COL EDWARDS: I can tell you that -- and I'm kind of a metrics guy, every now and then. I'll tell you that in June of 2013, we had -- on the most popular social media site, Facebook, we had just under 180 folks that were friended on that program. We are just below 400 today, which has shown a growing interest of family members as we continue to -- everything from including it on business cards to, again, word of mouth being very effective. And it draws people to these venues we've mentioned.

DR. PHILLIPS: And Tweeting is another way that these folks really -- I mean, because they re-Tweet, and it's just astronomical as a geometric process. I'm just curious because my day job, I do some of this. And I think it would probably be a no-brainer for these folks

that attend with posttraumatic stress disorder because there are confidential questions and things that they can't think of or they don't want to ask, but on a one-to-one basis or using social media, people just talk about everything.

LT COL EDWARDS: Yes, sir. And I think we have some pretty effective parameters in there. But the disclaimers on our Facebook site, to make sure that any conversation is addressed promptly and brought out of that social venue into a personal venue with the individual concerns.

DR. PHILLIPS: I know we all have good intentions, but HIPAA rules should go away when people use Facebook.

LT COL EDWARDS: Yes, sir. And I know some of the other comment venues that I get -- and, again, I hate to throw another couple out that were not on that slide, but on some of standard Army venues, ma'am, couple of retreats, family retreats, Hardwick Chapel, Strong Bond Program. We have another one taking off in January trying to run semiannually at a minimum.

So it's another opportunity for great attendance.

And the communication forum being the ombudsman program has also been rather effective. I know a lot of folks get hesitant or cold feet when we talk about the ombudsman program, but I think you've got an effective way to utilize that program not only for the service members, but for the family members. So as they build relations -- I think we have a launch right inviting four ombudsman, really one aligned per company right now. And it's been a great voice outside the standard day-to-day business.

Some of the challenges in improving practices -- actually, let me go back one slide because I don't think I talked about it. Some of the pictures and the agencies that support the Warrior Transition Battalion. I talked briefly about the Soldier & Family Assistance Center, so it's 14 services that are comprised of the SFAC. There are a number of those across other WTUs that cuts anything from HR to office and personnel management, has the Child Youth Services program

we talked about, other outreach VA, paralegal, as well as Voc rehab, social security services, social services and the like. So 14 services. They've got an incredible complex right next to our headquarters, and what great access to our soldiers.

I want to be able to toot their horn because we had a visit recently from the House Armed Services Committee professional staff members, Ms. Deb Wada was one of those members, and came through -- and they loved the idea of having the SFAC. The SFAC falls under ASA. It is not a MEDCON entity, but it has proven its weight in gold. Having the convenience of having a facility with 14 services like that on post, in fact, next door to us, has really absolved the accountability issue that our senior noncommissioned officers have as we're doing the frontline work for our soldiers that are in transition. To have them go across post, to having them even go off post for some of these services, a 30-minute appointment can turn into a

half day. We've all seen that before. By having SFAC next door to us, we get them in the fight, they get priority access, they and their families, and right back out the door again. And so that incredible effort is being led by a gal by the name of Ms. Gabby Diaz.

CO-CHAIR CROCKETT-JONES: So the child youth services is like the -- for registration purposes, a family member can go to the SFAC to get into that facility? I'm trying to understand it, because I know there was at one point ID cards. You'd get family members into the SFAC to get a streamlined, you know, no-line process to get their ID cards, and it was pulled out.

But one of the things we think about is that if you can just get someone into the building, family member, the resources for the benefits they're eligible for and different programs, you know, they're more likely to get in touch with some of that information. We have a lot of trouble getting folks connected to

resources, family members.

So if you're saying that registration for child and youth services can happen at your SFAC, is that what you're saying when you say child and youth services? Are you saying that child care is provided there?

LT COL EDWARDS: Child and youth services is offered within the SFAC. I think the capacity right now is about 50 children based on the review. But it facilitates so much.

It facilitates just what we were targeting, ma'am; that being the attendance, the family members being -- the spouses of our service members being able to attend their appointments with them, go through some of these FRTs we're talking about. It's a wonderful activity to have for a child and parent night out. Another program we've been running for well over a year right now to allow service members and their spouses to take that evening of respite and have our caregivers, our supporting staff take care of their children for the evening.

CO-CHAIR CROCKETT-JONES: So what's happening is it's child care provision, it's not like they're a registration. That's okay. I wanted to get a clear picture. Thank you.

LT COL EDWARDS: Yes, ma'am. And the other great facet of the SFAC, of course, is employment opportunities. We talk about OPM and we talk about supporting federal and nonfederal opportunities for our services members. It is also extended to family members. And we've done a very good job of ensuring that they're there at the same Hiring Hero events, that their job opportunities are open. We've got NAVAIR coming in here in February, another very successful program. So we have got a number of venues that are offered to all.

The Warrior Family Support Center --

EXECUTIVE DIRECTOR DAILEY: Hold on real quick. The Task Force is very familiar with the SFAC's visit every one every time we're there. What we found consistently in most of them is that they are not staffed. Just on top of your head,

we didn't ask it. What do you think your staffing level in the SFAC is right now? 80 percent? 90 percent? 50 percent? 50 percent has been the norm in the last three we've been in.

LT COL EDWARDS: I think we had a problem. Our only problem since I took command this summer was that revolving around the government shutdown. Other than that, the services have been plentiful for our service members and families, so it's not been problematic. And, again, Ms. Diaz is very communicative if there is a shortfall. Understanding that several other agencies participate in that SFAC setting that are not necessarily within her control, we talk about ACAP and we talk about our VA representation, a lot of it is out of the -- really the benefit for that organization to be on site as part of that one-stop shopping type mentality there as part of the SFAC. But no problems that I can raise at this time in the staffing.

The Warrior & Family Support Center,

this is really unique to San Antonio. I think Walter Reed has something of sorts, but the Warrior & Family Support Center is really that respite activity. So this is a 100 percent donated facility, unique in San Antonio. On our campus there are the Warrior Transition Battalion, which has really everything for the communication needs of our service members, to education, emotional support, a plethora of activities.

And we talk about the ability for folks to go on trips with families. We have break away that governs the Hero Miles For Overseas, or the Hero Miles Program, for flying family members in and out. If you have time in San Antonio and you've not seen this facility, I highly encourage it. It is a beautiful facility. It is always a stop for a lot of our DVs that come to San Antonio. And they average about 100 activities a month. And, again, all coming through by way of nonprofit donations that supports our communication opportunities to family members.

So, again, bring food, they will come. I'm not kidding. Bring food to that facility, they will come and you get the message out for hot topics for our families. So we use that as a force multiplier.

Challenges and proven practices. Although it's not on the slide, I went into that when I talked about the entry eligibility of COMPO 2, COMPO 3. So one I would add to this slide and for the record is the LOD concern, going back to your recommendation No. 7 as a Task Force.

But some of the other challenges I did want to note on here was that involving the Career & Education Readiness Program. Another opportunity, whether it be work studies programs, internships, I think you're familiar with Operation War Fighter, another very well-established program. E2I, I know that the Congressional -- or the DoD paperwork or letter is out there. I think the service letters have to allow E2I to really take hold for some more nonfederal entities that want to be able to

provide some of these work and internship programs for our soldiers.

But really what is the big impediment for us right now is that we as we lower that population I talked about earlier. We have the highest acuity patients, are the ones that are residing here. So whether or not they are able to participate in some of these programs is a challenge for us right as we try to move them through rehab, yet talk them through transition, and some of these opportunities here. So something that we will continue to work through.

Communication with parent units, so the COMPO 2, COMPO 3 complexity of those not having their family members with them on station is something that we continue to try to address. Again, I talked about building relationships with our state TAG offices, U.S. Army Reserve Command, and engaging parent units.

So when they arrive and they provide that parent unit information, we immediately reach back to that unit. We let them know the current

status of their soldier, that family members are welcome. We provide contact information by mail, e-mail, whatever fits that need, to ensure that they know who to come to so that parent unit did not have a problem getting information about their service member here on station.

But parent unit outreach is key and more complex when you talk about that parent unit still being downrange. And that is something we are continuing to work with rear detachment, the skeleton crews that are left behind, to make sure they understand where their soldier's at and the availability or access the family has to that soldier.

And I think, again, a lot of the folks that are coming here to San Antonio, to provide sensing session with their soldiers. These happen very often. I'd say that we have the BCT level commanders or above showing up almost on a weekly basis, if not state TAG offices and the like. So, again, very fortunate. They may be attracted to San Antonio, but we provide them the

venues, and they certainly take feedback and improve.

Length and unpredictability of IDES. We talked about that, but I think have made great improvements, and we understand that we have those limitations at our level.

Proven practices --

CSM DeJONG: Sir, before you go on.

LT COL EDWARDS: Yes, Sergeant Major.

CSM DeJONG: A couple of things that we've noted over the last couple of days and these are some changes that are coming up.

As far as challenges, do you hear anything from your Cadre based off of the potential for that special incentive for Cadre members to go away? Is there any rumbling in the ranks that they're going to lose that compensation pay, and is that going to affect your ability to maintain quality Cadre within your formation?

LT COL EDWARDS: I am going to defer that to the Sergeant Major on this. I've not

heard complaints, and that must be my optimism, Sergeant Major. But certainly the Sergeant Major, has an answer for that?

CSM RIDINGS: I'm Sergeant Major Ridings. In answer to your question, there is going to be some rumblings. I've not heard it specifically directly to me, but I have heard some concerns that have been voiced through the First Sergeants and the Platoon Sergeants. I don't think it will directly affect our ability to have a viable staff of care in the Cadre, though, because many of our Cadre, as you know, Sergeant Major, they do it for more reasons than the money.

I don't think that will have an effect on it in terms of negativity, in terms of care for our warriors and our soldiers in transition.

CSM DeJONG: Then along those same lines, if I may back up to -- a couple slides back, you had one of the ways that you limited your length of stay was early transfers to CBWTU. And what we are finding out this year is that

CBWTUs are kind of struggling right now. There's models out there that they're going to possibly take CBWTUs away, have remote care managed by the MTFs and/or the battalions on a military post.

First of all, I guess my question is, what CBWTU do you guys normally feed to, and are you seeing any potential changes of that going away, or have you heard that?

LT COL EDWARDS: Sergeant Major, I've got a couple of answers to your different questions.

One, predominately utilization of CBWTU Arkansas for us.

But have we heard the rumor on the street? Absolutely. There is an Army-level General Officers Steering Committee in June of this year with a lot of pre-decisional advertisement on the restructuring of WTUs, CBWTUs, and community-based care for our soldiers. So certainly word is out there. I don't think it's had any pre-impact on our current transfer process. I think we've been fairly successful in

that regard if they're eligible and accepted.

CSM DeJONG: Do you feel that as an institution you could manage remote care along with managing the population that you have?

LT COL EDWARDS: Yes. Yes, sir.

CSM DeJONG: Thank you.

LT COL EDWARDS: The proven practice, I think, we really wanted to advertise this morning was that of the care of our high-risk patients. So when we talk about high risk, we typically categorize them, at least within the RB -- WTUs as those in red or black status as determined by their self-assessments, as well as the assessments of both their command team and medical management team, social work, nurse case management, and the like. And so the practice of the twice-daily contact of high risk soldiers by the chain of command is nonnegotiable in our ranks.

We instill both in the Army Cadre course that all folks are required to go through, we've complemented that by increased frequencies

on suicide prevention and intervention training. A lot of this is not book or PowerPoint lecture. We're actually talking about role play, giving different scenarios. We have individuals that are acting as the service member themselves or the distraught family member to ensure that our frontline leaders are better equipped with the correct modalities and how to direct and care for those folks in need.

Master resiliency training is part of the Army's R2C campaign, Ready and Resilience Campaign, is adding more to what we already had. We have the luxury of having 21 master resilience trainers right now. We've got plenty of depth because the ASIs are identifying these folks, and have been providing a great skill set for the CSF2 program and to implement the Chief of Staff, the Army's RTC campaign.

And then care monitoring of HR. So while we'd like to say we're training our Cadre and staff members to look for the visible signs or needs of our high risk individuals, we are now

dipping into the ranks to make sure there's adequate training, for the soldiers to be able to look to their left and right. Those families that are conferring with one another on or off location, to be able to have a venue or a modality to report the needs or the distress by family members so we can better address those.

And, again, I think every program we've got has room for improvement. I'm very proud of what we're doing right now here in the San Antonio community.

CO-CHAIR CROCKETT-JONES: A question for you is, is there any attempt -- it just occurred to me -- to sort of track if you have a persistent return to high-risk status so that nurse case managers, so the recovery lane can sort of be modified? Is there enough communication, I guess is what I'm asking, between medical case management and your Cadre to know that someone who persistently returns to high-risk status, make sure that they're really in the right treatment plan, et cetera, do you know if that's covered?

LT COL EDWARDS: Ma'am, I'd like Captain Lozano to answer that for you, our nurse case manager.

CPT LOZANO: Captain Lozano, Case Management. So, ma'am, the question generally, is there enough communication between the command side of the house and the medical side of the house. Correct?

And I'll tell you there is. Currently case managers are essentially housed all the way down from the command side, so communication is constant. It's daily communication.

On top of that, we have a weekly meeting, a triad meeting, where we discuss all the soldiers that are high risk. So the answer is definitely yes.

CO-CHAIR CROCKETT-JONES: Okay.

DR. PHILLIPS: I have a question about slide 3, if you could possibly go back to that. And I may be interpreting it incorrectly, so please don't be shy about telling me that.

Looking at the combat wounded and injured deployed, that's about 35 percent of the population as compared to the illness and other injury, which is about 65 percent. I just did some rough math, 312 to about 176.

What I was curious about, and correct me if I'm wrong, on the larger amount, the 64 percent of illness and injured, do you know if those folks have been deployed in the past, or are some of those illnesses or injured related to pre-recruitment conditions? Do you have any information about that?

LT COL EDWARDS: I don't want to speculate, sir, but I'll ask my surgeon if he's got any insight.

MAJ HIPP: That's a very hard thing to track. Certainly many, many -- most of our service members have been deployed. But when trying to track it if it was pre coming into the military, I mean, again, those should have -- I'm not tracking that data currently is the long and short of it.

DR. PHILLIPS: I'm just curious, because in the past, we've come across situations where there are service members in a unit, in a WTU or WTB, that perhaps had preexisting pre-enlistment conditions that were kind of missed.

MAJ HIPP: That has come up several times. So a preexisting condition before coming into the military, if it is, let's say, exacerbated by the military, then that becomes a thing that we treat. And that's pretty loose.

DR. PHILLIPS: It's a fuzzy area, I know.

MAJ HIPP: But there are some that we have denied for a line of duty, because they clearly had it before. We've had some that even documented it in their exam when coming into the military, that they've had this condition.

But we do need to know if they have been deployed before and that injury occurred downrange. If they go into the hospital, they get different compensation that's related to it, even

if it's two, three deployments ago. So we do track those things.

DR. PHILLIPS: Thank you. I know it's difficult to come up with those numbers, but at least from my point of view -- or the committee's point of view, it's important for us to try and at least know.

LT COL EDWARDS: So, ladies and gentlemen, subject to your questions, this concludes the slide presentation.

CO-CHAIR CROCKETT-JONES: Is everyone clear? Did you guys get the information you need about the program? I think that we've grilled you enough. And I want to thank you, Lieutenant Colonel Edwards, for your briefing.

And we're going to break for lunch. Thank you once again for all you're doing for our service members.

LT COL EDWARDS: Thank you. And please take care of our wonderful soldiers that are coming here this afternoon as part of the soldier panel. I think they're excited about the

opportunities.

CO-CHAIR CROCKETT-JONES: Thank you.

(Whereupon, the foregoing matter went off the record at 12:01 p.m. and back on the record at 1:06 p.m.)

CO-CHAIR CROCKETT-JONES: Welcome back. This afternoon, we welcome Dr. Elizabeth Halmai, Medical Director for the San Antonio Polytrauma Rehabilitation Center, who will be briefing us on the mission of the polytrauma center as well as its relationship between the rest of the VA and DoD military treatment facilities.

Information for this brief is under Tab L of the binder. I'm going to turn it over to you for your own introduction.

DR. HALMAI: Thank you. Can everyone hear me okay? I heard somebody already stole my joke about being vertically challenged, so hopefully you can see me and hear me. I also have to apologize in advance for a name change. And I'm hoping some of the people that work for

the VA can understand where I'm coming from with this. All I needed was a new ID badge, but I had to get a -- change my name just to get a new badge.

So anyway, you might see "Elizabeth Johnson" in some places and you might see "Elizabeth Halmai" in other places, but we are the same person.

Really what I wanted to do -- and I'm so excited to be here. I really love giving presentations about the Polytrauma System of Care. It's been really the only thing that I've actually done since I graduated from residency, and so today what I wanted to do is give you -- I wanted to answer all the questions that were actually put forth.

And we are going to give you an overview of the Polytrauma System of Care, provide you with some statistics that we're currently seeing within the system of care. I'm going to discuss this big topic of transitions from active duty to veteran status. And then at the end we'll

kind of end with discussing maybe some of those challenges or maybe things that aren't working so well within that transition. So that is my goal.

And if there's any questions that I'm not able to answer, I will gather those questions, and when you all come for a tour on Thursday, we will get you those answers.

I am sure this slide is not unfamiliar to most of you. So this term "polytrauma" is really a newer term that has actually been the result of this current conflict. And it really is just a term to describe these very unique, complex injuries that have actually occurred as a result of a single event. And those can be a multiple of different types of injuries combined together, including head injury, spinal cord injury, amputations, musculoskeletal injuries, and, of course, psychological trauma.

Equally as complex and unique is the type of care that we actually need to provide these service members and veterans as well. And so the level of care that's provided does need to

include all of the below. Oftentimes the brain injury is the primary injury which can actually make treatment of other conditions very difficult. And so you do have to keep in mind that we're simultaneously treating things like a severe head injury, maybe an emerging consciousness disorder, in addition to a spinal cord injury. So all of these things can be very difficult to treat at the same time. But in addition to that, more importantly, all of these injuries do require a very coordinated and interdisciplinary team approach to treating them.

So in 2004 the VA was actually challenged to -- or charged to actually develop a system of care that would actually be able to treat these returning service members and treat these very complex injuries that we were actually seeing. So as a result of the Veterans Health Programs Improvement Act of 2004 the Polytrauma System of Care was actually developed.

And this is our current mission statement. And what our mission is is to provide

a comprehensive, patient-centered integrated system of rehabilitation care for Veterans and Service Members with Polytrauma and Traumatic Brain Injury.

And so this is actually an overview of what the Polytrauma System of Care looks like. So it is a very comprehensive inpatient and output approach to treatment. And the Level 1 level of care are the actual five Polytrauma Rehabilitation Centers. That is where the inpatient care actually occurs. And the five centers are currently Tampa, Minneapolis, Richmond. Palo Alto, and San Antonio being the newest. After that, Level 2 through Level 4 are outpatient therapy programs.

Level 2 is referred to as a polytrauma network site, and we'll go into a little more detail about some of these later on. But it's a very integrated comprehensive outpatient program to treating some of these complex injuries once they're ready for outpatient care. Level 3 and Level 4 are not quite as

comprehensive as Level 2, but they're still able to provide a lot of really excellent care.

This is just a pictorial representation of that. So you can see that all the red dots do represent the Polytrauma Rehab Centers across the country. And then you can see all the other outpatient clinics that are within the system of care as well. And you can see some of the areas of the country are much more populated than others, so the VA does tend to utilize Telehealth on a fairly regular basis to reach some of those areas that are not as accessible to veterans.

And we are going to go into a little bit more detail about some of the specific transitional processes that occur later on, but this is really just an overview of what the transitional process through the system of care actually looks like. And so as you can see, after an injury, surgeries, medical conditions, those patients do need to be stabilized. Once they're stabilized, they would actually enter into our

rehabilitation program. And just based off of the level of injury or the severity of injury, they could actually fall into several categories.

For those that are very severely injured with head injury, they might fall into our emerging consciousness program. For those that maybe don't have as severe of a head injury, they would fall underneath our inpatient rehab program. And for those others that maybe don't require inpatient rehab, obviously outpatient therapy would be available.

Once the rehabilitation is actually completed, community reintegration is actually a huge goal. And I know this is the same for the DoD as well. And so the VA has done a really good job of trying to create programs to work towards this goal. And we're actually going to talk about one of these in particular. So this is the transitional residential program that we do have here. Other options might be a really aggressive outpatient day program or other outpatient care programs where maybe they might be sent out to

other specialties.

Once patients are reintegrated into the community, we do follow them for a lifetime, at least for the severely injured, just making sure that we're addressing all of these issues on a regular basis.

And you can see down at the bottom, you know, family support, case management, benefits management, and medical information management, these are -- actually should be constant throughout. There should be constant communication between the staff as well as the families and service members or veterans so that they feel supported throughout this whole process.

Well, these are the five current polytrauma centers. And we're going to go into a little bit more detail about the inpatient rehab centers, but, again, for those of you that get the opportunity to see later on, this is the San Antonio facility.

So the five Level 1 medical centers out there really are geared towards providing the

highest level of inpatient care. And we'll be going over what the services are that we actually offer. They're typically a 12- to 18-bed inpatient unit. Each one of the Polytrauma centers has a slightly different number of acute inpatient beds, but they have multiple other programs that are associated with the polytrauma centers. And we're going to talk in detail about the transitional rehab programs, typically a 10- to 20-bed separate inpatient stay.

The emerging consciousness program, which is really geared towards those patients that have suffered a very severe head injury. So they're typically in a vegetative state, coma, or emerging consciousness state or minimally consciousness state. And they would typically come to our unit for about a 90-day trial and with the goal of emerging from a disorder of consciousness, at which point we would actually transition them into our rehabilitation program.

Each one of the centers also has an assistive technologies lab. This should really be

kind of a one-stop shop for addressing all of those assistive technologies needs, whether it be power mobility with power chairs, environmental controls for those people that maybe aren't able to manage all the equipment that they might have at home, or assistive communication devices, or all those cognitive aids that we use right now, such as iPads, iPods, iTouchs. And in addition to that, all the polytrauma centers are constantly working towards improving other Telehealth networking to be able to improve the communication that we have with some of those veterans or service members that might be a little bit farther away.

So the PRCs are really viewed as being the national leaders in these areas. We really do try to provide education, we try to participate in as much research as possible. We're very much in collaboration regularly with DVBIC as well as the TBI model systems. So there's a lot of ongoing collaboration.

All the facilities are currently

CARF accredited, except for San Antonio. We're working on it for next year. So we'll all cross our fingers, but it should go well.

All right. For the good stuff. So those are our numbers right now. We do have 2013 numbers, however, they're not finalized yet. So a little bit later on I'm going to give you kind of a rough estimate of what those look like. But the numbers that we currently have at least that are more formal are here. So since we've been open in March of 2003, over 2700 patients have received their care at a polytrauma rehab center, with 1500 being active duty, another 1200 being Veterans and 1100 being injured in foreign theater; and at least 166 with a disorder of consciousness state. Again, those are the more severely injured veterans and active duty service members.

One of the questions -- and I apologize for not having a slide on this -- was really wanting to know percentages of the different types of injuries that we were actually seeing. And so I do have those numbers, I just

don't have a separate slide which I can get for you. But what we're finding is that since we've been open since 2003, for those that have been injured in combat, at least 86.5 percent have been -- have had a brain injury of some sort. 29.8 percent have had vision loss. 29.8 percent have had PTSD. 20.1 percent have had hearing loss. 18.8 percent have had orthopedic fractures. 10.1 percent have had wounds or other sorts of infections. 9.7 percent have had other anxiety disorders. 6.9 percent have had amputations. And 1.9 percent have been burns.

So in regards to current utilization of the PRCs, what we shoot for is an occupancy rate of 85 percent. Last year we didn't quite meet this. Our average occupancy rate across all the polytrauma centers was 75 percent, but that can range anywhere from 50 percent up to 100 percent, just depending on what's going on with the war at the time or what we're actually seeing stateside.

The average length of stay is

typically about 46 days, with a shorter length of stay of 28 days for those that are maybe less severely injured. And for those that are more severely injured, such as a disorder of consciousness state, you might see more of an 83-day length of stay.

Discharge designations usually do vary a little bit; however, the majority are able to return home or to, let's say, their military treatment facility.

And one of the other questions was our referral sources. Where do most of these patients actually come from. And so we do receive most of our referrals from Walter Reed National Naval Military treatment facilities and other VAs. Obviously, SAMC is in this too. And I can tell you from the San Antonio perspective, we actually get most of our referrals from SAMC, but in regards to all the polytrauma centers combined, that is what we're duly seeing.

Okay. So to be able to provide this very comprehensive approach to treatment, you have

to have a very comprehensive team. And I've worked at other rehab facilities, and you typically have kind of the dedicated staff such as a physiatrist, rehab nursing, speech therapy, occupational therapy, physical therapy, and rec therapy. And that's really what constitutes that core team. As you can see, we actually include multiple other individuals at the polytrauma centers because there are multiple other needs.

One of the directives that has actually come down over the last couple of years is that every person admitted to a polytrauma center that has had a traumatic brain injury must be screened for visual issues. And we actually saw that in those percentages. There's a large percentage of these individuals that have vision issues of some sort, so all of our TBI patients will get screened when they come in by both a vision therapist, as well as an optometrist who deals in polytrauma-specific injuries. And so that blind -- we have a specialist as a part of our team. If they need to provide therapy

services, such as accommodation treatment or even treatment for those that maybe have lost all vision, such as blind cane training, we can actually address that as well.

We do have a counseling psychologist up on the unit to help these individuals adjust to their current condition, adjust to the transitions that they're going through. And oftentimes we'll actually start initiating PTSD treatment, even on the inpatient side of things. What the literature does tell us is the sooner that we can actually address PTSD, the better we're going to do later on, so we do try to go there if we can.

In addition to that, we do have a neuropsychologist on our unit who provides a lot of really excellent information in regards to what exactly is going on cognitively. And it really does help to drive the plan of care from the cognitive standpoint.

We have a family therapist. She's been a newer addition over the last several months. Really there to help support the family

through this process, help to provide them the counseling that they need. We do couples therapy, we do family therapy, and we actually even do child play therapy, if that's appropriate at the time. She will actually contact schools when it's appropriate to figure out how the children are actually doing in school. So it's been a very big part of our program.

We have a lot of educators up on the unit both for nursing staff, other staff, and patients and families.

Case management, I can't say enough about. They are -- they are self-explanatory. They drive this whole thing, I think.

Speaking of driving, we have a driver trainer that, if it's appropriate for some of our individuals while they're on the inpatient unit, to get their driving assessed, we do get that done while they're there. And for those of you will be coming on the tour, you will get the opportunity to see our equipment that we use. It's pretty great.

We do -- since we are collocated in San Antonio with the CFI, we do see a fair number of amputees over at the polytrauma center, and so orthotics and prosthetics are a huge part of our program. The military lesions are always a welcome part of our team. They've come over for several of the conferences that we do.

We have a wound care team to address some of those issues. We do work closely with the burn unit, and once the patients from burn unit come over, we do our best to adequately manage those wounds while they're there.

Nutritionist, pet therapy, has all been pretty important to our patients, and the assistive technology specialist is also very important. And I didn't add this, but another new addition we have is a neuropsychiatrist. And this particular individual has been extremely helpful with continuing to help manage some of those things like the sleep disorders that occur with head injury, the behavioral issues that can occur after head injury, and so we have a very, very

comprehensive team.

MR. DRACH: What about audiology services?

DR. HALMAI: Next slide. Thank you.

So in addition to the comprehensive team that we have, we use consultants all the time for a variety of different services. Several of these we use for all of our guys that come in. We use our pain clinic fairly regularly. Audiology is one that we use regularly. Chaplain services we use regularly. Some of the other services up there -- and this is one of the benefits of us being in same city as San Antonio are our active duty service members have the ability to go back and forth between the facilities to have their follow-up with their orthopedic surgeon, which I think a lot of times is a huge -- it's a huge benefit. It would be difficult to be in different cities and still get that same follow-up.

With that said, if there is a new sort of injury that comes up or if SAMC maybe wants us to take over care of something, we do

have all the appropriate consultants that are there to manage their care, but audiology is a big part of what we do there as well.

In regards to discharge, we went over this just a little bit. But at least -- almost two-thirds are able to return home or another 20 percent are able to return to some sort of military housing. So we're really looking at over 80 percent of the patients that come from the unit are able to return to some form of home environment, usually with family, sometimes the medical barracks, sometimes the Fisher house, sometimes the Powys guesthouse. Whatever is going to be appropriate for them in their situation.

All right. Now I'm going to give you a little bit more information specifically about San Antonio's Polytrauma Center. And, again, most of you will be able to get the chance to see this in a couple of days. But we are the fifth and newest Polytrauma Center, and we did our opening ceremony in October of 2010 -- I'm sorry -- 2011. We did open up what we're

referring to as a bridge unit the year before. We carved it out of one of the units of the main hospital, just to be able to have the opportunity to get our staff up and running. But the official opening ceremony was October 2011.

It is three levels and it is a combination of inpatient therapy, outpatient therapy, outpatient clinics, including musculoskeletal medicine, EMGs, our TBI clinic, in addition to our 12-bed inpatient unit. So this building is solely dedicated to polytrauma and PM&R.

We talked already about referrals, where those come from; a little bit of everywhere. And we've already talked about the types of injuries that we actually see. These are just some pictures that you guys will get to see later on. But the reason why I put these up is because I like to be able to get the opportunity to talk about how different this facility is from what you would typically expect from, let's say, a hospital setting.

And that's really the goal of this building is to not have it look like a hospital. You want this to be somewhere where people want to come and get better. You want this to be somewhere where families feel comfortable, so we try to really give it a very home environment or more of a hotel sort of feeling. So you'll see a lot of very soft lighting, a lot of very soft colors. You will not see any med-gases anywhere. They are actually tucked away in cupboards. You will not see lift systems. They are actually tucked away behind closed doors. You will not see, let's say, linen carts out in hallways. Those have their passageway that they go through. So everything is really to provide a welcoming environment that people actually want to come and stay.

So a little on the numbers for San Antonio. This is as of last month. We've had a couple more than this, but we've seen approximately 261 patients come through the Polytrauma Center. Almost half of those having

been polytrauma. The remainder have been other types of rehab conditions, such as strokes or other neurologic conditions, like Guillain-Barre, those sorts of things. Over one-third having active duty, and the average age has been about 45. And our average length of stay for polytrauma patients specifically is about 38.7 days.

So once patients have actually achieved their goals on the polytrauma rehab center, our goal is really for them to be what we call modified independent. And what that means is that they are capable of doing everything that they need to do on their own from a daily living standpoint. So they can walk, they can toilet, they can bathe, they can shower, they can dress themselves. But just because they're capable of doing those activities doesn't mean they're ready to go home or doesn't mean that they're ready to return to a living situation with their family.

And so the VA recognized this several years ago, and that's when they developed these Polytrauma Transitional Rehabilitation

Programs. What these are, there is one at each of the polytrauma sites, but they're typically a 10- to 20-bed extended-stay rehabilitation facility. So these 10 to 20 beds are more of an apartment-style living situation.

The average length of stay is going to be a little bit longer. It's going to be anywhere from one month to six months for some of these individuals. And really the focus at this point is no longer on getting them independent to do those things like bathing and dressing, but it's really to get them back out to the community again. How do I develop a grocery list, how -- what do I do when I go to Wal-Mart when there's so many different people there, it's hard for me to be in crowds, how you expect me to go shopping. Get back out there and go to movies. How do I interact with my family in a social situation. These are some of those things that we actually try to address.

In addition, we also try to go after what do they want to do vocationally later on. Do

they want to stay in the military; is that at all possible. Do they want to return to school. So these are some of the issues that we start addressing on our side and then we can turn those over to the DoD once they're ready for discharge.

With that said, the focus is really on them being very independent. And so we still support the family during this process, but there's a little less family interaction at this time. We limit the visiting hours to kind of after therapy times, just so the patients can really focus on what they need to do during the day.

MR. DRACH: I see you bring it up here under independent living. Independent living is one of the five tracks on the VA Voc-Rehab and Employment Program. What kind of collaborative efforts -- or collaboration goes on between the medical staff and the VRE staff, if they are at this point involved in the independent living services? And this may sound naive on my part, but the medical staff does the ADL training,

and -- can you just talk a little bit about that?

DR. HALMAI: Absolutely. And I do talk about this as being one of our challenges at the end. But Voc-rehab is really something that we -- some of the other polytrauma centers have been able to get an FTE specifically at the locations to be able to really start that process. It's something that we are really wanting to push for is having more vocational rehab specialists or technicians at these sites because we really do feel it extremely important. So it is -- we are in the discussions of making this a stronger collaborative effort. We're just not there quite yet.

MR. DRACH: Thank you.

DR. HALMAI: So some of the numbers for the transitional programs for FY08 to FY12. They've seen over 400 patients. The average length of stay is about 67 days, with an average age of 32. Approximately 25 percent have been OEF/OIF. And we do get female population every once in a while, so we've seen some good numbers

so far.

And regards to PTRP. Fairly similar to what we're seeing from the polytrauma centers. So we're still being able to discharge at least 84 percent to some sort of home or military housing environment. Those that might have to go to another level of care -- it might be that, let's say, they don't have any family members or they're not necessarily ready to live independent in the medical barracks quite yet. They might just need still some ongoing supervision, so they might be referred to a separate program to continue to receive some of those services; or -- you know, heaven forbid, there's a medical complication which actually occurs, which is very infrequent, but they may have to return to the military treatment facility for additional care.

In regards to vocational outcomes. So this is something that they looked at, you know, later on down the line after a group of individuals had actually gone through. And I think these numbers actually say a lot for this

program. But at least two-thirds have actually been able to sustain some form of employment, whether it's remaining in the military or moving on to some other form of vocation. And least -- or around 6 percent have been able to go on to be students. My experience, at least more recently, has been that student piece of the pie has actually grown even a little bit more than that, so it's a fairly successful program.

MR. DRACH: I'm sorry. I'm impressed with the 66.7 percent who are employed. Are you doing any tracking within that? Are you doing any longitudinal or will you be doing any longitudinal studies?

MS. HAMAI: I do think that that is the plan. This is actually from central office, so I could actually find out what their long-term plans are in terms of following these individuals, and hopefully have that for you on Thursday.

MR. DRACH: Thank you.

DR. HALMAI: So just like I gave you some numbers for the San Antonio Polytrauma

Center, I also wanted to give you some numbers for the Polytrauma San Antonio Transitional Facility as well. So this is one of our new buildings. And it's a standalone building, it's approximately two miles away from the VA facility. And, again, it is ten individual rooms, plus two independent apartments, with shared areas like a kitchen and those sorts of things.

So far -- we've only been open since April of 2013 for the San Antonio Transitional Facility, and we've admitted a couple of more since then, but at least as of last month, we had admitted 21 unique patients. And the average length of stay of 62 days. The average age was 34.6. Half active duty, half veteran population. And most of those have been polytrauma. But we will admit, let's say, somebody who sustained a stroke that still had ongoing cognitive deficits.

Most of the admission criteria for kind of meeting the requirements to be admitted to one of these transitional programs are, you must have had ongoing cognitive issues in addition to

probably a behavioral component. And we can actually address both of those aspects.

So as promised, even though I didn't have official numbers for 2013, these are kind of some of the unofficial numbers. And this will just show you by site the number of unique patients that were admitted to both the Polytrauma Rehabilitation Centers as well as the transitional programs. And so far, FY13 it looks like there's been a little over 300 admitted to the PRCs, and a little over 180 admitted to the transitional programs. So still fairly good numbers we're seeing so far.

So now we've gotten to the point where we've addressed not only their inpatient acute rehabilitation issues, but we've also addressed some of the issues with returning to the community or the environment to live independently. So the VA also has these outpatient programs, and so the polytrauma network site clinics are this very comprehensive outpatient program that has a very similar team to

what we see on our inpatient polytrauma rehab center. They have all those same individuals with therapies and family therapy and psychology. And those people meet on a regular basis to discuss our outpatients as well.

There's about 23 in the nation. Each VISN tends to have their own, some VISNs have one or two. The polytrauma centers are kind of the regional leader for education and research. The polytrauma network sites tend to be the leaders from the VISN level. So you'll get lots of referral questions, lots of questions about appropriate types of therapies. They're all accredited as well.

Our main referral source for bringing patients into the polytrauma network site clinics stems from the screening tool that we're currently using to screen all the individuals that come into the VA for mild traumatic brain injury. And I'm sure several of you are very familiar with this screening tool.

So this screening tool actually came

to be in about 2007. And basically the mandate is any OEF/OIF veteran that comes into the VA system must be, screened for traumatic brain injury. And so since 2007 over three-fourths of a million have actually been screened for mild TBI at this point in time; so we're doing a very good job of getting these people in. Approximately 144,000 have screened positive to these four questions, and have actually agreed to follow up.

So these four questions don't necessarily commit somebody to having had a head injury, but it's basically just saying you are at risk for having one. You were in the right situation, you maybe had some symptoms afterwards, we need to look into this a little bit more. And so after again 2007, 108,000 have actually completed those comprehensive evaluations and 62,000 have actually had a confirmed diagnosis of mild traumatic brain injury, which keeps us in this 8 percent range. That's 8 percent of those returning have had a -- they've been at risk for mild traumatic brain injury, so we're still seeing

those same numbers.

MR. DRACH: I may be getting ahead of you. Once you have that confirmed diagnosis of mild TBI, what are the next steps? What do you do?

DR. HALMAI: We will talk about that.

MR. DRACH: Okay.

COL MALEBRANCHE: Before you head on, one thing I thought was interesting to -- or to note is, DoD and VA have the same screening tool. And that was very important to have those same four questions. I remember when this first started, and I know that DoD uses this in a lot of their post-employment assessments. Do they refer the positive screenings to VA from those activities or how -- do you get referrals DoD directly, I guess is what I'm asking.

DR. HALMAI: Not usually. Every once in a while we'll receive a referral. Typically since SAMC has a very excellent TBI clinic, most of those positive screenings would

probably be referred down to the TBI clinic there. Or, for example, at Fort Hood, they have a very excellent TBI clinic up there as well, so they might actually get referred over there. So it's very rare that we will actually get an active duty referral into our Polytrauma Network Site Clinic. We're more than happy to do, with TRICARE authorization, those sorts of things; but typically, those are taken care of on the DoD side.

EXECUTIVE DIRECTOR DAILEY: And really quickly, Ms. Halmai. This set of statistics is -- I'm sorry. On the previous page on page 27. It is VA-wide, it's not just here in San Antonio.

DR. HALMAI: Correct. This is VA-wide.

EXECUTIVE DIRECTOR DAILEY: Okay.

MS. HAMAI: And even though I talked about the Polytrauma Network Site, this isn't specifically for the Polytrauma Network Site Clinic, this is all of those Level 2 through Level

4 polytrauma clinics that we talked about before.

CO-CHAIR CROCKETT-JONES: I just want to point out that if someone who enters the VA Health System who comes in with a diagnosis already in place does not necessarily move on to comprehensive evaluations. There is an assumption that that is done at the DoD when they are screened and found -- and diagnosed. But although the screening tool's the same, the evaluation is enormously different in what is evaluated between DoD and VA. So I might suggest that it's probably not a very large number, but those who come in already diagnosed with mild traumatic brain injury might -- if there were a way to TAG them to get a second evaluation since the VA's evaluations is much more comprehensive.

DR. HALMAI: And believe it or not, the majority of those people do get actually rescreened when they come into the VA system. And so I can't even put a percentage on it right now. I could probably get it for you for Thursday to tell you how many of the people that we have come

in for comprehensive evaluation who have been previously diagnosed TBI from the military. So we actually do see quite a few of them. Yes, ma'am. We sure do. And they -- they will get treated exactly the same way that somebody who had never had a diagnosis before does.

COL MALEBRANCHE: I think that's actually where I was -- I recall when we were visiting on the site visit there was some discussion -- and maybe it was Guard and the Reserve that was getting referred to the VA, but that they had been screened in DoD, didn't realize that they were screened again and evaluated. So I wonder, not necessarily like an MTF, but this is like a Guard or Reserve unit coming home and said, "Oh, yes, I got my TBI care from the VA." I was wondering how that transition occurred.

CO-CHAIR CROCKETT-JONES: I don't know if they get rescreened.

COL MALEBRANCHE: This is a different --

CO-CHAIR CROCKETT-JONES: Yeah.

MR. YACKEVICZ: My name is Tom Yackevicz. I'm the program director for Polytrauma. I just wanted to add that since we opened up our PNS, we are fully staffed now. When they come in the -- our PNS site, the coordinator does a screening in two categories: Newly diagnosed/previously diagnosed, and they do try to obtain those medical records, if possible, if they can whether from Reserve National Guard or from SAMC, wherever; but they put them into two different categories.

If they're previously diagnosed, they're going to look through those records and then redo the screening all over again to find out what level they're at and reintroduce them to speech pathology or cognitive therapy.

CO-CHAIR CROCKETT-JONES: I think this is also just happening because people get -- when they retire, don't necessarily go to a place that has the polytrauma cells or the programs, or even a TBI clinic within a reasonable scope. And there isn't necessarily a whole lot of

automatic -- you know, they might fall off on the visual because -- they're diagnosed, but they're in a place where there is no particular treatment or dedicated group. And this is just something that I personally noticed.

And I've been wondering if that marker, that diagnosis, for instance, just having written medical instructions for someone with mild traumatic brain injury who has a problem retaining their instructions between the office and home, if there was a marker on a file that says "MTBI" I've got to print out -- I've got to write it down, I've got to write it down, print it out. This person can't just be given verbal instructions, because they might not retain them, things like that.

I don't think anything like that has -- is happening. Certainly I know it isn't happening in the civilian world, but it's just something I have noticed at -- in my new sort of visual of the VA.

DR. HALMAI: And this might be --

maybe our clinic has a potential for a best practice, but our medical director for our outpatient clinic, we do have a comprehensive form that every patient gets when they leave the office, and it tells them exactly what -- what their follow-up is actually going to be. We actually try to get the clinic appointments already in place for them by the time they leave, because we know that there is a huge likelihood, a lot of times, for them to maybe forget about their appointment or not show up.

In addition to that, they're going to receive other phone calls or other letters in the mail, but we try to give them at least something physical before they leave that tells what was talked about and what appointments are going to be set up for them.

And we do so for even those individuals that might be out where there's not an actual Polytrauma Network Site Clinic, but maybe more of a point of contact site. There are several conference calls that go on regularly

between the sites within the VISN, so that these other locations out there know that we're still here. So if you still have questions regarding somebody or if you'd like for to us to evaluate this person, if it's maybe a little bit more of a difficult case, we're always open to being helpful in whatever way we can.

All right. So this just kind of shows the numbers that we've seen over the years. Again, this is nationally for the polytrauma clinics, but the numbers have gone up every year. This year is a little bit off from last year, but the numbers keep -- they've kept going up.

So just a little on our specific Polytrauma Network Site Clinic here in San Antonio. Again, it's really dedicated to mild to severe traumatic brain injury, plus other polytrauma injuries as well. Again, it's a very aggressive, comprehensive program that involves all of these same individuals that we discussed before. The consults are received as a result of the positive TBI screening. Because, you know, we

are a Military Town USA, we do see a large number of veterans come through our doors here, and so right now I think we're third nationally for seeing the number of patients in our clinics.

And this is to answer your question, sir. So the tool that we actually use to provide this comprehensive evaluation is the Neuropsychological Symptoms Inventory that actually reviews all of these different symptoms that may or may not be related to head injury, but they're at least symptoms that these individuals are actually experiencing. So headaches, dizziness, visual issues, sleep problems, hearing loss, concentration, mental health issues, sleep disorders. All of those things will actually get addressed in our clinic. And, again, we're going to address these issues regardless of if they had a confirmed TBI diagnosis or not. What we do know is regardless of that, these symptoms still need to be treated and so we're going to get them what they actually need.

MR. DRACH: Are you seeing a

relatively high reception of getting treatment from the ones that are being diagnosed?

DR. HALMAI: Absolutely. What we usually hear when people come into our clinic is, "Where has this clinic been?" You know, "Why haven't I gotten this care somewhere else before?" "This is what I've been looking for."

Those are some of the things that we hear commonly. So for the most part, these guys are just glad that somebody is listening to what they're experiencing right now. And then to also know that they can follow up with us, but we're also going to discuss their case in an interdisciplinary approach so that all of those team members are going to sit down and discuss their care together.

But there's just something about -- and I'll talk about this at the end a little bit, but there's something about knowing that you have a team working for you as opposed to one provider. That makes a really big difference. And, again, our goal, similar to the PTRP, is community

reintegration. We want to see these guys back to work, we want to see them back to school, and we actually have other programs right now where we're trying to implement really making this a reality.

So these are some of the more local numbers right now. So as I said, the numbers for FY13 are a little bit lower this year. It's about 50,000 we've seen. San Antonio has seen about a thousand new patient consultations over the last year, and we've seen -- we've done approximately 6600 encounters over FY13.

So I'm going to transition now over to the topic of transition, and I'm going to talk a little bit about the -- some of the national programs that are in place right now to hopefully help out with this transition from active duty to VA, and then I'm going to end a little bit more with what I think maybe we're doing well in San Antonio, in addition to what some of the other Polytrauma Centers or PNSs are doing as well.

And I know you are very well aware of this. This topic of transition is not

something that just -- you know, that myself and the clinic worries about, but it's worried about on all sorts of different levels. So Secretary Shinseki really has some goals in mind to make this transition from active duty to the VA as smooth of a process as we actually can. And the majority of it does involve just interagency communication, collaboration, developing a sustainable model that's going to be able to last over a period of time.

One of the things he did talk about is this idea of a Lead Coordinator. And I'm going to go into that just a little bit more, after -- I'm going to actually start with the liaison program, though, because it's been around a little bit longer, and I'm sure a lot of you are well aware of this.

But in 2003 the VA the DoD developed a partnership. And so social workers and nurses are actually embedded at the military treatment facilities. So here in San Antonio I believe we have about four that are embedded, not only

inpatient but output at SAMC and at the CFI. And so, again, their goal is to try to assist with transitioning these active duty over to VA status.

This is just kind of a representation of what potentially an output flow would actually look like from the active duty side over to the VA. This would specifically be for the Polytrauma Network Site Clinic, and then I'll talk a little bit more about what our transition looks like on the inpatient side.

But typically, the initial contact is actually going to be made by the liaison on the active duty side after a referral is made by the DoD case manager. At that point, the liaison will actually touch base with the veteran or the active duty service member or the active duty service member and the family. They will actually get them in contact with OIF/OEF/OND office at the VA. They're going to set up appointments with them, and then they're going to come in and do some of the screening tools, such as the TBI screening tool, the PTSD screening tool, the depression

screening tool. And as a result of that, they will actually get referred over to those appropriate clinics. The appropriate consults would be put in place.

So in our case, if the TBI clinic reminder is positive, they'll actually get -- they will be contacted by the polytrauma team and will actually be scheduled for follow-up. And this just talks about what happens when they get into our clinic, which we've already talked about a little bit.

The inpatient process I didn't necessarily include because it really is kind of a case-manager-to-case-manager handoff. But for our inpatient process, the liaisons are involved. What happens is, they actually have access to the report, so we do know when there's a potential referral coming our way.

Once we've actually received a referral from the case manager at the DoD, the liaisons will actually touch base with the patient and the patient's family, provide them with some

education regarding the system of care. They would then try to set up something like a tour for family to come over and view our particular unit. They do help the case managers set up transportation, lodging, those sorts of things.

Once the active duty service member is transitioning over to our inpatient program, our case manager kind of takes over at that point. They do a really good job of staying in contact with the liaisons -- the military liaisons as well, as well as the case managers on the active duty side, giving them weekly updates, if not daily updates, making sure appointments are kept, making sure that we're reviewing benefits and resources with them, even on the Veterans side of things.

Discharge planning early on. We've got to start those talks early only so that we know what to plan for later on. And obviously, just providing good family support.

And then after that, again, there's another warm handoff back to the case manager at

the military, and then the service member will then transition to the WTB typically.

So this is just a little bit on our liaisons and why they actually are important. But really for the most part, it's just to coordinate, collaborate, and educate patients and families as they're transitioning into the VA system.

COL MALEBRANCHE: On the previous slide that shows the OND/OEF/OIF Veteran, but active duty would be the same. Right? The same process, active duty would get referred and be seen and evaluated.

DR. HALMAI: Absolutely. I'm just basically referring to that particular person that's transitioning through that process.

COL MALEBRANCHE: All active duty or future veterans.

DR. HALMAI: Exactly. Yes, ma'am.

And so I'm just going to move into a little bit on the Lead Coordinator role and -- make sure I have enough time here.

And so this is the topic that has

been kind of probably the most recent program that has come up. I'm pretty sure it's up and running in some places. It's not quite up and running yet in San Antonio, but there's a lot of talks going on right now as to how we're actually going to make this work.

But basically, we are not hiring any new FTE for this program, we're basically taking all the case managers that we currently have and making them a point of contact. Because traditionally what would happen is a service member might have ten different case managers for ten different clinics, and that just makes the whole process extremely confusing. They need a point of contact at DoD, they need a point of contact at the VA, and then they need another point of contact back at the DoD again just to make this handoff very smooth. And that's really what this Lead Coordinator role does.

So the Lead Coordinator would be initially the case manager at the MTF. There is a check list that must be filled out to make sure

we're addressing all the needs of this patient and the family. When they're actually transitioned over to the Polytrauma Center, the Lead Coordinator is now the case manager at the VA. And, again, this check list is gone back over again to make sure we're keeping track of everything that needs to be kept track of. And then again when they transition back to the DoD again, that lead coordinator role transitions back over to the DoD. So really, at any one point, they should only be having one point of contact to where they can go and actually get their questions addressed.

And this checklist is pretty comprehensive. And part of it is actually this Interagency Master Comprehensive Plan. That really addresses multiple areas, such as career, daily living, family, finances, health, legal, military, and spirituality. So it's fairly comprehensive. And I'm assuming that we will be starting this sometime in the near future.

So I did want to add a little bit on

what I feel like our best practice is, at least for us locally. And this isn't just unique to us here. Other places are doing this as well. I did mention the Lead Coordinator as being a best practice because I do think it's going to be something that is going to be very helpful. We do a lot of video teleconferencing. And this is not only when they're actually transitioning into our unit, but also when they're leaving our unit.

There is -- I can't say enough about the ability of the patient and family, as well as the teams, to be able to talk to each other before that transition actually occurs. Setting up those expectations, answering those questions, making sure that family and the patient have all the information they need before they actually get to our door. It's extremely important. And the same when we're actually transitioning somebody somewhere else. We want to make sure that the patient has all of their questions answered, that there's really not anything that's kind of hanging out there that's going to make this transition

difficult in any way. So detail is extremely important.

We have an awful lot of family meetings just kind of keeping everybody on the same page at all times. I think that's very important for transition. We do a lot of tours for families. We feel like it's very important for them to know where they're coming, be able to answer some of those questions, make sure they feel comfortable with where their family member is going.

Part of the Polytrauma System of Care. We also have our own document called The Reintegration Plan of Care. It's a very comprehensive document that actually discusses all of their therapy needs, their medical needs. And so this is actually done seven days before discharge. It's a document that can actually travel with the patient wherever they're going, whether that be to another VA facility, whether that be back to the DoD, to the TBI clinic over at SAMC. This document can travel with them wherever

they go. It tells them kind of what they've been doing and where they're at now and what their recommendations are in terms of ongoing rehabilitation care. And then in addition to that, like I said, we do use the liaisons.

Our transitional facility right now is actually doing something with families that are -- I do think it should be a best practice later on down the line. So as I said before, the goal in the transitional facility is independent living. So there is less family involvement, but at the same time, you still need to help those families with this transition. It is very difficult for them.

So this is basically once a week. They get several hours of supportive services, discussions on resource management, caregiver support, TBI education. They get to actually sit down with what we refer to as our lead therapist and discuss the process of where their loved one is at, and just regular family conferences. So I do feel like this is actually a very good best

practice.

And I'm going to end on this slide, because this is what we do. And this is -- you know, this is actually why we do what we do. This is actually a service member. And I feel like this particular service member says a lot about how the VA and the DoD work really closely together. This was a service member who was injured by an IED about a year and a half ago. He stayed with us for approximately four months on our Polytrauma Center. He had a severe traumatic brain injury plus a spinal cord injury, plus multiple fractures. He did not take "no" for an answer. When he was told that he would probably not walk again, he said "That is not good enough."

And so he has continued to get therapy services, both through the DoD and the VA. He gets his pain management through the DoD; he gets his spinal cord injury services through the VA. Lots of really excellent coordination between the two facilities.

His two main goals were to -- he

wanted to walk down the aisle for his best friend's wedding, which he's already done that. And he wants to walk down the aisle for his own wedding, which will hopefully happen within the next year or so. He wanted to wait until his fiancee finished school, which is very responsible of him. So he's doing very good.

But as I promised, I did want to actually mention a couple of the things that I feel like are maybe areas that we still can work on a little bit more then it comes to transition. And I know most of these things are not going to be new to you all, but I'm going to say them anyway.

But electronic medical record is still very difficult. I know there are a lot of opportunities out there where different sorts of systems actually are being looked at. We do use remote data an awful lot to try to obtain information, but that can be very difficult in regards to obtaining inpatient information sometimes. Some of us do have access to a

centrist, but there's just multiple different systems going on and it's just very difficult sometimes to actually get the information that's needed. And I do know that that's something that is being worked on. Regardless of all of that, even though those are issues, the communication between the case managers, we always get the information that we need.

One of the issues that we ran into early on when we were first starting the Polytrauma Center was almost a lack of education on what the VA actually did. So active duty service members thought that the second they entered the door of a VA, they were going to become a veteran. And we had to do a lot of education about, you know, we're just part of your rehabilitation care. But part of that is also there's turnover that occurs on the DoD side, so just constant education and going back over. And we have this down to a science now where we know when there's new people coming in, we go over, we give a new presentation, but it was a learning

process, in the beginning, just making sure we're getting all the appropriate education out there to make sure this transition happens the best way.

Community reintegration is something that is just a huge goal for everybody. And it still has its issues but the VA is looking into some other programs. Increasing the vocational rehab component to things. We actually have a pilot program going on right now through the utilization of health coaches, which we're really hoping is going to be helpful in regards to helping these guys establish some of their own goals because that's really where we run into some of those problems is, they almost -- they're almost not able to come up with their own goals anymore.

A universal formulary would be something that would be really great one day, just because we do have different formularies but it is something that would be helpful on both the inpatient and output side.

And finally, I did mention this

before. This interdisciplinary approach to treating patients. I feel, in my personal opinion, it shouldn't just be inpatient rehab or it shouldn't just be outpatient rehab, it should really be for almost any specialty out there. It should be in pain clinics, it should be in primary care, it should really be everywhere. Because that -- like I said, when patients know that they're actually being managed by a team, there is so much more buy-in and I really think we'd actually see a very successful process.

So that is all I have.

CO-CHAIR CROCKET-JONES: Any questions from the Task Force? Okay.

A question about your family conference day that you have every Friday. Is it -- how do you -- is it mandatory for families to be there? How much buy-in do you have? Are the families there?

DR. HALMAI: That is a really good question. It's actually fairly new so the buy-in so far has been really great. I don't know what

it's going to look like long-term though. It is absolutely not mandatory, it is very optional. And what we're actually looking at doing is opening that up to our polytrauma families as well, so that, again, there's more collaboration amongst families, they're talking to each other a little bit more. Families will talk to each other more so than they'll talk to family therapists sometimes, so really getting them all together. So the buy-in has been good so far. I'm just not sure what it's going to look like later on down the line because it's a very new program.

CO-CHAIR CROCKETT-JONES: Thank you very much for your time, and we look forward to seeing things later. Thank you.

And I think we have a few minutes. Maybe 10 minutes till our next briefing, so at 2:15 back at the table. Thank you.

(Whereupon, the foregoing matter went off the record at 2:03 p.m. and back on the record at 2:20 p.m.)

CO-CHAIR CROCKETT-JONES: We now

welcome Air Force Tom DaLomba. Am I correct?

Maj DaLOMBA: Yes, ma'am.

CO-CHAIR CROCKETT-JONES: The 59th Medical Wing Patient Squadron Section Commander. Major DaLomba will discuss his Wounded, Ill, and Injured population, family assistance, and unit staffing. Please turn to Tab M to view Major DaLomba's information and briefing information under Tab M.

I'm going to turn it over to you so you can introduce us and start us down this path. Thank you.

EXECUTIVE DIRECTOR DAILEY: And I'm going to interject just a little bit here for my members' situation awareness.

We've got Major DaLomba here because the first thing you do, ladies and gentlemen, tomorrow morning, those of you going with us on the site visit is we will go straight to his patient squadron and we will set up for a focus group. So there won't be any new briefing tomorrow morning, there won't be opportunity to

get a feel. This is the feel, so feel him up.

(Laughter.)

Maj DaLOMBA: All right. On that note, good afternoon, ladies and gentlemen. My name is Major John DaLomba. I'm the Section Commander of the 59th Medical Wing Patient Squadron at Joint Base San Antonio Lacklund and Wilford Hall Ambulatory Surgical Center. And here with me is Lieutenant Colonel Bill Fecke, who is the 59th Medical Support Squadron Commander, and also the 59th Patient Squadron Commander at Wilford Hall as well.

Let me just start with the mission of our Patient Squadron. Our mission of the 59th Medical Squadron is to provide administrative oversight and supervision to wounded, ill, and injured active duty and Reserve Component airmen through their recovery, rehabilitation, and reintegration. The 59th Medical Wing has the largest patient squadron in the Air Force.

I have a data-heavy slide here, so we'll take a look at some demographic

point-in-time data from the 5th of November. On that date, we had a census of 55 personnel. So this is a typical profile for our unit. We typically range between 45 and 65 personnel between those who have PCS or are assigned to us, and those who are TDY who are attached to us.

On the upper left graph, you can see the breakdown between wounded, ill, and injured. The wounded number of nine consists entirely of combat-injured personnel. Combat-injured personal tend to have a combination of orthopedic, neurologic, and some mental issue as well. In the ill the injured columns you can see the breakdown there as well. Also not included in this slide are non-battle ill and non-battle injured personnel, and we have five of those as well.

In the upper middle graph, you see the break down between our assigned PCS and attached. As of this date, we have 41 assigned and 14 who are attached TDY to us. As far as the breakdown of married versus unmarried, 25 of our assigned are married and/or have children, and 16

did not. Five out of the 14 TDY personnel also are in the married group. And that breaks down to 61 percent for the personnel who are assigned to us, and 36 percent for those who are attached to us.

Taking a look at the Staff-to-Airman ratios here. You can see the breakdown by discipline. Our nonmedical care manager. The nonmedical care manager is employed by the Warrior Care Support Branch of the Air Force Wounded Warrior Program located at JBSA Randolph. We have one nonmedical manager who actually sits in our office two days a week. The benefit of this -- and you've heard about nonmedical care managers from previous briefings.

What's nice about having them all at JBSA Randolph is that we have a proximity to them and can actually come down to our unit from time to time. It's very helpful to actually have somebody on site from that unit. And the Staff-to-Airmen ratio for that is 40 to 1.

The next column is our medical case

manager. I'm going to break down staffing our patient squadron staff level a little bit later. The ratio for medical care case manager is 37 to 1, and that is 55 personnel to 1.5 FTEs right now. And, again, I'll talk a little bit more about that.

For administrative personnel, these are the people who answer the phones, who manage the rosters, and things like that. We have two contract admin personnel that it breaks down to 27 to 1.

Recovery care coordinators also work for the Air Force Wounded Warrior Program. There are three recovery care coordinators located at JBSA of the 43 that are regionally located throughout the world really. And the breakdown is 25 to 1 there.

For the last four columns you can take a look at our active duty and GS civilian staff. We have an active duty Tech Sergeant, an E-6, who serves as the direct frontline supervisor for all the E-5s and E-6s. We have a Staff

Sergeant who is the direct supervisor for all the E-1s through E-4. We have a GS-11, who's a retired Air Force Senior Master Sergeant who is the supervisor for the Senior NCOs, who are currently all Master Sergeants. And then I serve as the supervisor for all the officers. And as of this day, they're all Captains.

The average length of stay for our assigned personnel is 370 days, with a range of 23 to 1230 days.

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

Maj DaLOMBA: Yes, ma'am.

CO-CHAIR CROCKETT-JONES: The practice at your location, what is the difference in duty performance from your nonmedical care manager and your recovery care coordinators? How are they different?

Maj DaLOMBA: Thank you for the question. A nonmedical care manager is primarily looking at personnel benefits and entitlements, financial needs, employment, education, and

connecting personnel with needed resources, where the recovery care coordinator is primarily responsible for the comprehensive recovery plan, coordinating the medical and nonmedical services, minimizing gaps and delays in treatments and services.

There is overlap between the two. I'm going to -- when we get into the best practices slide, I'm going to talk a little bit more about how we all come together so you can see how we communicate and coordinate.

There is overlap between the services, however, we do have an RCC located in our office as well in addition to a nonmedical care manager who's there for a couple of days of week. So we're able to communicate and we can actually divvy out responsibilities. We also huddle on a daily basis. And this has also helped us so that we can make sure that nobody's stepping on each other's toes.

EXECUTIVE DIRECTOR DAILEY: And let me interject also. The DoDI does separate out the

duties for a nonmedical case manager and an RCC. The position gets blended in many other locations. So here they have managed to kind of peel away the nonmedical case manager duties and the RCC duties. The Navy has tried -- I'm not sure where they're at with it now. Marine Corps, their section leaders kind of do the nonmedical case management piece, and the RCCs do the overarching transition, and move them down the road, create a plan. The Army has a lot of those nonmedical case management and RCC duties invested in the squad leader.

Maj DaLOMBA: All right. So next we'll take a look at how personnel get to us. So bottom line, airmen are either aeromedical evacuated to us or they're not. Communication typically begins through the RCC chain. Casualty reports would flow through the RCC, who in turn communicate this to the Patient Squadron. This is often how we first learn of personnel who are injured or ill.

For air evac personnel, the Patient Administration Department at SAMC and the

Aeromedical Staging Facility Wilford Hall Ambulatory Surgical Center will communicate air evac status, estimated time of arrival, et cetera. A flight will typically land at Lacklund Air Force Base -- actually Kelly Field or the San Antonio International Airport. The member is transported to SAMC and is met there by an RCC when they arrive. The RCC will arrange lodging, transportation in the event an Airman is not admitted following medical triage.

If inpatient, the member will remain at SAMC or be transported to another facility where, they'll receive their inpatient care. If they're outpatient they'll receive follow-up appointment information and receive transportation to lodging, typically on or near the SAMC campus.

If they aeromedical evacuated from the AOR -- this is for combat-injured and non-battle ill and non-battle injured personnel. They are automatically attached to our Patient Squadron and become TDY to us automatically, with the exception of the personnel who are remaining

overnight. And even with those people, we'll keep an eye on them, because if their overnight stay turns to something a little bit longer, then obviously, we'll attach them.

Generally speaking, we'll attach our -- attach our personnel to the Patient Squadron if their TDY is expected to last at least 14 days. For non-AOR air evac and all other personnel, the Chief of the Medical Staff at the 59th Medical Wing is the approval authority for assignment to a Patient Squadron. This involves communication between the losing and gaining SGH, and also an accepting physician at JBSA.

We also prefer if they have family in local area. From the point-in-time data that I gave you of the 41 assigned personnel, 14 did have family -- or do have family in the San Antonio area, or at least within a day's drive of our location.

We also look to see -- if we think there's a reasonable expectation that they may return to duty, that their AFSC -- I'm sorry --

the Air Force Specialty Code is located at JBSA as well. This can, in many cases, prevent an additional PCS for these members, which is helpful.

We begin tracking personnel once we're aware that they're coming to Joint Base San Antonio, and this prevents the surprises that we don't like. We've already developed a checklist that we've distributed to the SGH community through the AFMOA chain which we developed to address the needs of the SGH community, many of whom we discovered weren't necessarily familiar with how to transfer a person to a Patient Squadron. The checklist has a lot of common issues and it answers about 90 percent of the questions, and it fosters communication between the losing and the gaining MTFs as well.

So next I'll talk about how we keep informed about the needs of our airmen and their families. The most important thing that we do in the Patient Squadron is communicate with one another, and I mentioned that a little bit

earlier. Our biweekly interprofessional case management meeting is a formal, structured meeting during which the entire team discusses pertinent medical, nonmedical, and administrative issues. We review every member on the unit and use the input to update our roster.

From the administrative side, we have the Patient Squadron leadership, which includes the member's supervisor and commander. There we address any administrative issues that are going on with the Airman.

Our Physical Evaluation Board Liaison Officer will provide updates on progress through the Integrated Disability Evaluation System. For the medical side, the medical care manager is really the lynchpin and the vital link to this meeting. The vital link to all three components here, the medical care case manager will also present the case and discuss the medical information and then go from there.

The Chief of the medical staff, as I indicated earlier, is the approval authority for

personnel who will PCS to the Patient Squadron. The SGH also sits on the Deployment Availability Working Group, which will assign a Code 37 to these personnel, which will begin the Medical Evaluation Board process. And also it's important that this person is involved with the more complex issues that we see, just with respect to referrals and other complex medical things that are taking place.

All of our personnel have a primary care manager through the internal medicine clinic at Wilford Hall. We did this because a lot of our folks have very complex issues that we're dealing with -- complex medical issues, and we discovered that the internal medicine physicians were the physicians best suited to service PCMs for this population.

In addition, at this biweekly meeting we have an internal medicine liaison who's present, and we can actually do PCM assignment at this meeting saving the member an in-processing step when they actually arrive to our unit.

From the nonmedical side, you're familiar with the roles of RCC and the nonmedical care managers, so I'm not going to go through that again. But beginning in July we were assigned a chaplain resident. The San Antonio Military Health System does have a chaplain residency program. This person has been a tremendous added value to our unit. In addition to the pastoral care and a level of support that this person provided that nobody else on the team really can provide, the chaplain also provides privileged communication to our members.

As I mentioned before, communication between the losing and gaining Chief of Medical Staff is critical. This flows down to communication between case managers and RCCs as well. We conduct daily huddles with the Patient Squadron staffs, including the RCC and nonmedical care management. We're all in the same office, so that's very helpful where we can actually all get together and make sure that we're all meeting their needs.

We also have frequent communication with Air Force Wounded Warrior Program, who are 25 miles away at JBSA Randolph. And we can discuss personnel pay issues, benefits, entitlements, and they also are responsible for the assignment of a family liaison officer for our seriously injured or our very seriously injured personnel.

So let's take a look at some of the additional assistance available to families. As I mentioned, the RCC establishes and maintains the comprehensive recovery plan, which covers a lot of the needs of the member and his or her family.

Other sources of assistance available include the First Sergeant, who really is our first line of support whenever we're dealing with an issue with a family. That's our go-to person.

The chaplain I mentioned earlier. A tremendous value at having this person there. The airmen & Family Readiness Center is located on JBSA Lacklund, and on every Air Force installation they offer a number of support services as well.

From the Army briefing earlier this morning, you heard Colonel Edwards talk about the Warrior & Family Support Center. SAMHS includes SAMC and Wilford Hall, as we heard from yesterday's briefing. And so our personnel are also allowed to use the Warrior & Family Support Center as well.

We've actually had a number of events over at the Warrior & Family Support Center. We've had several Commanders Calls over there and -- in the past we've had three. And so just to make our airmen aware that that resource is available to them.

We found that people who actually receive care at SAMC, typically at the Center for the Intrepid, are familiar with it, but the people who are primarily at other locations, most likely at Wilford Hall, they're not necessarily aware of this great asset.

Military Family Life Assistance Counselors can offer private, confidential counseling services to DoD beneficiaries. We've

actually had these people speak at our Commanders Calls, and we're actually having them speak at our next one. And also, Military OneSource is another source for counseling and assistance.

We really use a recovery team concept. The staff, the RCC, the case manager, the nonmedical care manager and the organizations above, we all work together to make sure that we're addressing families' needs at the time that they need them.

So next we'll take a look at our In-processing and IDES briefings. For In-processing, about 40 percent of our married airmen will attend the initial in-processing appointment with their spouse. This doesn't include all the other little things that have to do with an in-processing, getting short records and things like that. We're talking specifically about initial briefings with the supervisor, with myself, and also with Colonel Fecke.

We developed a welcome packet that contains a letter which clearly delineates the

chain of command, and also the roles and responsibilities of different personnel who they will interact with; specifically the medical case managers, the RCCs, and the nonmedical care managers, in addition to a summary of our common policies just to set the expectation up front just so that people understand kind of what the guidelines are.

When our in-processing personnel meet with the supervisor and with me, we go over that letter pretty much word for word, just so that they understand what we expect, and so then we can answer any questions they have. At the initial IDES briefing, about 50 percent are accompanied by a spouse or a family member.

At the MEB section we will encourage family member attendance especially for members with cognitive issues. The RCC and nonmedical care members also will try to encourage spouse involvement at this meeting as well. In addition, the RCC will attend in the absence of a family member if that person is not available to attend.

Next, we take a look at support groups. As I mentioned earlier, our personal receive care both at SAMC and Wilford Hall. I've listed some of the support groups, specifically for cancer and PTSD, which are two of the common diagnoses that we see. But there are other support services and support groups through the airmen & Family Readiness Center, which are listed here. Financial management, bereavement, new parent support, caregiver, and also play groups which are really important for families with young children.

Other support services that are available to our folks. The United Way and 2-1-1 Texas-Connecting People and Services offer a number of support groups for family members. In addition to the National Resource Directory, which we usually will utilize the nonmedical care manager to access services through that.

I mentioned the Military OneSource, the Warrior & Family Support Center, and then Military & Family Life Assistance Counselors

earlier. And also the Wilford Hall auxillary offers play groups as well for our families with young children.

We do maintain a continuity binder so that we can actually encourage attendance at support groups for personal who express an interest in that. On that note, we haven't really tracked closely the utilization of support groups for our family members. However, beginning yesterday, we started a Unit Climate Assessment, which is going to run through next Friday. With Unit Climate Assessments, we have the opportunity to develop multiple questions, and we actually ask at least six specific questions of our support group about a desire to attend them, would you like to be notified of them as well. So once that UCA wraps up, we'll actually have some information on that.

Moving on to best practices. We've updated our in-processing requirements. I mentioned the welcome and orientation packet. And this was actually developed as a result of

feedback from some of our members who were saying, "I don't know who my supervisor is", "I don't know who I go to for this," "I don't know who I go to for that."

So what we did is we -- like I said, we listed specifically what they were, and that way we were able to get them -- to present it up front to our personnel so that they would actually have answers to the common questions there.

We just started doing this in May, and so we made a concerted effort to reach the people who have actually been with us for a longer period of time to meet them as well and actually have them sign off that they had read this as well. We do set an Airman First expectation and we do this to let them know that they're still part of a team. They're still part of the Air Force team, they are still valued members of the Air Force family.

The direct frontline supervisor piece that I mentioned in one of the earlier slides is really about a new development as well.

We started doing that in about May or June. And it helps me as the Section Commander to know that I can go to one person to address a need with a particular individual, but it also helps the members because they know who they can go to, really with any issues. And then we can certainly go from there.

And I mentioned the interprofessional case management meetings. This has really been a huge thing. Like I said, the meetings are biweekly but we have a smaller meeting on off weeks in which not everybody attends. It's usually minus the SGH and internal medicine, but everybody else can attend, case managers are there. So we're actually reviewing cases on a weekly basis, it's just formally set up as an every-two-week basis.

I mentioned the internal medicine primary care manager. Again, that's helpful because we now only have to go to one clinic if we have any PCM issues that we have to address.

We have 24/7 support for our

personnel. We have a BlackBerry that our NCOs take home every night and on the weekends. And people do call. Sometimes they just need someone so talk to, or they do have an issue that needs to be addressed.

We have a daily check-in process, as well. All of our personnel are required to check in by text or by phone by nine o'clock every day. For our personnel who are more high interest, typically some of our mental health patients, we require them to check in more frequently; twice a day by phone. Some personnel we have working in the facility, and we will have them checking on them in person, so that we can actually have eyes on them at least once a day. And our high-interest personnel also are checking in throughout the weekend, as well so we can keep tabs or them. This allows us to maintain 100 percent accountability for all of our personnel throughout the duty week, and more often for our high-interest personnel.

I mentioned Commander's Calls, which

we hold about every one to two months. Our last one was on the 22nd of November. The next one will be on the 19th of December. Like I said, we've had some at the Warrior & Family Support Center, just to make people aware that that facility is there. We usually proceed or follow that Commander's Call with a tour of the Warrior & Family Support Center, and people come up to us afterwards and say, "I didn't even know this place existed," so it's a great thing for them to know about that.

We do have a Facebook page. We have 62 "Likes." We'd like more. So please "Like" us. And we use that -- we do use that for primarily announcing events that are taking place, mostly nonofficial communication. We've found that for official communication, we prefer to e-mail, call, or meet people in person for that.

I'm going to foot stomp the adaptive sports program. This is really the Air Force Wounded Warrior Program's adaptive sports program. AFW2 held an adaptive sports camp in March of

2013, and it was a two-day event. We made it a mandatory formation for half of the first day. And that event, among a few other events that they held were recruiting platforms for the Warrior Games, which some of you may be aware of. We were able to -- on a 50-person Air Force Team, eight of them were from the 59th Inpatient Squadron. Of the 30 medals that the Air Force won, six were won by our personnel. So we're very happy about that.

But adaptive sports isn't just about sports in competition. We're happy about the medals, but really it's about letting people know it's going to be okay. It's a very supportive environment, it's a great opportunity for getting people out the door and giving them a great functional outlet to use.

I'd like to talk a little bit about DoD/VA collaboration. In May of this year, we had a Wounded Warrior Care Summit at Wilford Hall in which we invited all the branches of service: Army, Navy, Air Force, Marine, Coast Guard, Public Health Service, and the VA to attend. It was

intended to be a grassroots day where we could all sit in the same room and just discuss some of the common issues that we have. We weren't looking to change any policy at the meeting, it was really just to have a discussion.

We had a follow-on meeting in September which a couple of you attended and presented at, and then we'll have an additional one this coming winter.

This kind of came together at the same time that the IC3 was looking at the lead coordinator checklist, and also the Air Force is currently involved in a pilot using the VA's Federal Case Management tool for establishing and documenting a Federal Individual Recovery plan for our personnel. This pilot study is actually running through the 15th of December, so it's not quite done yet, but we have 62 personnel who are enrolled in the program right now in the pilot study. And this is an opportunity to use an existing VA systems platform to document so that we can actually keep that Lead Coordinator concept

going between the DoD and the VA there.

Challenges: I told you I'd talk about staffing. Our biggest challenge that we have is resourcing. We currently have 6.75 FTE in the Patient Squadron. I'm the .75 and my other hat is as an occupational therapist, and that's where I spend about 25 percent of my duty within the clinic. We do have one medical care case manager. I mentioned 1.5 earlier. 0.5 is through the Wilford Hall Medical Management Department. So we own one occasion manager and we get 0.5 of a case manager through the Medical Management Department.

Our manager is a GS-11 civilian. We have a Section Chief who's an E-6, an NCOIC who is an E-5, and two contract admin techs. For the contract personnel, the medical care case manager, and the administrative technicians, these personnel are resourced specifically to this Patient Squadron. The rest of us are all taken out of hide.

The interesting thing about this is,

this contract started in fiscal year '12. Prior to that, we didn't have any resources specifically dedicated to the Patient Squadron, all were taken out of hide.

Planned fiscal '15 staffing is for an active duty licensed clinical social worker who will certainly go IC role that I currently serve in. And also two active duty medical administration personnel. So we've gone from zero dedicated resources to three contract, to three active duty resources. But the important thing about this is that the Air Force medical leadership and the 59th Medical Wing leadership are dedicated to the success of this mission, and we'll continue to pull people out of hide to make sure this mission does not fail.

Assistance and training: About 20 percent of our personnel have a primary mental health diagnosis. So supporting the mental patient is a primary concern. As I mentioned, those who are of more high interest to us are checking in on a more frequent basis, just to make

sure we hear from them or see from them more regularly.

The majority of our staff are administrative and have no training in mental health or psychology. We identified that this was a problem last year, and we did a pilot training session last year in which one of our licensed clinical social workers and a 4 Charlie, a mental health technician, came to our clinic and did training for our personnel. It was very successful.

And the intent was not to make anybody a mental health worker or social worker or psychologist, but to make people aware of some of the issues that they're going to see with this population, and to know where to go in case there's a problem so that we can prevent a crisis from happening.

Like I said, it was successful, so we redid it again this year. And I just got word yesterday that it's ready for roll-out. The intent was to roll this out to the patient

squadrons throughout the Air Force so that personnel and mental health clinics can actually train Patient Squadron personnel who are primarily administrative personnel so that they'll know also how to identify these people, and identify problems as well.

So as you can see, the 59th Medical Wing Patient Squadron has an important mission serving the needs of our wounded, ill, and injured airmen and their families. We're thrilled to have this mission, and we're constantly looking for ways to improve. I've highlighted some of our recent improvements and challenges, which remain opportunities to improve. This is an exciting mission that I'm very, very happy to be a part of. Serving this population is very challenging, and it's been the highlight of my career.

And, pending any question, this concludes my presentation.

CO-CHAIR CROCKET-JONES: I've got a question for you. I'm sorry. First of all, the check list that you used for entry to screen folks

for coming in the unit, I would love to get a copy of that.

EXECUTIVE DIRECTOR DAILEY: I've got it. I thought I sent it to you, but if I didn't, I will.

CO-CHAIR CROCKETT-JONES: I do have one, but I still -- I would love to -- I'm trying to create some cross-look to see what everybody's using.

The other thing is, you listed Military OneSource in a couple places as a resource. Are you aware of and do you guide those folks to the Wounded Warrior Specialty Consultants at Military OneSource? If not, that's something you might want to consider. There is a special program for Wounded Warriors and their families. Phone -- phone source through Military OneSource.

Maj DaLOMBA: Yes, ma'am.

CO-CHAIR CROCKETT-JONES: That's probably something -- I was going to say, you didn't list as a best practice, but I'm interested to hear about a line I saw there that an RCC

attended the briefings in lieu of family member. This sounds like potentially a very good practice, especially for those folks who have maybe attention/cognitive issues, other health issues that may get a very overwhelming briefing, for them to go in that first time to the -- and try to understand the IDES process. A family member sitting there is great, but you send an RCC in lieu of a family member. Now, how -- can you talk to me a little bit more about that?

Maj DaLOMBA: Yes, I can. Like I said, we have three RCCs in Joint Base San Antonio, and we work very closely with all of them. One is located at Wilford Hall. The person who assigns our RCC maybe assigns them to personnel who are located at SAMC. Our Medical Evaluation Board Section is down the hall from us, so if we -- and we're aware of the issues of the cognitive limitation we have with our personnel, and this is where the communication really comes in, so -- we know what's going on, so when we know that an initial MEB briefing is coming up, we will

raise the flag at our interdisciplinary meeting and say, look, this is -- this person -- if they have a spouse in the area, then we'll certainly -- we'll all make sure we foot stomping that. You want to make sure your wife attends or your husband attends this meeting.

And that's where we will engage the RCC who tend to have a different relation to us because we're also in a supervisory chain as well. So I don't want to make it sound like it's an order commanding you to do this. So the RCC can take a much kinder and gentler approach as far as encouraging that.

Now, we've had situations where -- I mentioned we liked to have personnel who have family within a day's drive. That's not always practical. First and foremost is medical care, and that's the reason for them being here. So if they don't have family in the area, and some people just don't, then we'll actually -- we'll bring this up at our case manager meetings, letting them know that this person has got an MEB

brief, and the RCC will just say, yeah, we'll take it and we'll go and attend with that member.

CO-CHAIR CROCKETT-JONES: How do your members feel about that? I mean, I'm just -- this is -- I haven't seen this other places, and I'm really -- I'm kind of interested in this as being something that could be tried in other places.

Maj DaLOMBA: Well, it's -- they're not being ordered to do it.

CO-CHAIR CROCKETT-JONES: I understand. I'm just saying one of the things that we know from looking at the data is that the more about comprehension of the process a service member has as they go through IDES, the more likely they are to be satisfied with their initial outcomes, and the less anxiety they have, especially when they get to the end -- the last portion of the process where they're really just waiting for papers to come back. They pretty much know what their ratings are, they're waiting for the physical paper that says that.

And, you know, that last month or two before they get DD-214, there's a lot more anxiety if they don't understand the process in that time. And so I'm just seeing this as a -- potentially a suggestion to go everywhere to say that where it's possible, if someone needs somebody, you know, an RCC could -- you know, in those places that have that -- the wherewithal to do it.

I'm not suggesting that somebody be forced to do it, I'm just saying, you know, have you gotten feedback from your service members regarding having someone sit in there with them, even if it's the RCC, as a way to get a better comprehension of what's going on? Have you gotten any feedback?

Maj DaLOMBA: We've -- nothing specific that I can speak to. But often, the RCC if they're not in the briefing with them at that time, they're often meeting with them shortly afterwards, and so they're able to explain what's going on. And that's -- that's been very

positive. It's helpful for us having the RCC literally 15 feet away from me so that I can keep close tabs on what's going on with folks.

CO-CHAIR CROCKETT-JONES: Do you think as the Lead Coordinator concept emerges and gets more codified, how do you think that's going to fit in with your sort of -- the three lanes, medical, nonmedical, and RCC? How do you see -- right now, your medical is your really your lead, or is the RCC really your lead? What do you think it's -- how do you think that's going to fit with this emerging ...

Maj DaLOMBA: Well, we've had a lot of discussion about that with this FCMT pilot. And I'll say that medical case managers, RCCs, nonmedical care managers, the Patient Squadron staff all receive training to utilize the FCMT program. We were all trained in how to initiate a FERP, we're all trained in how to transition a FERP from one to the other. And we are also working with the VA case managers on this as well for the transition for the cases.

It's a good question, and I'm not sure exactly where this is going to go. As far as -- it depends on really where they are in the process. Initially -- we talk about initial injury in the recovery stage. It's really the medical care case manager who has the primary role there, because that's when typically you're having the greatest amount of medical interventions, the most surgeries, the most therapy and rehab appointments, medical care.

And then it transitions. The RCC is kind of there throughout, but their role tends to ramp up a little bit more as you move into the rehabilitation phase. And as you move into the reintegration phase, that's when the nonmedical care management really comes in.

Their role is a lot more -- I don't want to say important at that point, but they're really more the key player at that point, and that's how I see it.

CO-CHAIR CROCKETT-JONES: Anybody else have any questions?

EXECUTIVE DIRECTOR DAILEY: I do. So just so we understand who are -- the population we have tomorrow. Back on page 2 where you talked about your current census and staffing. So we're going to talk to your service members in the focus group. And if I understand the chart right, you have one nonmedical case manager who's down there twice a week, sits in the room with you guys, and is working issues for the -- for your 40 patients.

Maj DaLOMBA: Yes. Yes, ma'am. We do have -- we have one who's with us -- the Warrior Care Support Branch has many nonmedical care managers, and the one nonmedical care manager who's with us may not necessarily be the nonmedical care manager for all of them necessarily. This is the primary nonmedical care manager for the patient squadron, but we have -- there are a couple of others who also provide services to personnel.

EXECUTIVE DIRECTOR DAILEY: So when we ask about nonmedical case management, they could actually be talking about one of four or

five people touching them from the Warrior Division.

Maj DaLOMBA: I think it's closer to three, but that's accurate.

EXECUTIVE DIRECTOR DAILEY: Okay. All right. And so we'll talk to them about medical case management, and you have 1 to 37. So you have one medical case management handling your squadron, your patient load there. Right?

Maj DaLOMBA: One 1.5. We have two people, but really it breaks down to 1.5 FTEs.

COL MALEBRANCHE: Okay. So that .5, they have a caseload. Is that correct?

Maj DaLOMBA: Yes, ma'am:

EXECUTIVE DIRECTOR DAILEY: So you have 37 people listed here -- well, you have 37 for your medical case -- medical care case. I mean, that's less than 41. Does that mean that those -- that the difference between 37 and 41 is the .5, or there are four people who don't have a case manager?

Maj DaLOMBA: No, no. Everybody has

a case manager, ma'am. And I don't have the specific breakdown. It breaks down to, I think -- 36 and 19, I think, is the breakdown between one case manager to another as far as the number of cases.

EXECUTIVE DIRECTOR DAILEY: Okay. So when they talk to us about their case manager, it could be one of two case managers and they're the only two they could be talking about?

Maj DaLOMBA: Yes, ma'am. And I'm glad you asked that question, because for this point-in-time data, at the time we had one inpatient at the time. So that person would also have an inpatient case manager who's providing discharge planning services and whatnot. So there's an additional case manager that I wouldn't count in this calculation. In addition, for 11 of our 14 -- I'm sorry -- 10 of our 14 TDY personnel, they came from other CONUS or OCONUS bases, so they would have been followed by an outpatient case manager at that location as well. However, what we can communicate, what we can control, are

the case managers we have at our location and that's why I gave you that calculation or that number.

EXECUTIVE DIRECTOR DAILEY: Okay. So for our members, when we're talking about case management tomorrow, let's try and make sure we're talking about what's going on here, and if not, distinguishing between here and other case managers they had in other locations.

And I just also wanted to make sure about your number here, 41. All of them, whether they're assigned or TDY, they're all physically here in San Antonio.

Maj DaLOMBA: No. At the time -- I can't remember the exact point in time, but we did have one person who was in Houston at the time.

EXECUTIVE DIRECTOR DAILEY: So for all intents and purposes, they're all physically here.

Maj DaLOMBA: Or they're en route to us. So I start tracking them once we're aware of them. We get information, like I said, from the

casualty reports and also through -- typically, through the RCC chain. So once we're aware of them, we think they're probably coming to us, we start tracking them. With air evacs, we know when they're coming in. It's very scheduled, it's very routine. With the non-air evac personnel, it's -- it's not as easy to predict.

EXECUTIVE DIRECTOR DAILEY: But the intent of Patient Squadron ultimately is to have them here at San Antonio. You're not doing any remote -- very little remote.

Maj DaLOMBA: No. And we have abundant medical resources through SAMC, through Wilford Hall, and just throughout San Antonio.

EXECUTIVE DIRECTOR DAILEY: So you're bringing them in on a basis, they filled out the checklist, they're meeting the requirements, and you've got 40 people physically here now that you're caring for medically/non-medically. What is --

MR. REHBEIN: Sir, is it 40 or 55?

Maj DaLOMBA: 55. 41 have PCS to

us. They are permanently assigned to us, and then the other 14 are TDY.

EXECUTIVE DIRECTOR DAILEY: Okay. All right. You're at -- Wilford Hall, you're now a surgical clinic. Pretty much an outpatient surgical clinic. And you have a -- you have an internal medicine staff, and that's where you're getting your PCM from. Correct?

Maj DaLOMBA: Correct.

EXECUTIVE DIRECTOR DAILEY: So when they talk about PCM they're talking about -- and that is someone that each one of your service members have met with?

Maj DaLOMBA: Oh, yes, ma'am.

EXECUTIVE DIRECTOR DAILEY: Been evaluated by? Good. Okay.

So they know who their PCM is here. They should know who their PCM is here. And so you frequently -- your scope has been brought down a little bit at the clinical -- as a clinic, surgical outpatient hospital. And I know you've got BAMC down the road, so here's my question.

Are you having to send people out on the network? You have 37. Most of them are cancer, I would assume?

Maj DaLOMBA: I can give you the diagnostic breakdown. The primary category's neurologic disorders, including TBI is about 11 personnel; cancer is about 11 as well; mental health is 10; combat injured is nine, and then it goes down from there.

EXECUTIVE DIRECTOR DAILEY: Are you getting all your services from either your clinic or the hospital at BAMC? What's your -- who, if any, are you sending out to the network?

Maj DaLOMBA: Not very much. I will say for inpatient rehabilitation services for those complex polytrauma/multitraumas, we have used the VA Polytrauma Center. We've also used civilian inpatient rehabilitation facilities to offer people who were part of inpatient rehabilitation, because those services aren't provided at SAMC, which is the -- SAMC is our inpatient platform. When Wilford Hall was a

medical center we handled the inpatients in-house. Now all the inpatients have just moved to that location.

So for the service that SAMC doesn't provide, for example, inpatient rehabilitation, they will go to a civilian facility or to the VA.

EXECUTIVE DIRECTOR DAILEY: But your mental health is all being done at SAMC.

Maj DaLOMBA: No. Thank you for bringing that up. We do -- there are -- there's an inpatient mental health center in San Antonio called Laurel Ridge Treatment Center. And some of our personnel do utilize services there as well. I don't believe for the point in time that I gave you, any of our personnel were located there at that time. And that's -- they provide inpatient residential treatment. They also have an intensive outpatient program as well.

EXECUTIVE DIRECTOR DAILEY: Yes we've heard a lot about Laurel Ridge. It's pretty popular with the CBWTU at Arkansas.

Okay. I think I've got it. You're

the largest. In other locations that may have a Patient Squadron throughout Air Force are probably only running a census of four or five maybe.

Maj DaLOMBA: The two other large patient squadrons are located at Andrews Air Force Base in Maryland and Travis Air Force Base in California. And they run between 15 and 25. And then everybody else is smaller. It's ten or less. And any Air Force MTF can stand up a Patient Squadron.

EXECUTIVE DIRECTOR DAILEY: And then my last one is about command and control. It doesn't look like you hold formations. I mean, your NCOs account for people the same way we see and account for people in a CBWTU. It's a call-in or text.

Maj DaLOMBA: We do -- we do have command and control formations. And those are the monthly Commander's Calls that we have, and that's --

EXECUTIVE DIRECTOR DAILEY: I'm just thinking morning formation.

Maj DaLOMBA: No, ma'am.

EXECUTIVE DIRECTOR DAILEY: No morning formations, no afternoon formations, but you would ask your high-interest individuals to come in and visit and get a visual.

Maj DaLOMBA: Absolutely. Yes, ma'am.

EXECUTIVE DIRECTOR DAILEY: Okay. I got it. Thank you.

Any other questions?

MR. REHBEIN: If I may, sir. The 14 on TDY, will they stay on in that status their entire time here in the Patient Squadron?

Maj DaLOMBA: General speaking, our TDY personnel will remain on TDY if we expect that their care is going to last 90 days or less. If we think that there's a reasonable expectation they're going to return to their duty station within 90 days, they'll stay TDY. If it's going to exceed 90 days, then we communicate with the chief of the medical staff and we begin the administrative process of setting up a permanent

change of station for these personnel.

We have a couple of outliers. We have two reserve component personnel in this census that I was talking about. One had only been there for maybe a couple of weeks. One had been here for a significant amount of time. And the reason why is because we can't PCS Reserve personnel, they have to remain TDY.

The other piece is, Special Forces sometimes will prefer to retain administrative control over their personnel, so they'll keep them here TDY for an extended period of time. And that explains one other person who is on TDY for a longer period of time. But yes. Generally 14 to 90 days is the TDY period. We do have some TDYs that will convert to a PCS.

And in the checklist that I mentioned earlier, we asked specifically if there's a reason to get somebody out here quickly. We don't want the losing facility to worry about generating PCS orders, so send them TDY. We'll take care of the PCS later. We want to get them

here for the medical care that they need so they will get the right care on time.

MR. REHBEIN: But that status does affect delivery of services to the family. How is that accomplished for those -- I see five here that are married that are on TDY status, which means spouses and families are somewhere else.

Maj DaLOMBA: That's correct, sir. And they would still be enrolled in TRICARE region that they're in, depending what location they are.

MR. REHBEIN: I'm thinking more along the lines of the attendance briefings, which is impossible. How do you keep -- how do you keep them informed on what's going on?

Maj DaLOMBA: And that's typically handled through the medical case management and also through the RCC chain to communicate with the command back there. Also, since their command still retains administrative control over them for the TDY personnel, we'll communicate with them often as well, and so that they can get information that way as well.

If we know that the TDY personnel are going to PCS to us, obviously we can facilitate that process and get them us to us, and that takes care of that problem.

CO-CHAIR CROCKET-JONES: Feel comfortable? Okay. Then thank you very much. I'll look forward to talking to your folks tomorrow morning.

Maj DaLOMBA: Thanks.

CO-CHAIR CROCKETT-JONES: We'll have a brief break until 3:30 when our next group will be here to brief us. Thank you.

(Whereupon, the foregoing matter went off the record at 3:10 p.m. and back on the record at 3:24 p.m.)

CO-CHAIR CROCKETT-JONES: We're ready to get going. This is our panel. Before we start a discussion here, perhaps it would help you if we give you a summary of the Recovering Warrior Task Force.

We were formed to assess the programs and policies that affect all recovering

service members in all the services, and then transition across the DoD. And we have a little bit of a foot in the VA door as well.

We consist -- the Task Force as a whole consists of 14 members: Seven military and seven nonmilitary. And you have a sampling of that membership around the table here. And I'm going to have everyone introduce themselves so that we can get this discussion on a more comfortable level.

So why don't you -- Mr. Drach, would you introduce yourself?

MR. DRACH: Hi. Ron Drach. I'm a non-DoD member of the Task Force. I'm a Vietnam Veteran, wounded in Vietnam in 1967. I worked for the Disabled American Veterans for 28 years, and the VA for two and a half years. Thank you for being here with us.

COL MALEBRANCHE: I'm Karen Malebranche. I was with the Army for 30 years as a nurse. I am currently at the VA; I've been there for ten years. I'm also the daughter of an

Army brat, so -- or I'm an Army brat myself. So I'm glad you're here. Thanks for coming.

MR. REHBEIN: My name is David Rehbein. I'm one of the civilian members of the Task Force. Two Army years a long, long time ago. I spent the rest of my career as a research scientist. I'm very heavily involved in the American Legion with 30 years there, including a year as one of their National Commanders. So lots of experience in veterans benefits.

DR. PHILLIPS: I'm Steve Philips. I'm a physician. I have 25 years active and Reserve. I work at the National Institutes of Health, Department of Health and Human Services, and I'm a non-DoD member.

CSM DeJONG: Command Sergeant Major Steve DeJong. I represent National Guard Bureau. I'm a veteran of Iraq and Afghanistan. Combat wounded in '04 and back in the WTU again in '09. So I've got a firsthand working knowledge of being in a WTU for a long time.

CO-CHAIR CROCKET-JONES: I'm Suzanne

Crockett-Jones, and I'm the civilian cochair of the Task Force. And I'm the spouse of a recovering warrior who has transitioned out of the Army and is now a veteran that's being seen at the VA.

I'm going to ask you all to do some introductions to let us know who you are, and then we can start a discussion based on the questions.

I don't know how many of you have seen the questions, but I'll sort of give us some topics, and it's -- we realize it's a dynamic exchange. We might get a little off track. It's okay. We're grateful that you could take the time to share your experiences with us and give us your opinions.

So if you -- I would like the members to turn to Tab N of our briefing books, and meanwhile I'd like to turn it over to you all to go down and give us an introduction, and give us some background information about yourselves.

MSG (Ret.) EHRIG: Good afternoon. My name is Bob Ehrig. I'm a retired Army Master

Sergeant, 17 years. I was wounded in August 2006 in Ramadi, Iraq. I was, I guess, there when the WTB/WTU were formed, so I guess I'm the old guy at the table. I'm also a strong veteran advocate in the community and I also act as a Veteran Service Officer for a county social services agency helping veterans in this community specifically, and I still get care today at BAMC.

MSG ALDERETE: I'm Master Sergeant Alderete. I was injured in Baghdad, Iraq, back in 2010, and I've been in the WTU since July of 2010 going through several injuries with my legs and the left side of my arm and shoulder. I'm currently at this WTU at BAMC working -- as part of my recovery program, I'm working in the S&B shop and working in the operations NCO.

SSG BURGESS: My name is Staff Sergeant Daniel Burgess. I've been at the WTU for just over two years. I was injured in RC South of Afghanistan. I stepped on an IED when I was attached to the Marine Corps. I'm a triadic amputee, other internal injuries, currently going

through my board process. I'm an Army Reservist, and since my time here at the WTB, I've been an advocate for Reserve National Guard Rights, making sure the equality is the same as what the active component and the Reserve National Guard gets. Been going through the Senate and doing a lot with the higher echelons up within the Reserve Command.

SSG FLORES: Hi. I'm Staff Sergeant Flores. I've been in eight years. I'm a veteran of OIF and OEF. Served '07 to '08 in Iraq and Afghanistan, and 2011-2012, got injured in both. Been at the WTU since June 2012. I sustained several injuries and currently going through the medical board and receiving therapy.

SSG SMITH: I'm Staff Sergeant Michael Smith. I'm -- I have both Iraq and Afghanistan tours. I sustained my injury in 2011 -- August of 2011. I'm currently waiting on my COAD package for my Continuation on Active Duty service, and that's it.

COL HOWELL: Hello. My name is Colonel Howell. I'm am formerly from the Utah

Army National Guard as an AGR officer. I have 27 years of active duty service. I was mobilized in 2005 down here to Fort Sam Houston; I've been here ever since. My left knee wore out on me and I had it replaced in March of this year, and I'm just waiting to retire.

Oh, one other thing. I'm also taking advantage of the OWF Program, and I'm working as an intern with the IRS as a Criminal Investigation Analyst.

SSG LAGE: My name is Staff Sergeant Michael Lage. I got injured June 2007. I've been in the WTB since then. I went COAD for Continuation On Active Duty in 2011. So I work in the administration office, and I have two more years till I retire.

SGT (Ret.) NELSON: I am Retired Army Sergeant Todd Nelson. I was injured in August 2007, in a suicide bomb blast in Kabul. Traumatic injury to the face and head. I've since retired after three years in the WTB, and then I transitioned into a civilian career at USAA where

I advocate for military hiring, and specifically disabled veteran hiring.

SFC TAYLOR: My name Sergeant First Class Taylor. I was injured August 2nd, 2011, by RPG to the face. I have injuries to my brain, my eyes, my ears, nose, just about everything. I was deployed Iraq three times and Afghanistan once. I'm currently in the WTB recovering, pending a med board.

CO-CHAIR CROCKETT-JONES: Thank you all for that. I want to open the topic with some of the information we'd like to hear from you. Your impressions and your successes, the frustrations you've experienced with the IDES process.

For those of you especially who have -- who are in or completed the Integrated Disability Evaluation System and the PEB process.

Top of the mind, just start with the things that occur to you as having been significant in that process for you. Anybody want to open up that comment?

MSG ALDERETE: I will, ma'am. I currently have been waiting for a VA response on a -- not a rebuttal but an appeal since March of this year. And the Army side accepted the appeal and said it was good, they would forward it to the VA. And I've been waiting since March just to hear from the VA and I haven't got any response. So that's one of the frustrations that I have that we wait so long in the WTB to get any information fed down back to us. Sometimes it's quickly. I've had -- I've been here waiting since 2010. I've gone through the process and got all my surgeries, got everything taken care of, but I've been waiting. I've seen many other soldiers come through that came through, got all their surgeries and got everything done and are already gone, and I'm still here.

CO-CHAIR CROCKETT-JONES: So frustrating snags in the road.

How about -- in general, how do the members of the panel feel about the amount of information and the understanding you had of the

process when it started versus how it played out and how it's evolved, and how you finished it out. Do you feel like you understood the process and did it -- was it what you expected? Anybody want to comment?

SSG SMITH: So at the beginning, it's so much information. Sometimes it's overwhelming just because there's so much going on so fast. Especially if it's something that you haven't been through coming back -- coming from the combat side, HR is just not in our -- that's not our specialty. So when you're throwing a whole bunch of information at us at one time about our future, it's hard to get it all in. And you're not -- you're not going to take it all in in one or two meetings. It's literally impossible.

We have guys -- guys and girls every single day getting out and retiring and not -- still not knowing what's going on. And I understand myself as the NCO -- we're all up here NCOs, but the colonel. But we're all in here

seniors, so we understand it's self-development, we have to seek the information to understand that. But most of the WTB are younger -- all younger, lower enlisted. So when all that information is being disseminated and everybody's trying to understand, there's a lot of things that you still miss. And what ends up happening is, they get out, they retire, and they figure out -- or they find out later through the VA system that there was a whole lot more that they were supposed to obtain and there was a lot more that they were supposed to do before they got out, and now it's an issue.

SSG BURGESS: To piggyback on what Sergeant Smith was saying. There's a lot of issues -- when I started it, I can speak personally with dealing with TBI and dealing with everything like that. There's so much information, and I still have trouble now day-to-day remembering what happened yesterday. And when you get handed all this information, I might leave, forget where I set it down or forget

to pick it up when I leave. And nobody's there making sure, hey, do you understand everything, do you understand everything, and they cut a lot of spousal interactive out of it.

And so, like, I'm lucky. I have a spouse that came with me to all my appointments and made sure she knew what was going on, because she knew what was going on, but you've got a lot of these guys who don't know what's going on and they don't have that support to make sure of that and reaffirm it, from just that NCO in their life that -- we're used to taking care of our soldiers, making sure of that.

But you've got so many Cadre that are overwhelmed with the amount of soldiers, that they can't sit there and go to a deployment with a soldier to make sure -- that's suffering from severe TBI, who can't remember what they did two minutes ago. So that's a big issue, just as Sergeant Smith said, with the amount of information, that you can't comprehend all that at one time because I think the IDES briefs started

being like two hours -- three hours long and it's pure information. And I mean, I know I couldn't even understand half of it. I just like, oh, I can sit down and talk to each individual later on.

CO-CHAIR CROCKETT-JONES: So would a lot of you think that -- go ahead.

SFC TAYLOR: I think one of the issues that we ran into in Germany was lack of knowledge, and lack of logistical support. I mean, the soldiers were -- when I was first over there, when they would get briefed on this stuff, it was kind of like they were fed it, kind of like that one soldier was saying, but it's very -- it's even more difficult for us in Europe, because we're already injured, and now we have that -- pretty much the only plan is to get back to the states. And what I was seeing happening in Germany, and a lot of other soldiers were -- a lot of the soldiers that were seriously injured that should have been able to go to, those MTUs, but due to the fact that they were full with other individuals who wasn't combat injured, these

soldiers were diverted which made it somewhat harsher for them and their family that they had to plan and anticipate for on arriving back to the states to get their treatment. It made the process that much more difficult for them in Germany versus the states.

CO-CHAIR CROCKET-JONES: So I want to ask you -- I want to say that basically what I've heard from y'all -- and I want to see if I can get some nods or hand raising, that someone sitting next to you in that initial orientation about IDES is a helpful process. It's having a second set of ears. Yeah?

(Nodding affirmatively.)

CO-CHAIR CROCKETT-JONES: How about the knowledge and support and/or accessibility of the PEBLO? The Physical Evaluation Board Liaison Officer, the PEBLO that you get assigned when you start this IDES process? Tell a little bit about that.

MSG ALDERETE: I believe my PEBLO was very knowledgeable, very good. She's always

kept me informed of everything that's going on. She's very accessible. Anytime I needed anything, she's there available for me to ask questions or whatever. If she doesn't know it, she knows where to go, and that's basically what she tells me: "I may not know right now, but I'll get the information to you." And she does. She follows up with me. So that's been a very good help in my process. I'm just -- I'm just trying to figure out where the disconnect is from having to wait so long here.

CO-CHAIR CROCKET-JONES: Sure. Anybody else want to comment on that PEBLO? You're all pretty quiet.

How many of you have availed yourselves of the legal support services that are dedicated specifically to IDES? How many of you've talked to the IDES lawyers?

SSG BURGESS: The IDES lawyers have actually been very helpful. I had to appeal my board. Actually, I didn't -- it wasn't a full appeal, it was a rebuttal because the MEB doctors

who write your NARSUM, you -- I spoke with her for not even an hour, and she just started rewriting my whole behavioral health into what she believed it should have been. And it was just crazy. And it was completely more or less wrong. I mean, it was polar opposite of what it should have been.

So the IDES attorneys helped me out in getting it fixed and getting it corrected through my behavioral health providers and with the attorney to get it fixed. So they were very helpful.

CO-CHAIR CROCKETT-JONES: Has anyone used the legal services for something other than rebuttal appeal prior to that? Prior to, you know, initial services. Anyone done anything like that. Okay.

Does anybody else on the Task Force -- feel free to jump in if you ...

DR. PHILLIPS: You're doing great.

CO-CHAIR CROCKETT-JONES: Okay.

MR. REHBEIN: Suzanne, if I may for a minute. Did all of you know that you had access

to that kind of legal support? That was told to you, that was knowledge that you had, so that wasn't something that you had to develop on your own?

SFC TAYLOR: Yes, sir. In Germany, it's a lot different and difficult, because all you have pretty much is cards and numbers that you've got to call. And a lot of times when soldiers are trying to call and get their information, it's very difficult for the soldiers to get ahold of them, because mainly it's only like one person. A lot of resources in Germany are centrally located, so maybe one or two people. And if those two personnel are not around, the soldier -- everything in Germany stops.

Like 2012, they had a change out of the person that -- the IDES manager that places the soldiers in the states for some reason. So over a hundred soldiers got backed up. Then when they were supposed to leave -- or tentative leave dates from Germany before they were able to come to the states, so it caused a lot of kind of --

they had plans on coming to San Antonio somewhere, and now all of a sudden they're having to go to another place.

So, again, their families in the states who they may not be -- who may not have seen their Soldier since they've been injured, now have to plan to relocate somewhere else because the plan that they originally had, they thought everybody was going to be a part of is no longer the plan. And that seems to happen a lot. One of my own soldiers, where it took so long that soldier ended up losing his mind, and they let him out from Germany, versus getting him back to his father in the states.

SSG BURGESS: My PEBLO, when I got my -- when I got my MEB back, my PEBLO told me directly, he said take this folder to the attorneys, sit down, make sure it's written correctly, even though I had already said, "Hey, this is improper." He was, like, "Well, go sit down with the attorneys, make sure it's done."

So depending on your PEBLO, what the

Sergeant here said, I have a good PEBLO when he says, "Hey, make sure you take this to the JAG, and go sit down and talk with them to make sure that you know what you're talking about and you're going to the right avenue and approach."

MSG ALDERETE: That's the same with me. She recommended me to directly go to the attorneys and get their input and see that the packet that is actually being represented is representing what I want, not what somebody else wants. So they were very helpful.

SGT (Ret.) NELSON: The -- I went -- I went to see legal after I got -- my PEBLO gave me my case, because there was missing information. What I thought was interesting was, I was the one that had to identify that there were things that I put on there that did not show up. I thought that was interesting. So I don't --

CO-CHAIR CROCKETT-JONES: Where would you have expected that information to come up?

SGT (Ret.) NELSON: Exactly my

point. Exactly my point. Now, I had been -- I had multi-trauma, and a lot of us multi-trauma, you can't even really keep track of everything. You don't understand all the stuff. I just noticed there was some missing stuff there. So I went back -- and luckily, like, I had made notes in advance of what I had already put in originally, so I was able to go back to my notes and ask what happened. And, of course, the lawyer just basically took my notes and sent it in and, sure enough, oop, they all showed up.

So the point is, is I don't know if we have a process in place for tracking our expectations -- you know, what the claim was versus what they come back with. If not, it's a gap.

CO-CHAIR CROCKETT-JONES: All right. I'm going to switch gears a little bit on you, unless there's anyone wanted to say something about their IDES or their process. I'm going to switch gears and ask and also ask you guys to jump in if ...

Okay. So in this process generally -- generally the family members or caregivers of one sort or another, and I'm wondering how many of you had a family member assisting you through this? A spouse, a parent, a sibling, even a buddy. And how did the -- basically, the institutional side of things interact with that person? Did they include them; did they exclude them; did they -- I just want you to comment on that -- on that topic in general, however it occurs to you.

SSG SMITH: I kind of have a unique situation. So when I came back from Afghanistan is when I was injured. And I was actually a part of a recruiting command in Nashville, Tennessee. When I lost my arm, I went to -- when I lost my arm, I had multiple surgeries, and I was getting bills for it. My mom came from -- my mom had to quit her job in Dallas to fly to Tennessee to take care of me for about a year. During that whole time, I was getting billed for it. Like TRICARE didn't pick it up.

I didn't know anything, nobody told me anything about my mom being a caregiver and she would be -- like, we would be compensated for her taking care of me. Like nobody told me that. I didn't know anything about TSGLI, I didn't know anything. That information wasn't provided for me at all.

And then the only reason I got sent to Fort Sam to the WTB is because I actually have a cousin that works in neurology in the Air Force, and she told me about it. So that's how I ended up there. And then once I -- once I got to Fort Sam, I still didn't get the adequate help for my mom taking care of me, because -- I mean, being above the elbow, like I -- you would have to relearn -- I had to relearn everything, so nobody -- I just know that that information flow about the family, like most everybody --

(Inaudible dialogue.)

SSG SMITH: Yeah. Nobody told me anything about that. I don't think that information is out there for everybody. I've

talked to several soldiers that had no clue about any of that stuff, and they're active just like I am.

CO-CHAIR CROCKETT-JONES: What was the MTF where you received your initial --

SSG SMITH: Say that again, ma'am?

CO-CHAIR CROCKETT-JONES: What medical facility did you receive your initial -- or the bulk of your care?

SSG SMITH: Vanderbilt Hospital, ma'am.

CO-CHAIR CROCKETT-JONES: So civilian hospital.

COL MALEBRANCHE: If I might, you -- in looking at caregiver and support and some of the things you didn't know, if you -- even if you had a family member, did you have somebody from the military or the VA, like a case manager, RCC -- at that point, I know your injuries are all at different times for you. Yours was 2011. Right?

SSG SMITH: Yes ma'am.

COL MALEBRANCHE: And you didn't have a RCC or a case manager when you were at Vanderbilt?

SSG SMITH: No, ma'am. I can tell you exactly how that went. For a whole year, I didn't talk to anybody in the military at all. For a whole year, nobody came. I didn't talk to anybody. Nothing.

The only reason why -- the only way Fort Campbell stands out is because that's where the nearest installation is. Me and my mom, we drove to Fort Campbell ourselves, and we pretty much demanded to talk to the hospital commander at the time. And he looked at me like who are you and what happened. And I told him. And then that's when -- I mean, I was on the radar. I had a total of 12 surgeries in a year's time and nothing or nobody.

COL MALEBRANCHE: And you were getting billed by the facility. No TRICARE, no contract person came in?

SSG SMITH: Yes, ma'am. I had like

close to like 250,000 billed to me, and that didn't get taken care of until probably six months ago.

COL MALEBRANCHE: And they knew you were active duty?

SSG SMITH: Yes, ma'am.

CO-CHAIR CROCKETT-JONES: I think we're all going to have to take a moment to digest that information.

For the others on the panel, how many of you had at one point a nonmedical attendant, a family member, acting as a nonmedical attendant?

(Show of hands.)

CO-CHAIR CROCKETT-JONES: Five of you. How many of you had a spouse receiving SCAADL? Anybody familiar with that program?

(Show of hands.)

CO-CHAIR CROCKETT-JONES: Three.

Go ahead.

SSG BURGESS: In regards to the SCAADL, I was -- I had had -- I got out of the

hospital in January of 2011, I had an NMA from January all the way through the end of May. And when we found out about SCAADL, we went to put into it. We met with the WTB OT for 30 minutes. She put in the system that I had a two-hour appointment with her, and turned around -- all I did was more or less walk in say, hey, this is this, this is what my wife is doing for me to apply for SCAADL, and she turned around and denied me, and said that I sat in her office for over two hours, coherent, and everything, when I actually got up and left out of the office.

And when I went to challenge her, I got put down by the WTB and they said, no, what she said is right, you were -- you aren't authorized SCAADL. You don't meet all the requirements.

So that's a real -- and at the same time they denied me, who is a below-knee amputee with TBI and everything, I watched them approve another below-the-knee amputee, who walked in with his girlfriend to sign his paperwork for his

SCAADL, and his sister who was his primary care provider was living in another state at the same time. And when I brought that up, they told me to be quiet.

MR. REHBEIN: You say when you found out about SCAADL. How did you find out about it?

SSG BURGESS: I found out about SCAADL after I was out of the hospital because they told me when I was ...

MR. REHBEIN: You just stumbled across the information?

SSG BURGESS: Right. I was just listening to people talking, and somebody brought it to my wife's attention and asked her if we were receiving SCAADL, and she was like, "No, what's that?" And when we found out what it was, that's when we went and put in for it. And when we were putting in for it, they were like, oh, everybody was put in for it at that time, when you're in the hospital, and we were like, no, we weren't.

And it's the same way going back to -- like what Sergeant Smith said about his

injury and my injury. Because when I first got here, they told my wife to go home, or for me to go home to the VA and get care, due to the fact that I was a reservist. And if I wanted to receive care, I had to go home, to the VA, or I could stay here without my family. So there's -- that disconnect right there has been worked through a lot, and a lot's been changed from that disconnect now, but, no, you still have that disconnect.

CO-CHAIR CROCKETT-JONES: Can you remember who she was talking to; who asked her about SCAADL? Was it another family member or was it someone in the -- in the process or in Cadre or somewhere --

SSG BURGESS: It was a family member.

COL MALEBRANCHE: And you also were -- 2011 was your injury as well.

SSG BURGESS: Yes, ma'am. I was injured in Afghanistan in 2011.

COL MALEBRANCHE: And you're a

reserve?

SSG BURGESS: Yes, ma'am.

COL MALEBRANCHE: And did you have a case manager, RCC, anybody from the VA? Did you go to the VA, and did they help you?

SSG BURGESS: I came here strictly to BAMC when I came back out of country. I had a case manager in the hospital, and they kept on -- when I came here to the states, they said I was an active duty soldier, so they were treating me like an active duty soldier. And then one day when I was -- I guess I had had a coherent moment, I was like what are you talking about, I'm a reservist, because I had prior active duty before, and I go, I'm a reservist, you don't PCS me here. And they looked at my wife and they go "We can't help you," and turned around and left.

And after that, we were kind of strung out until we got my command -- my reserve command back home all the way down to Fort Bragg, where my Branch Command was at, and got everybody else involved to figure out everything and what

was going on.

COL MALEBRANCHE: So at this point in time, do you have a case manager, Recovery Care Coordinator, any of those people that you know of that are helping you?

SSG BURGESS: Yes, ma'am. My case manager helps me daily. I actually just talked to her on the phone today. She's a -- my case manager I got when I got out of the hospital has been the greatest thing in helping guide me through everything. And now they actually have the Reserve Liaisons now implanted into the WTBs. They just haven't -- they came back in June, I believe, is when the program got restarted back up from the reserve component.

The National Guard had their liaisons here, and now the Reserve has their liaisons so you have that capability to be able to talk to somebody within your branch to be able to be, like, hey, this is a problem I'm having, how can I deal with it. The unit who does -- the way an active component talks, if you're in a reserve

component -- because if you don't have a line of duty for National Guard Reserves, you're not going to -- they're not going to recognize your injury. So you need to have that line of duty saying this happened to me while he was on active duty status so I can file my claim with VA.

COL MALEBRANCHE: So there's a liaison for Guard and liaison for Reserve in the WTB.

SSG BURGESS: Yes, ma'am.

COL MALEBRANCHE: And they are active duty? Civilian?

SSG BURGESS: AGR.

COL MALEBRANCHE: They are active duty AGR?

SSG BURGESS: Roger.

SSG LAGE: I want to say, before I started as a squad leader, everything that Sergeant Burgess was saying is accurate when the SCAADL first came out. The last two years as a squad leader, they were slowly developing a process and how to better serve the soldiers and

the process that the soldiers have to go through to get approved or denied.

Right now, the WTB has a good working process for those soldiers that are initially getting into the SCAADL, but when Sergeant Burgess first started in the SCAADL process, it was still fairly new to the WTB, and so their process was not -- it wasn't working right.

CO-CHAIR CROCKETT-JONES: I hear you.

COL MALEBRANCHE: So for those of you that are in the WTB now, today, and a new person comes into the WTB, do you feel -- are they getting adequate help or are you doing a lot of this as colleagues, peers?

SSG LAGE: Well, the process when the soldier initially gets to the WTB is they're assigned a case manager, they have a squad leader, Platoon Sergeant, and their company. And, as I mentioned, with the IDES, they're bombarded with so much information that they really don't know

which way to turn, and they have to slowly process this information in. As we were talking about having a family member or a friend there to help attain this information as well so they could take it back and figure out what they're receiving. This is just a lot of information.

But as far as I know, what I went through and as I was a squad leader, they were getting the accurate information, it just -- sometimes it just comes across as too much, so they're not sure which way to go.

COL MALEBRANCHE: So things have changed then for the better, it sounds like what you're saying, in terms of process.

SSG LAGE: From what I can tell; yes, ma'am.

COL HOWELL: When I came into the process back in February of this year, it worked like clockwork. I haven't had many problems at all. Everybody's well trained. There's some bureaucratic glitches, but the WTU at BAMC is excellent. It's just the time it takes to get

through the process that is the problem. And most of the soldiers learn the process because they talk to each other. I mean, there's a free flow of information in the WTU. When they get out, most them are fairly competent in understanding the whole process in my opinion.

SFC TAYLOR: On the SCAADL and overseas OCONUS, there's still issues. I know a lot of my soldiers -- because I wasn't the only one in my unit. A lot of the soldiers that were injured, they required NMAs and they were not provided for them -- provided those NMAs due to the fact there was no nurse case manager for any of them or myself while we were at the hospital. So we didn't find out any of this stuff until -- like the Colonel said, till we got back to the unit, and you see another soldier walking down and accidentally -- you know, which way to the TBI, because I think I have to go there, all the training that I had.

And because of that -- I mean, I guess that process is still very difficult, but

like a lot of soldiers that I had to deal with, and myself included, we had to stay in the unit for roughly a year before we were even put into an IDES situation overseas, so -- and you see, the process is a lot different for a soldier who is assigned to an overseas location when they're injured than the soldier who is assigned home when it comes down to SCAADL.

CO-CHAIR CROCKETT-JONES: And you spent a year in an oversees unit beginning the recovery process before you were put into an IDES process?

SFC TAYLOR: This is correct. Yes, ma'am. I was not allowed, because of some issues, to come back to the states to get my medical care. My unit -- my medical providers wanted me to come back to the states to get care, but my unit would not. So there's -- I was here a couple times at BAMC on TDY. And what the doctor recommended was what eventually got me here.

But a lot of my other soldiers, they had to have implants put in their leg from the

blast -- they had to have metal implants. And we had no facilities to help them with wheelchairs. So these soldiers -- we had to build ramps and such at the installation for -- to try to get these soldiers around and do the best that we could while they're all still assigned to the unit that they were injured in to accommodate them, until they were put into IDES. And that was just a very painful process. A lot of miles back and forth to Langstuhl, roughly a six-hour trip, and caused a lot of pains and a lot of hardship.

COL MALEBRANCHE: And you just came back here in 2011, so that would have been in 2010-2011?

SFC TAYLOR: Negative. I didn't get to BAMC until November 2012, ma'am.

COL MALEBRANCHE: So you were in Langstuhl, and this was occurring then during 2009 --

SFC TAYLOR: Yes. But me and all the majority of the soldiers that had -- for some reason, we didn't have that nurse case manager at

the hospital, so none of us got orders to leave. Even though the providers clearly identified that all of us needed to come back CONUS, to either Walter Reed or BAMC, we were not. But a lot of those soldiers, we didn't get -- the last one just left this past May in IDES, and was hurt in 2011, but he just now left Germany through IDES in May of 2013.

DR. PHILLIPS: First, I want to thank you all for coming and for your comments. And I know it's probably not that easy to be sitting up there.

To follow up on many of the things that you have been talking about, I would ask you to try and help us even more by saying this: If you were totally in charge of the process and you could speak randomly, if you were totally in charge of the process, would you identify areas that can be simplified or made easier for you. Just tell us what you would do and how to help so that we can try and support that effort.

MSG ALDERETE: Thank you, sir. I

think the squad leaders do an outstanding job and Platoon Sergeant do, but I think if they were trained a little bit more on the whole process, because they know some and they know a lot, Sergeant Lage will attest they get a lot of training, and they know a lot of stuff that's going on. But a lot of the process information gets sent back up just to higher personnel.

A lot of times, it's hard to get those appointments to get to see them where you have your squad leader or your Platoon Sergeant or somebody in that lower chain could be better trained to assist you in what to do and what not to do.

DR. PHILLIPS: To follow up on that, are they on site long enough or are they are rotating off frequently?

MSG ALDERETE: I've had -- I believe I'm on my fourth or fifth squad leader.

DR. PHILLIPS: In how long a time, roughly?

MSG ALDERETE: Well, I've been in

the WTU going on three and a half years. I've had -- I think the first one I had for about six months, and then the next one close to a year, and then six months.

DR. PHILLIPS: I don't want to put any words in your mouth, but would it be helpful if there was a longer --

MSG ALDERETE: More stability. Right.

And it's not only that they're either PCS or anything like that, it's just that here recently the WTU has been restructuring and went from a big WTU to a small one, so they had to make some adjustments. And in doing those adjustments, I went from one company to another company. And so all this moving around and doing things like that is where you can get a lot of changes.

DR. PHILLIPS: So better training, and continuity.

MSG ALDERETE: Right.

SSG LAGE: Each soldier's squad

leader are different. The majority of them, they come in, they do a two-year term. So if the soldier just happens to get luckily enough to get squad leader when the squad leader gets there, he's going to have the majority of the two years, if the soldier's there. But like Master Sergeant Alderete was saying, we just had that restructuring at the WTB, so there was a lot of movement going on.

But for most soldiers, they try to keep the soldier with the same squad leader for as long as possible. Before we just restructured, they did a big move to put all the severely injured soldiers into a company. And so they've been moving for like a year and a half, two years, the MTBs been changing. So a lot of soldiers have been moving and changing to different squad leaders, but they do try to keep them longevity, so they can build a rapport with the squad leaders in the chain of command.

DR. PHILLIPS: I think I know the answer, but there's no backup squad leader, say,

for you or for someone else? Is there any mechanism like that?

SSG LAGE: Well, what most of the platoons and companies try to do is, each platoon has four squad leaders, and each squad leader will have about seven to ten soldiers. But they try to get it to where all the squad leaders know all the soldiers, so if that squad leader has to take leave, or something happens, another squad leader can cover them, and he knows the situation with that soldier.

So they try to integrate as a family so all the squad leaders in a Platoon knows all the soldiers, so if something happens, they cover down so the soldiers still feel comfortable talking to a new squad leader.

DR. PHILLIPS: And I forgot to ask, but is it the same for Active, Reserve, and Guard? I mean, I know there's some differences, but ...

SSG LAGE: Yeah. We're intermixed with National Guard and Reserves, so everybody's the same, yes, sir.

SSG BURGESS: From what Sergeant Lage was saying, is -- and it is a good for us in the way it's integrated. I've had the same squad leader for, I think, about a year and a half right now. And she's phenomenal. And within the structure, I know every squad leader that comes into the company. I mean, me being the NCO, I make sure they know who I am, know what's going on, and make sure I'm integrated.

I've been one of the ones that are jumped down and around. I was in the severely trauma -- in the trauma company, and when they got deactivated, we got moved all around and everything, but they kept our platoons intact. We merged into -- I think it was two or three -- three platoons. We merged company into three platoons, and then moved those three platoons into another company. So we all stayed together as a company, and integrated back into another company, which caused Master Sergeant Alderete and his company to be dispersed more or less into -- but they kept the platoons together and moved them

around.

But in -- if you could wave the magic wand, having somebody like Sergeant Lage, who's one of the most knowledgeable squad leaders that I've known since I've been here -- and from an amputee's perspective, seeing another amputee go in and himself and in his day-to-day job, is somebody that I -- if you could take somebody who's been in the IDES process, who's stayed in the military, who knows the process of the recovery process, and input that as your command structure, even your lower-level, your squad leaders or platoon sergeants within these companies, because that way, that soldier could see, hey, I can bounce information off, and you have that individual who is, more or less, a subject matter expert, because they've been through that whole process and they know the way it works, so they can guide those soldiers if they're going to transition out of the military, or if they're going to apply for COAD or COAR and stay in the military. So they have that knowledge

and they know what avenues to approach how to guide that soldier into making sure they're making the right judgment calls and doing it all.

And with your comment on the Reserves and National Guard, we're integrated solely into the company. Like we are part of the company, we are part of the WTB. There is no difference, we're not treated differently, we're not -- we're identical to the active duty component guys. We dress the same, everything. The only difference is just -- the only thing we have to do is make sure we stay on top of our orders.

SFC TAYLOR: You said if I could change a couple things. If I could, I would. And there's definitely some things that I would change. First thing being the way the IDES process was working oversees. I talked to my chain of command before I left that WTO over there and told him what I had seen, and what I thought should be changed.

Now what's going on was soldiers

would go to an IDES person. An IDES person would give them 20 locations they could go. The majority of the soldiers would pick two locations: Fort Sam and Walter Reed, because they had the best of the best when it comes down to everything. There's only one problem with that. The soldier that really needed to be there is the combat wounded, but because all these guys are in front of them, they're not going to be able to get there until -- by the time they ever get there, it's going to be closed. This happened a lot of times over there with us, the WTUs would be open, and WTUs would be closed, and the soldiers that got in were not necessarily the soldiers that needed that specialty care.

And it's not -- there was nothing -- it was nothing on as far as how they were coming in, it was based on, we were giving them options to pick, and not everyone needed that specialty care.

Again, that caused -- again, it caused a lot of hardship on different soldiers

because they would have to go somewhere lesser, and so forth, like Fort Stewart, more so than a Walter Reed or a Fort Sam, because Fort Sam is now closed because 20 guys just went in. Maybe none of them are combat wounded. There are those guys that took all that was open, so now that soldier has to either wait six months, or whenever it opens, or he'll have to go -- to go get all his care, he may have to go to the only MTF that's open that may not be the best.

So the one thing I would do, I would say is, these soldiers that go on downrange and serving our country, at least give them the option for them and their family to be able to help them get to those facilities that they feel that will best suit their medical needs and their family needs, where -- we need to put a soldier in for when they transition to leave.

The second thing I would say is, going back to what the soldier said. Is put someone in the hospitals, into the units, that actually went through the process. Again, I see

Sergeant Lage around, and he's somebody I kind of guided with my own eyes.

But you don't really have that in the units. You don't really have that. When you're selling the IDES process to soldiers and you're saying, you know, this is how the process goes. You have most likely a person that's selling is not one of us. So all -- I'm assuming that they're doing this based on, this is what you're expecting, versus Sergeant Loge would be giving the same information. That's going to be a little bit different, because he can actually tell me from this experiences what I may be experiencing or what I may be going through. And it tends to be a little bit more reassuring in a person who may not always be as sure of what they're going to -- what's going to happen to them. So I would have to say keep people like this around.

CSM DeJONG: Let me comment on that real quick. We've asked that -- we've been around the world asking -- we spent time in Germany as a

Task Force evaluating the process there, and the focus groups that we've done, I've asked specifically how many of you as transitioning service members or soldiers have been offered to come back to a WTU or would be willing to come back to a WTU. Very few do.

Some of it is because the frustration that they've dealt with throughout the process. They want to -- when they're done, they're done. We've recognized as a Task Force, since our existence, that that is probably the best people to put in those positions is those that have the working knowledge from the inside. It's not always that easy. I mean, we still are a volunteer Army, and someone has to stand up and say "I want to do that."

All the commands said that they'd be willing to take them on a COAD process, if someone was willing to do that, but it's kind of -- it takes both sides to get that.

I understand what you're saying, but it takes people to step up and do that.

SFC TAYLOR: Sergeant Major, as far as in Germany, again, I was there. I was told when I started the process when I was first injured in Germany that it would be better and easier, which it has been, for me to come to Fort Sam or go back CONUS, because it would be more facilitative toward me being able to go on the COAD program, than it would it be oversees.

So most soldiers that are oversees, their chance of them being able to get in the COAD program -- again, it's not saying there's less or more, but the process of them getting into the COAD program like there is in the states, it's very minimal compared to the states, where you have more people pushing you in that direction than you do there. And it's not that it's the chain of command, it's just due to the resources.

In order for them to do a packet or a lot of stuff that they could do here at Fort Sam for me to get my packet rolling oversees they have to send it back CONUS through another time zone, and I know --

CSM DeJONG: I think you misunderstood. I'm not saying that Germany or Europe, for instance, or anywhere outside of CONUS is the best -- is the best area to transition. We understand that. We noticed that. But what I'm saying is anywhere within CONUS that we've asked, very few recovering or transitioning warriors want to stay in to do that. Even though we feel -- and I personally feel they would be a wealth of knowledge within that position.

SSG SMITH: Sergeant Major, I'm a 15-year, I got to an E-7, and that was one of the first things I wanted do when I got to Fort Sam is, I talked to Sergeant Lage. We went on a skiing trip, and I talked to him about staying COAD, because I felt like that was the best -- that was the best position for me to be in. Being in recruiting, communicating all the time, I felt like it would be better for me to walk in Sergeant Burgess's room, as an amputee, to be able to tell him, hey, I understand what you're going through, if you need anything, you know, you can talk to

me. I know your pain. I know what you're going through.

And you're right. I feel like the best squad leader, the best soldier to be in that position are soldiers that want to be in that position. And there's not many of us that want to be in that position, and I understand that.

One of the guys that I saw when I got in told me, be sure you set yourself up for success. Do everything that you need to do, so I'm in the peer mentoring program. I've done everything possible to show the Army that I still have more to give, that I'm an asset, because I'll be able to help other Wounded Warriors.

I've submitted my packet just here recently. I've got letters from two stars, one star and it's still not a definite. I just got word today that it's -- that I have like a 30 percent chance on staying COAD to be a squad leader, just because COAD is not something that the Army's pushing for right now.

CSM DeJONG: Well, we're also in a

difficult -- we're also in a drawdown, so it's ...

SSG BURGESS: Sergeant Major, the same thing as the Sergeant sitting here. When I got here, I was like I'm staying in, I'm not getting out. And I was working my chains as a reservist, putting in my COAR packet to translate back to from dealing with the difference from the COADs to the COAR, because I'd have to go back to a regular TPU status and then apply to go AGR to go back to that squad leader status at a WTU where hopefully I'll be able to be put back on Title 10.

The only thing that's swayed my decisions and everything right now with everything is all the red tape and the bureaucratic stuff and -- that I have to try to cut and weigh my benefits and -- and that makes it harder, because I want to come back and still help the soldier.

Just as the Sergeant said, I'm a peer here. I'm a part of the Warrior Council. I'm doing everything I can to make sure I'm integrating back into the process, help out the WTB whenever they need it. Whenever they call,

hey, all right, I'm here to help. But it's that integrated process where you're sitting there, is my packet going to make me accepted.

And then from the Reserve perspective, I go back home and then I go back to the regular drilling reservists, and then I have to wait, hopefully in the time of six months, because I had an active AGR packet before I started IDES and it was already approved, already had a slot and everything. But the second I started IDES, it went away, because I'm not allowed to hold an AGR packet. So then I have to wait until my COAR was approved, get my AGR packet again, and then apply for COAR again to go AGR.

So I mean, the process is a little bit more -- I mean, just with the drawdown and everything, it's kind of like -- and then you weigh the -- if I retire right now, I retire on an active duty retirement, or do I risk falling into the Reserve Retirement System. So there's -- that portion has a big weight on the Reserve National Guard guys.

CO-CHAIR CROCKETT-JONES: I want to move to a topic, because I want to hear from the two folks up there who have transitioned out of uniform.

Do you think -- tell me about the process pre DD-214. Did it prepare you for the time for getting out? Have you been -- have you felt -- did you predict where you were going to land? Did you have plans for your retirement? Did they work out? Has that changed? Talk to me a little bit about the transition from uniform to civilian.

MSG (Ret.) EHRIG: Don't you want to go first, Tom, since you've got a job?

SGT (Ret.) NELSON: I'm sorry. Could you say that again? I didn't know you were addressing me.

Go ahead.

CO-CHAIR CROCKETT-JONES: Yes. Tell me a little bit about the transition and your preparation for getting out of uniform and going -- and becoming a civilian. Did you have a

plan? Are you -- did your plan work? Did you have to rework it? Were you prepared? Were you prepared for getting out of uniform and becoming a civilian?

SGT (Ret.) NELSON: So my plan was to go civil service, and so I worked with OT and all the folks I could get my hands on to come up with a plan. And I would work with the resume writing folks there. I'm sorry. I forget the department that helps you with that. And we put together a good civilian resume. And I was enrolled in college during all my surgeries, and -- but I still had a year and a half to go to finish my bachelor's degree. So I had a good resume, but I still had to finish it.

So my plan was to get out, finish my degree, and go work civil service. I found out that, you know, even if you have a Retired Sergeant Major block to your resume into the battalion commander who is hiring your job as 63 Zooloo, a civilian counterpart, it doesn't mean squat in the civil service. Because it's all by

name basically.

So that ended quite abruptly, and I started hitting the street looking for jobs.

CO-CHAIR CROCKETT-JONES: Did you use any in-service -- were you aware of any employment services? Did you use like say E2I or DVOP, the Department of Labor, anything like that? Was any of that offered to you? Did you take advantage of it?

SGT (Ret.) NELSON: Again, it's the communication, I guess. I know a lot more about it now that I'm on the employer side than I knew about it back as a transitioning vet. So just -- you know, again, I knew -- I had a resume and I thought I was solid. I did not see a gap where I knew what I could do. You have to -- you have to know there's opportunities in order to pursue them. And if you don't even know they're out there, then you're not going to look, and that's probably what it was. Because I felt like I had done everything that there was possible and that if that didn't work, then -- and knowing that I'm

a Wounded Warrior and the Sergeant who dropped it off on the Colonel's desk. If that didn't work, it was over.

And so -- but it all works out in the end. I ended up finishing my bachelor's degree and I picked up a job at a career fair. But again, you know, it was -- I'll give you a little insight about that. That transition process, it doesn't necessarily go where you think it's going to go. And thankfully that education it opens more doors than just a civil service career. And that's kind of -- you know, I had hoped that we're doing that for our troops there that -- that we're articulating that, because, again, there will be doors slammed but it will open up new ones.

COL MALEBRANCHE: Did you have any assistance from the VA at all during this time, like ERE or a counselor or any of that?

SGT (Ret.) NELSON: Again, I didn't pursue anything -- I didn't know what was out there, again, as far as that goes. It was just

one of those things, like -- I found out through the med board when I got out my VA pay didn't start, for example. This is an example.

My VA pay didn't start. Army -- I was supposed to get CRSC, and the VA said the Army was paying me, and the Army said the VA was going to pay me. I was supposed to get two checks. Anyways, I found out through all of that there's this thing called the Veteran Services Organization that could advocate for me. But by that time I had it all figured out.

And that goes back to the same thing. It's -- a lot of times, it's just you have to uncover this stuff as you go. You don't even know the resources are out there. And so no. Short answer, no, I did not go see -- but if -- you know, in my particular case, I asked everybody and everything and yet there's just probably so much going on out there, we need a single touch point that is easy to access so we can go get information on demand.

MR. DRACH: Did you go through ACAP

or DTAP? Were you aware of Operation Warfighter? And the last part, did you get your bachelor's degree through VA voc rehab?

SGT (Ret.) NELSON: Lots of questions there. Yes, I went to ACAP. Okay. I got a rubber stamp on that. The other question was ...

MR. DRACH: At ACAP, did anyone give you any information about employment resources?

SGT (Ret.) NELSON: Well, I went through everything, and you know that ACAP is down there and I sat down -- but, again, I thought I had my map already drawn out. So when you go to them and you say I know what I'm going to do, this is easy. Come on, I'm an E-8, there's jobs everywhere. So they go, you got this. You got it. And so that's kind of the deal.

I mean, maybe they don't know how much of a challenge as it's going to be, or whatever. I was just so self-confident, but I would probably lean more towards that. My confidence level was so high, they probably

couldn't have -- they probably couldn't have told me that this was going to be a challenge.

So -- but yes. So I did. I went down there, I told them here is my plan: I'm getting my bachelor's degree, I'm going through this, and I'm doing that, and I'm going to pursue this. And they're like, looks like you got it all planned out. I showed them my resume. It was boom, boom, boom, locked and ready to go. So they left me alone, more or less.

And I know that that office is there and I've been back, but again after I transitioned out, getting over to the installation is less and less likely, so ...

MR. DRACH: So when did you get your bachelor's? After you got discharged?

SGT (Ret.) NELSON: Yes. About 12 to 18 months after I got out of the service.

MR. DRACH: And did you get that through VA voc rehab program?

SGT (Ret.) NELSON: That was your next question. Yes. That was through VA voc

rehab.

MR. DRACH: And voc rehab did or did not help you with employment?

SGT (Ret.) NELSON: So, again, I finished -- that all happened relatively fast, as far as getting that rejection and getting picked up by a civilian company. That happened so fast, I really didn't have a chance to flounder. I was very fortunate in that respect, because I actually still had about a month of class left when I got -- I just told them on my resume I was done and I explained it to the recruiter, that I'm pretty much done, and so I passed the gate.

MR. DRACH: Thank you. Okay.

MSG (Ret.) EHRIG: Okay. The reason I wanted Todd to go first is because -- well, we know each other.

I'm a burn patient, I forgot to tell you. I apologize. I don't look this sexy all the time.

I got medically retired in 2008. The one thing I promised myself was that, as a

senior leader, I was not going to get out and let another soldier I could talk to ever go through what I had to go through. Yes, it was a different time, and things were transitioning. I did go through ACAP. And to answer your question on that part, no. They did not help me.

The one thing I have done since I've gotten out is learn the systems on the inside and out, and also to understand what the problems are, what the dysfunctions are. TAP has improved, I'll give it that. That they have improved, but the overall posts that I'm getting from the veterans I'm connecting with -- and I connect with thousands a year -- is that they're still not getting what they need.

In his situation, he was lucky. He secured employment pretty quick. In my situation, I did not. And the one thing I noticed on the outside was that unless I was in D.C. or some other highly concentrated area like that, employment for a senior enlisted person was very slim, because they wanted to hire everybody else

with less skills. That was reality. I was told I was overqualified, and that's the first time in my entire adult life that I have ever been told that I am too skilled to do something. And that's from military and nonmilitary personnel both.

Overall, though, when I compare things, I look at it and I talk -- I think about all the people that I talk with and get a relationship with them and understand what the problem is. So my situation is kind of an outlier, compared to the overall group of people trying to get help. You know, they express concern that TAP is either in a hurry or not providing the resources on the outside. They're providing the standard party line where we say, okay, X, Y, and Z, DoD program, this program and that program, ESGR for National Guard Reservists. But the reality is there's thousands of other programs out there willing to help, wanting to help, and paid to help Veterans that they're not connecting with.

As Todd said, and the example could

be to make one conduit. But the reality is, is that we can't get anything within the perimeter of the installation to work on the outside of the perimeter of the installation. It's just slowly happening right now. And, again, the only reason I know that is because I've been pushing for it in this community for five years. And whether or not that's now being pushed down from the DoD to highly encourage people to do that, I don't know. But it's just now starting after years and years of having a need for that problem.

CO-CHAIR CROCKETT-JONES: I have a question for both of you. Are you enrolled at the VA in the OIF/OEF program office? Either one of you.

MSG (Ret.) EHRIG: I am.

SGT (Ret.) NELSON: I might be.

MSG (Ret.) EHRIG: He is.

SGT (Ret.) NELSON: Okay.

MSG (Ret.) EHRIG: He is.

SGT (Ret.) NELSON: I have my doctor. I call my doctor, she helps me out, we're

good.

CO-CHAIR CROCKETT-JONES: There are case managers at the OIF/OEF office and that's what I'm wondering if --

MSG (Ret.) EHRIG: There are case managers, but to put it bluntly, they're inept. And the reality is, is they're overworked, they're not skilled in what they need to know for their positions, and when we try to reach out for more assistance, we can't get it. And I'll give you an example.

What I do is, I test the system all the time. And I know when they're supposed to contact me and what they're supposed to do and what services they're supposed to offer. So I try them out.

It took nine and a half months for my case manager to call me back, and it wasn't even on the voice mails that I put in. The only reason I got a call back from OIF/OEF case manager's office was because I know the guy who's a supervisor there, who's also a Wounded Warrior.

And I threatened to call Congressional on his voice mail just so he would call me back.

Now, I'm an E-8 with 17 years on active service. If I can't get in there, how does a Private or a Specialist or a PFC or a Sergeant, who doesn't know anybody other than that one person to touch, to get in? The most support I got was out of my Federal Recovery Coordinator, who was out of BAMC. And she cares more than ten caseworkers do about the people that they talk with. She is well overworked, she is well underpaid, but she cares about what she does and she cares about the people that she helps. And she's still only in that very small limited population of severely wounded personnel.

COL MALEBRANCHE: She wasn't able to get you into the VA system with the case manager?

MSG (Ret.) EHRIG: My Federal Recovery Coordinator was the one helped me the most with everything. VA, military, nonmilitary. I got into the VA system kind of by pushing my way through, figuring it out. And then I shared that

with other personnel. I -- you asked me before about voc rehab. Yes, I did use voc rehab. I received my bachelor's, and I'm actually working on my master's, because I felt that, you know, maybe if I'm overly, overly qualified, I might get hired. So if that makes any sense anywhere.

MR. DRACH: You're working on your master's now?

MSG (Ret.) EHRIG: Yes, sir.

COL MALEBRANCHE: I was just wondering. If the Federal Recovery Coordinator, who is a VA employee unless she's functioning out of a military place, did the handoff or connection to the VA for you in that case management piece, or was she doing all the case management totally for you?

MSG (Ret.) EHRIG: In my situation, and some of the situations I see, there's no real handoff. She kind of took over and tried filling in where everybody else failed. Whether that be on the installation or through the VA, she -- yes. I know she's a VA worker. She's assigned at Fort

Sam now in BAMC. And she basically was trying to pick up all the pieces that were missing or mistakenly done by the other personnel, instead of trying to do that battle handoff knowing that the person you're handing off to is failing at their position.

And I could tell you again, I use the entire system. I make the complaints, I express the concerns. I'm sitting here and coming up on 2014, I'm here to tell you that that system is no better than when I started in 2008.

SSG SMITH: You've got to know that from what we're saying, that it makes it really scary for our younger soldiers to get out. Like these soldiers are like 19, 20, triple amputees, double amputees, even single amputees. The things that these guys are going through that they're expressing, and they are high ranking. They got out as Master Sergeants with 20-plus years, that's probably combined of over 50 years of service up there, and everybody up here is pretty much. Saying like that what's in place is working; but

it's not working.

And it makes -- it makes -- I'm scared -- I'm not going to lie. I don't have a degree and I'm scared to death to get out, just because I don't know what's going to happen. I don't know if the VA is going to take care of me. I don't know when I need it, will they be there.

There's a lot of services that go on on Fort Sam, and anywhere else, but a lot of it is just because, hey, our company is here, we showed up. Will they really help you when it comes down to it? And I'm not saying like our hands are out or anything like that, but soldiers need assistance. So just think about that.

We had a soldier today. Left today. This guy is a triple amputee. He just med boarded out. He has no clue what he's going to do. Severe TBI. He has to go home and live with his parents. This dude is like 20. He has no idea what he's going do.

The squad leaders, they do everything they can, they did everything they

could. But there's so much information that there's no way they could possibly know what button to push. So unless you're one of those guys that's been able to politic and get out there and do your own legwork, you don't know what button to push. You could push a thousand buttons and still not push that "Price is Right button," and that's the problem.

So if these older guys with a lot of experience is having that trouble, I just want you to think about what the younger guys are having issues with.

I mean, to be honest with you, I think all of us would be scared to death to get out right now, unless you've politicked and you've communicated with other people and you have something solid. Very, very fortunate to get out and land a job with USAA, and -- I mean, the troubles that he's gone through, and I'm -- unless you have that forceful, that dedication, I'm just going to push my way through the system, and I'm going to do whatever I need to do, a lot of them

guys' spirit are completely broken and don't have that will, that energy to do it. Even if it's life or death or living in the streets or whatever. They don't have that energy to do it.

So what are they to do because there's nobody coming up to them like, hey, Private Such-and-such, I know you're not able to, but I'm going to help you do what you need to do. It's not there.

SSG BURGESS: These soldiers have the resources right here for them. Right here. They can walk over to the Soldier & Family Support Center, they can walk over to the Warrior & Family Support Center. They could walk up to the squad leader, walk into the commander's meeting, because the WTB has a strict open-door policy now. If you walk into the WTB commander, he'll talk to you. I mean, he's not going to shove you away or try to push you away. If you walk up to any of these NCOs, they're going to help you out.

But when these privates leave here, they're not staying here in Texas. They're not

staying in the Fort Sam area or Walter Reed area, they're going back to the boondocks or wherever they came from, and they don't have these resources to be able to go. Half of them don't even know that, hey, I should move into an area -- if they have traumatic injuries -- I mean, three of them are amputees up here. We should be going to a VA center that's going to be able to handle -- live in an area near one. We have to plan for the rest of our lives so we can get the care, to get the equipment we need to function on our day-to-day lives; i.e. a walker, hands to do stuff with, even the burn patients. So they don't plan that way. They're not thinking that way in life. And they go and there's no VA center around for four hours away, so they don't know the resources that are right there that they need to be able to help out with.

And, Todd -- I just talked to Todd last Thursday afternoon, reached out to network, because just as Sergeant Smith, I'm dead petrified because I have -- I'm losing my military career,

and I'm also -- my civilian career as a corrections officer, I can't go back and work inside a jail that I've been doing for 12 years as my public service job. So now I'm completely flipping scripts, to try to outwork, network and research to where I'm going to go.

And, I mean, I think I told Todd the same thing. You know, it's that famous question. They go, what do you want to do when you grow up. I'm a soldier, this is what I do, this is who I am. How am I going to change that? I want to be able to -- I want to be able to help soldiers out.

But just as he said, senior leaders. We're all leaders in the military; how are we going to go out? Because people are going to look at us and we're overqualified because we're going to be looking -- we want to be in that staff position to oversee, to take care of people, because that's what we do as NCOs and officers. We take of our soldiers.

CO-CHAIR CROCKETT-JONES: I have a question for you guys. How many of you have heard

of or used the E2I, Employment and Education Initiative? Any of you familiar with that?

SGT (Ret.) NELSON: I'm working with Lance Dowd right now. He's our local rep right now, so -- but as an employer.

MR. DRACH: Who do you work for again?

SGT (Ret.) NELSON: USAA.

MSG (Ret.) EHRIG: But he's not promoting it.

(Laughter.)

MR. DRACH: Have you ever heard of the Department of Labor's Real Lifelines Program?

MSG (Ret.) EHRIG: I have.

MR. DRACH: You have?

MSG (Ret.) EHRIG: The one thing I think that overall, not individually as y'all are, that I've noticed that's still missing that was missing when I tried transitioning out, and what I've again witnessed over the years, is that there's so much on the outside that DoD is not allowing the outside and the inside to connect to

make that transition. Everybody wants a warm handoff, and -- just like I said, I don't want to bash Wal-Mart, but their hiring initiative is kind of flawed because they're trying to hire veterans at individual hourly wages that will keep them in poverty. If that's what you call fair wages, then great. But I don't think the veteran should be, you know, looking at it as poverty, but the reality is is that, as all these soldiers have already expressed, they're not getting the information that they need to go on into the future, and that's what we're standing here and we're all asking about.

You know, Recovering Warriors -- I'm a Wounded Warrior and I'm still recovering, but the reality is that the same soldiers that I see coming out in the last five years are still not getting that information, are still not getting that connected, you know, continuation. The VA system is a continuation of the military in health care. It's supposed to cover those other services like education, like employment. It's not. So

what do we do to compensate for that?

Why not do what we know is there: Utilize the resource on the outside and make that handoff. You know, rather unorthodox and different for the government to do, but the reality is that, as a government, we are not fulfilling the needs of our veterans.

CO-CHAIR CROCKETT-JONES: Can I change gears for just a second with you guys? I'm not sure how many of you have gone through this process with a spouse or with your parents who was intimately involved in -- or a sibling. But if you can think for a second, did -- was their needs -- were they aware of their benefits? Did they have resources or was there a persistent need that didn't get met among those -- among your family members as you had this recovery and transition journey? Were you aware that there were benefits for family members, things like that? I want you to talk -- can any of you talk to me about that?

MSG ALDERETE: Yes, ma'am, I can.

When I first got here, I came from the WTU in Fort Bliss. And Fort Bliss, they couldn't take care of me or do anything for me, so that's why they interviewed me to -- or I requested to be transferred to Fort Sam. And when I got here, one of the first things that I was able to get informed of was the benefits that I could get for my family.

I was briefed on it by the Warrior & Family Support Center, I was briefed by the SFAC as well, and my chain of command. So I was able to reach out and try to get things for my family because of those folks being able to brief me and get me involved in trying to get all these things for me.

Now, what they're talking about, and specifically what he's saying, there is a lot of disconnect with a lot of soldiers. I'm also an E-8 and I'm used to going and finding my own information. So I did go and pull that information out, but you have the younger soldiers who don't have that ability. But as far as for

me, yes. I was able to get that information.

CO-CHAIR CROCKETT-JONES: I haven't -- Sergeant Flores, I'm going to put you on the spot. If you were queen for a day, you can do -- the first thing you get to do, you get to do anything you want to change this process, to change anything, policy program, little, big, anything that would change the process of recovery and transition, what would you do.

SSG FLORES: I think for me personally, the problems that I've had are the physicians. I've encountered a lot of problems with the physicians. One in particular -- well, actually, two in particular. One -- I know that there's a lot of soldiers that they see, and I don't particularly care that they put us all in the same hole.

There's some people that, unfortunately, take advantage of the system. I had one that just happened not too long ago, about 30 days ago, a neurologist, I'll just say that much. And I was referred to them because of my

migraine headaches that I got -- I had really them severe, and also, because I was supposed to be referred to a TBI clinic as well for my injuries. And I'm giving him all the problems that I've been having, cognitive issues that I'm having, and he just kind of looked at me and he's like, this is stuff that you're encountering because of your migraine headaches. And I'm like, no, this is -- these are different issues that I'm encountering. I have a degree in education, special education as well, and this is not the norm, and I'm going on and on.

And so basically the bottom line was, he told me -- he says, so you're basically just trying to get a larger disability. I said, excuse me? No. I'm really worried about what is going on with me, and I just want to know what exactly is going on with me medically. That's what I want to know. And I asked him -- I said, please don't put me in the same pool as everybody else. Look at me as an individual. I said, are you going to give me the referral to the TBI

clinic as my PCM asked, or do I have to go back to the PCM to get that referral?

He reluctantly gave it to me, but that's not the first encounter I've had that's not been a pleasant one. And that's the only problems that I've had personally with the system is that the doctors always want to downplay basically -- of the symptoms that you have.

I don't know -- personally for myself, I don't know if it's been because I'm a female -- and that's just the way I feel. The stuff that I've been through, I feel that had it been a male counterpart going through the same things that I've been through they would not be questioned as much as I have been. And that's just my take on it.

For the males, it's very easy for them to just say, okay, yeah, you know, yes, it's a TBI, yes, it's this, it's that, yes, you have PTSD. For me it's been a very long road, because of constantly having to -- I feel like I've got to keep fighting for myself to prove that, yes,

indeed, these are the medical problems that I do have, because I didn't have any of these issues prior to the deployments until I returned.

So that's the frustration that I've had to try to prove to them that, no, I'm not making this up, I'm not that kind of person, and I don't have that character.

CO-CHAIR CROCKETT-JONES: Do you have a nurse case manager?

SSG FLORES: Yes, ma'am, I do.

CO-CHAIR CROCKETT-JONES: Do you feel comfortable in the relationship with your nurse case manager or do you not feel like that person is a -- is the right advocate or --

SSG FLORES: No. I do. I have a very good relationship with her, and I have expressed all this to her. And that's why I've actually had to change doctors a couple of times, because of these incidents and the comments that were made. I went on two different occasions. You know, they were just surprised. They said they've never heard doctors actually do and say

the things that they have. This happened to me. I'm sure I'm not the only one, and I'm not going to be the last one.

The reason I reported it is so that another soldier doesn't come behind me. And, I mean, I don't have a lot of rank, but I am an E-6. I can imagine somebody else with less rank how they were being treated.

CO-CHAIR CROCKETT-JONES: How has this process as we've brought this process to the attention of your like Cadre and others, do you think that people are hearing the issues when you bring it forth out of the nurse case manager?

SSG FLORES: I think the nurse case manager actually is -- has been more willing to help and accepting of what's actually happening, because they have heard this problem before. It's not the first and it's not going to be the last. Unfortunately, the Cadre in my section have not been very cooperative. It's kind of -- it goes in one ear out the other, "Oh, it's just another problem that we're hearing."

I haven't had the -- everybody here has been saying how wonderful their squad leader has been, that Platoon Sergeant. I haven't had that. It's been difficult for me. Our Platoon has had a lot of issues. I've gone through four squad leaders, but that's just because our platoon has kind of been disarrayed.

COL MALEBRANCHE: So if you need help, who is your go-to person?

SSG FLORES: I always go to my case manager. That's usually who I go to. And she usually facilitates to the squad leader and then to the Platoon Sergeant, because it's just been a total mess. And not even -- the case manager doesn't particularly care for the -- our Platoon -- I have a new one now, so hopefully it will be a bit better now.

CO-CHAIR CROCKETT-JONES: Well, in the last couple minutes, is there anything else that any of you would like to bring forward to us, do you think that we've missed? Is there something we didn't ask you about that we should

have?

(Inaudible dialogue.)

That would be actually helpful for us. I'm going to get you to comment and then I'm going to ask each of you to tell me who is your go-to person. Who is the person when you have a question a an issue? Where is the first place you go?

So what were you going to say that we forgot? I would like to hear that.

SFC TAYLOR: As far as my comments on IDES, I just want to make sure that you're clearly aware that my issues were in Germany. They were not related to BAMC. BAMC had provided awesome care to me and my family. Everything that I've asked, they answered full on. It was just -- over there, just logistical part is very difficult.

CO-CHAIR CROCKETT-JONES: IDES is something that we have been noticing.

So go down the line. Who is your go-to person and currently who is that. And if

you are post DD-214, who's your go-to person.

MSG (Ret.) EHRIG: Mine was my FRC. Now I, I guess, I use a combination between her previous manager, who's actually in charge of the caseworkers and one of my voc rehab counselors.

MSG ALDERETE: I go to my case manager. She's pretty well rounded and understands a lot of the system. Being a nurse that she is and being in nursing for so many years, she has a pretty good training and experience and she's able to talk to -- on my behalf, go to different places if I need it.

SSG BURGESS: Same thing. Case manager. And it's not just my case manager. My care is Center for the Intrepid, so there's separate case managers from the regular WTB. And I go see all of them, and they're all very helpful and very knowledgeable.

If I ever have an issue, regardless if I'm just needing to pop in for a minute, I just pull one of the case managers aside and talk to her because she always has a level head. You go

and sit there you'll be, like, hey, this is a problem. Especially if I'm -- as she said, agitated with a physician. And I'm like I'm firing this guy. I would refuse to go ever see him again. She's very understanding and knows everything that's going on and she's been the only person that's been there since day one.

SSG FLORES: Mine's the nurse case manager.

SSG SMITH: I go see Alfonso, my communications go-to at CFI. That's who I depend on.

COL HOWELL: My squad leader and Platoon Sergeant are excellent.

SSG LAGE: I really don't have any current issues, but if I do, I talk to my FRC and the AW2F.

SGT (Ret.) NELSON: Back during transition, it was my case manager. It got to the point where it got on a first-name basis. And later to, you know, retirement parties and all that stuff, because it was really the center. And

then now I feel like if I needed something, if I needed a central point, if I needed to push, I feel like I could go to my AW2, who calls me about once every 60 to 90 days, just to check in with me, just to ask me if I need anything. If I don't answer, they still leave a voice mail.

And, again, I don't go for much, but I feel like at least there's somebody there that has no, like, party lines. To me it's, like, from my understanding, she could go anywhere she needs to go to get whatever I need to get.

And I think that -- just to summarize, you know, what you see here is a bunch of senior NCOs and officers. Right? So the perspective is is that -- a couple of things. One, they're going to leave us alone when we're there. They're going to respect us, that we're self- -- you know, we're going to take care of ourselves. So this is just one thing to keep in mind.

But the other thing, you know, we're also to the point where we, you know, are going to

go find out the information. And I think one of the major takeaways here is that the information is out there. I think Bobby and I can attest, it's out there. What it's hard to do is find the information. So a new initiative in the Army is in knowledge management. I think the AW2 and -- excuse me -- the Wounded Warrior Programs and stuff need to get some of the knowledge management processes stood up where that information is seamless, it's streamlined, it's not so scattered. They need that.

That's, to me, the biggest takeaway is it's out there. This group can find it, but we're scared for our troops that they're not going to be able to find it, especially when there are folks with TBI and issues -- cognitive issues as well.

SFC TAYLOR: Mine would be nurse case manager, my squad leader, and my AW2 rep while at work. But I also rely on retirees and soldiers who have been through the process with asking them questions so that it's not so

stressful to me when I get to that hurdle. Someone else has already crossed it that can explain to me what to expect, so it's not so scary.

CO-CHAIR CROCKETT-JONES: Well, I want to thank you all for your service. I want to thank you for sharing your experiences with us. This is how we reach consensus as a Task Force on what we need to recommend to the Secretary of Defense or to Congress that the law needs to be changed. This is how we check the intentions from higher up programs, versus the reality of how those programs work.

So you just have just subject matter experts who help us align our priorities as a Task Force. And I'm very grateful, and I wish you all the best. And those of you who have yet to transition, best of luck and I -- I'm wishing the best outcomes for you. And those of you who have already transitioned, I hope that you find your new normal to be fulfilling lives ahead.

Thank you again. And this concludes

our business meeting. Thank you.

(Whereupon, the foregoing matter was adjourned at 5:06 p.m.)