DEPARTMENT OF DEFENSE

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

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BUSINESS MEETING

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THURSDAY
APRIL 17, 2014

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

PRESENT

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

ALSO PRESENT

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

A-G-E-N-D-A

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

(8:33 a.m.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

will be looking at in May.

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

Number three, slide down a little bit more, would you please? There we go. Number three, to promote inter-agency healthcare collaboration in harmonizing components of DoD/VA and civilian IT systems. So, this A, B, and C under this one are some of the directions we would go. These are some of the data points that we have and could possibly flesh out at this point.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I recently sent out a packet of

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

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

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

recommendations.

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

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

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

Okay. Any other questions? Thank you.

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

So, we will convene again at 9:00.

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

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

Our first statement comes from Mr.

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

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

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

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

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

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

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

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

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

regardless of time served.

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

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

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

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

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

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

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

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

making the final disability - DoD disability determination.

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

I'll answer any questions that you may have.

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

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

DR. STONE: So why as an employer

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

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

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

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

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

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

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

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

MR. PARKER: Oh, absolutely.

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

MR. PARKER: Right, and I would

think -

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

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

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

DR. STONE: So why -

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

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

MR. PARKER: Well, and I agree. I

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

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

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

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

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

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

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

DR. STONE: But, again, I ask you

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

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

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

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

DR. STONE: Thank you very much.

MR. PARKER: All right.

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

MR. PARKER: Okay. Thank you very much.

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

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

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

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

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

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

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

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

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

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

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

compensation is provided for.

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

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

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

CSM DEJONG: Correct.

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

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

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

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

CSM DEJONG: And each pension

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

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

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

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

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

DR. STONE: See, now you begin to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. PARKER: Appreciate it.

CO-CHAIR CROCKETT-JONES: Thank

you, Mr. Parker.

MR. PARKER: All right. Thank you.

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

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

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

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

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

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

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

in curative benefits they have earned and need.

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

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

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

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

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

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

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

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

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

the DoD to reform. DoD did make notable reforms.

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

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

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

MR. GEHRKE: So I think the

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

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

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

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

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

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

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

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

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

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

with this PD removed from my discharge papers.

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

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

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

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

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

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

MR. GEHRKE: That's correct.

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

MR. GEHRKE: Yes.

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

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

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

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

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

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

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

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

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

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

MR. GEHRKE: Say that again.

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

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

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

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

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

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

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

would suggest that they do.

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

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

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

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

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

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

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

MR. GEHRKE: Thank you for your time.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

opposed to just filling bodies and stopping.

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

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

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

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

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

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

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

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

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

this study?

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

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

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

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

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

LT COL WONG: Thank you.

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

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

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

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

At the top, behavioral health

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

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

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

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

CDR CHARISSIS: After having been

diagnosed?

CAPT SANDERS: Correct.

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

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

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

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

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

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

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

The uniformed military has pretty

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

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

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

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

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

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

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

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

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

that we are reaping the benefit that is warranted.

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

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

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

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

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

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

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

And also continuing to operate

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

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

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

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

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

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

DR. STONE: Okay.

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

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

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

Guard seriously wounded and injured population.

I would like to begin with addressing recommendation 16, which is optimized SCAADL implementation. This had to do with the recommendation for proposed legislative change to exempt SCAADL from income taxes. The Navy partially concurs. We just want to make sure, we think overall that this will be good for the program but we want to make sure that the wording is correct. There has been some concern from our recovering service members and caregivers about the potential for if it is just tax free on the front and of kicking them into a higher tax bracket. So, we want to make sure that it is treated similarly to like the BAH housing benefit of where it would be nontaxable income that comes in and not have that effect. And we, obviously, need to message that after it goes out to ensure that everyone is aware that that is not going to affect them.

Yes, sir?

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

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

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

CAPT BREINING: Correct. Yes, sir.

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

request out to ensure that they receive the benefit.

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

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

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

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

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

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

move forward with our data collection.

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

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

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

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

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

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

CAPT BREINING: Yes, ma'am.

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

CAPT BREINING: Correct.

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

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

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

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

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

So, thank you.

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

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

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

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

separated.

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

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

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

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

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

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

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

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

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

CAPT BREINING: Yes, sir.

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

CAPT BREINING: Right.

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

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

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

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

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

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

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

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

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

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

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

Any other questions on that portion?

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

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

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

CO-CHAIR CROCKETT-JONES: Can I --

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

CAPT BREINING: Yes, ma'am.

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

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

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

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

MS. LARSON: All outgoing calls.

CAPT BREINING: All outbound calls.

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

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

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

CAPT BREINING: Absolutely.

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

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

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

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

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

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

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

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

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

adaptive systems that we provide.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

being applied.

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

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

CSM DE JONG: Absolutely.

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

needs.

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

CAPT BREINING: I appreciate that question.

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

programs.

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

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

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

population.

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

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

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

actually working.

So, some key initiatives that came along with this in separating out the NMCMs and the RCCs, making sure they understood their responsibilities. This is in compliance with the DoDI.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CAPT BREINING: Please.

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

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

people that qualify.

MR. REHBEIN: Absolutely.

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

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

CAPT BREINING: Right.

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

MS. HILLIER: Correct.

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

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

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

MS. HILLIER: I would say yes to that.

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

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

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

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

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

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

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

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

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

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

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

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

CAPT BREINING: And we got the

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

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

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

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

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

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

much know how effectively you have penetrated this population.

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

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

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

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

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

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

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

DR. STONE: Yes, I am not sure.

CAPT BREINING: I didn't mean to

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

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

CAPT BREINING: Absolutely.

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

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

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

application.

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

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

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

and how do we fit into that niche?

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

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

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

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

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

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

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

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

CAPT BREINING: Do we that number?
MS. HILLIER: Zero.
LTCOL KEANE: Zero?
MS. HILLIER: The Coast Guard does not have SCAADL.
LTCOL KEANE: They don't have SCAADL?
MS. HILLIER: They do not, sir.
LTCOL KEANE: Thank you.
CAPT SANDERS: Are you going to integrate the Call Center with your redesigned website so that there is an active integration between the two?
CAPT BREINING: Do you want to take that one?
MS. LARSON: Sir, that is a great recommendation. That is something actually we have been looking into to understand the cost associated with that. It is one of our wish lists.
CAPT BREINING: So the enrollment challenge is also with the medical community

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

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

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

Finally, through our transition

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

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

So, any questions? Thank you.

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

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

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

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

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

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

In the notes of the slide it talks

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

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

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

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

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

give us their manning.

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

The other aspect is --

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

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

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

MR. POWERS: Right now --

DR. STONE: How many people are

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

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

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

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

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

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

MR. POWERS: Yes, sir.

DR. STONE: Got it.

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

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

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

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

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

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

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

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

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

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

CAPT SANDERS: Thank you.

MR. POWERS: Yes, sir?

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

more personnel and funding?

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

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

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

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

exceeds $300 million a year in administrative load.

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

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

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

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

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

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

Now that is sort some of the

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

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

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

CAPT SANDERS: Okay.

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

MR. POWERS: Presently we are, sir.

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

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

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

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

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

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

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

So, the issue would be --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

are rejecting.

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

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

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

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

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

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

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

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

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

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

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

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

make a difference statistically that we have seen.

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

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

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

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

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

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

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

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

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

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

MR. POWERS: Yes, sir.

The final is that --

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

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

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

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

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

MR. POWERS: Sorry.

MS. DAILEY: You are over time. We can run down this rabbit hole if you want but just let me let you know that we are over time.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

and Dr. Poindexter will proceed from there.

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

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

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

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

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

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

MR. LARRY: Yes, ma'am.

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

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

MR. LARRY: Thank you, ma'am.

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

MR. LARRY: How many --

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

that are in the program?

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

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

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

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

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

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

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

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

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

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

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

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

DR. STONE: You could get out of

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

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

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

orders.

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

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

LT COL WONG: I just also want to

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

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

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

But for us in terms of those three

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

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

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

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

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

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

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

So we have to concur with that.

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

Any questions?

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

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

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

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

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

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

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

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

And one last one here on the

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

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

And every time in need help, there

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

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

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

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

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

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

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

there.

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

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

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

Recently, the person who, the two

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

And I know there is going to be a question.

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

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

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

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

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

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

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

Any other questions?

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

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

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

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

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

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

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

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

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

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

This is one of the toughest things for everyone.

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

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

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

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

There, I have given my little pep talk.

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

some of that hesitance.

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

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

Any other questions?

And now, I will turn it over to Mr. Tim Townes. He is with A1 Air Force Personnel and he is going to go over the last slides that we have.

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

and oversight for the program.

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

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

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

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

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

DR. STONE: What number did you budget to?

MR. TOWNES: I'm sorry, sir.

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

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

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

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

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

MR. TOWNES: The ones that are on

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Any questions on this one? Okay.

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

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

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

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

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

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

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

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

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

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

him to call and he does, eventually.

CAPT SANDERS: Before you move on --

MR. TOWNES: Yes, sir?

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

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

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

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

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

Did that answer the question, sir?

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

LT COL MEERSMAN: Yes, sir, we

can.

CAPT SANDERS: Okay.

LT COL MEERSMAN: Whatever discrepancy there is.

CAPT SANDERS: Thank you.

LT COL MEERSMAN: Yes, sir.

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

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

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

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

things we can continue to pay attention to.

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

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

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

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

Larry one more time.

MR. LARRY: Okay, thank you, Tim.

MR. TOWNES: Yes, sir.

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR CROCKETT-JONES: Thank

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

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

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

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

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

Thank you, my Air Force compadres.

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

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

(1:16 p.m.)

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

COL BUHL: Thank you, ma'am. Okay, am I -- I am. I'm on.

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

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

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

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

to go faster on things that need to be done. I have been watching it for two years.

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

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

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

(Applause.)

COL BUHL: More to come, we pray.

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

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

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

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

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

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

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

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

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

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

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

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

We also have had already nearly

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

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

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

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

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

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

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

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

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

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

Are there any questions on that?

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

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

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

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

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

for your Reserve Component --

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

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

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

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

COL BUHL: Catch-up would be the best phrase. We are working well.

Any other concerns? Next slide.

Again, we are deferring to DoD for decision. As you, I think, everyone at the table knows, we do not have a separate

Physical Evaluation Board, nor do we, the Marine Corps, have medical providers. And we don't have direct influence in the PEB. Our Care Coordinators do remind every Marine to take special note of the conditions that they are claiming. We assist them every step of the way to ensure that they are comfortable in the IDES process and with the documentation that is going into the IDES for submission. And when Marines or Sailors have concerns, both before, during, or even after findings, we have IDES attorneys that are on hand and ready and do assist wherever required.

If anything, the IDES is a very good news story, in terms of timeliness, of the integration that has occurred between the VA and DoD. And if anything, it is just steadily improving and we are pleased.

Paul, do you want to add anything to that?

MR. WILLIAMSON: Just the fact that the Department of Defense is in the

process right now of establishing a Quality Assurance Program. We have been reviewing what that new policy will involve.

In the in-state, there is going to be at least five different levels of review. There is going to be an in-process case review. There is going to be a post-process case review. There is going to be a consistency reviews process. Customer surveys, which are currently used as a measure of effectiveness will remain a component of that. And then the fifth piece will be VTA data review. Again, that is currently being utilized to monitor the effectiveness of the process.

Those are going to be the in-state elements of this Quality Assurance Program, which is intended to be completed and in place by the end of FY15. By the end of this year, the fourth quarter of 2014, this DoD manual, Volume 3, will come out and lay out the specifics of how this Quality Assurance

Program will be instituted. The goals and objectives will be in there. The roles and responsibilities with detailed disability case review and reporting process will be revealed, as well as the quality improvement activity reporting. And all of this will be reviewed quarterly by the Disability Advisory Council.

So, I think this is going to be a good step forward to ensure consistency of the disability evaluation process at all stages, the MEB phase, PEB phase, and then the transition phase going forward.

COL BUHL: Thank you, Paul. The next slide.

On this, the Marine Corps did not concur with the recommendation. And just quite frankly, along the lines of a previous question, we are unaware of any significant issues in terms of supporting Marine Corps family members, travel claims, or claim processes. And we don't think there is any change required for us.

We also do not want to prevent or in any way hamper our line leadership's ability to take care of our family members. We don't think there is a policy change needed in this.

DR. STONE: So, this is not asking for a policy change. This is asking for uniform application of the existing JFTR. Is your non-concur then asking for maximum discretion of the command to not follow JFTR?

COL BUHL: No, not at all. We are all legally bound to follow the JFTR, absolutely.

DR. STONE: So, I am just not sure why there is a non-concur, then.

COL BUHL: Well, I think -- Paul, do you want to step in on that one?

MR. WILLIAMSON: The non-concur stems from it is the unintended consequence that might result from a more prescriptive manner by which this would be instituted. It may solve this problem. It may have a

reaction elsewhere within the ability of commanders to issue invitational travel orders, those types of things.

Now, this issue is from our Pay and Entitlement, not from the Marine Corps Wounded Warrior Regiment but from the overall Marine Corps pay system looking at this, again, at the unintended consequence.

CO-CHAIR CROCKETT-JONES: I'm going to jump in because I think that this is a misunderstanding of the recommendation.

The genesis of this recommendation was that two service members, different services, find themselves in beds next to each other, same injury, same time lines. One manages to get their family members bedside pretty quickly. And the other service, because of the process that they use to follow JFTR regulations, takes seven days' longer and has more, they have added some stops in the paperwork. Those family members don't get bedside at the same time. And this is felt

painfully by the service members and their families.

And we want a duty to say services are equally obligated to meet the spirit of those permits and that those pay issues that get someone to the bed side. And we wanted them to eliminate some of these discrepancies by saying the end result is the way we measure this. Did you get the people there in a consistent and standardized manner? That was the entire genesis of this recommendation was to see those. As we go to more purple MTFs, we are going to have more and more people side-by-side in beds from different services. And where they are using different processes and one is a much better practice than the other, we want the answer to be we can do it that way and have the better effect. It is the genesis of this recommendation.

So, when we see the Marine Corps saying they don't concur, we are worried that this is the Marine Corps saying we don't want

to be obligated to get people to the bedside in every case. So, that is why we wonder why you non-concur.

All we are saying is we want people to get to the bedside in some standard fashion and with some equalized time lines.

COL BUHL: I know Paul wants to speak. I will tell you, look you in the eyes and tell you I would be standing in front of General Amos' desk and maybe Mrs. Amos would be nearby if I didn't have family members bedside post-haste. And we do. I am accountable for that. But, Paul, please.

CO-CHAIR CROCKETT-JONES: That is why we are surprised at the non-concur.

MR. WILLIAMSON: Part of this, too, Ms. Crockett-Jones, was not the case where one of the services, once a service member was taken out of a military treatment facility and transferred to a non-military facility, the issue of non-medical attendants was in question as well. Maybe I am taking

this a little bit further than --

TSGT EUDY: And that issue was addressed, actually, yesterday by the Army and the panel of one representatives amongst the services talking about getting together to make sure that everyone is doing it on the same exact time line so that the same entitled benefit that one member sees in another service are going to get it in that exact same manner, versus just a different sub-interpretation of the same language that everyone is reading.

MR. WILLIAMSON: Right. And to the point, as the Colonel stated, there is also no reason that the Marine Corps would object to any service member or their family realizing the same opportunity to have their loved ones bedside.

The non-concur from the Marine Corps was more along the lines of making this more prescriptive may have unintended consequences elsewhere within the JFTR. Not

to be seen but we are not non-concurring with the recommendation that all service members should have the opportunity to have their family bedside.

CO-CHAIR CROCKETT-JONES: Yes, I just -- this is one of those things where we haven't asked for a policy change. We haven't asked for a DTM or DoDI or anything. We have just asked that the DoD oversee consistency between services in providing this benefit.

So, I would just say maybe it needs another pass through to say is this really you are concurring but with a caveat of we don't want to change our policy. I just don't understand. That is why we don't understand the non-concur.

COL BUHL: I think it is fair that because there is some discussion here, that we will revisit this again. But I will stand before this Task Force and tell you that we, I pray in all cases, that any family member would tell you that the Marine Corps keeps

faith and goes above and beyond the call of duty to get family members there.

And where we run into requirements by the JFTR that we are unable perhaps to get an extended family member aboard or a fiancee that might not be legally covered, then we go to some wonderfully supportive non-profits to assist us. And I have never been refused, not in my tenure as a commander, with any requests of that nature, sometimes under extraordinary circumstances overseas, relatives, et cetera.

So, we feel very good and proud of what we are doing for our families in that regard. So, we will take a look at the language one more time, ma'am.

Moving to the next slide, SCAADL. We certainly understand that there is a defined intent for SCAADL and appreciate that SCAADL serves to offset wages lost by caregivers, oftentimes, leaving the workforce to support their catastrophically injured service member who might, otherwise without

their support, potentially be institutionalized, certainly in some of our more traumatic extreme cases. And in reality, we strongly believe that the benefits, this benefit supports keeping families together by providing that economic support to the caregiver under any circumstance, particularly at a very traumatic and vulnerable time for that family.

We absolutely want to ensure that all eligible families know about the benefit, have the assistance in applying for it, and receive a determination of their eligibility as quickly as possible, particularly in that critical early time where all that disruption has occurred with the family and family members are under a great deal of stress.

With regard to the entirety of this recommendation, we partially concur. And for the purposes of my response, I am going to address the improved awareness to the eligible SCAADL population. We have specifically

addressed this identified challenge with multiple outreach efforts. We have aggressively marketed the benefit to those eligible via our social media platforms. But I think far more importantly, through our one-on-one information push through our recovery care coordinator program, those RCCs. They are the campaign planner and they are consistent. They have been aboard in most cases for a long time, longer than the uniformed leadership and they are the educators.

We are also educating our leadership to this. I brief every Marine Corps Commanders course. The Regimental Sergeant Major briefs every senior enlisted seminar. So, we are pushing this out in the uniform chain.

We have, what I believe, is a very clear application and appeal process for Marines. In fact, speaking aside, I have had only one SCAADL reassessment that I have that

has been turned down that I have signed off on in my two-year tenure. So, we err to the side of taking care of our service members.

We work through the RCC's principally with the Marines, their families, and the medical case managers to ensure that the applications are completed correctly and submitted to the Wounded Warrior Regiment Pay and Entitlement Section for determination.

I will also add because the numbers, thank God, have come down so much in terms of overall numbers now with the reduction in the severe combat injuries out on the battlefield, we are able to get to the providers with that just in time training quickly because the numbers are manageable. I spoke with my Regimental Surgeon about that last night.

We also ensure that caregivers receive the required caregiver training through the Easter Seals while they are on active duty, so that we can ensure that there

is a smooth transition of benefits from DoD to VA. Our RCCs support the Marine and the caregiver in completing that VA caregiver stipend application and we follow it. We track it through final determination.

Additionally, we proactively provide the VA caregiver program manager with a monthly list of every Marine in receipt of SCAADL, so that they can plan ahead for incoming needs and actively reach out to the Marine and the caregiver to assist with the application process. So, we are hitting our VA leadership. And Sean Keane knows that all too well because he was our VA Headquarters Representative for a number of years.

Additionally, as I said, we are continuing to provide emergent means of communication for people and this is on the top of the list for an area that we will continue to push information out through various communication means.

LTCOL KEANE: Sir, I have a quick

point.

COL BUHL: Yes, Sean.

LTCOL KEANE: What you said seems contradictory to one line in here and what I learned being at the Regiment. As far as getting the word out, when this came out in 2010, the Marine Corps was the leading DoD agency in getting it. The Army was months and months behind us. We had Soldiers calling my office and calling the VA, how do we do this SCAADL. They didn't have an implementation plan.

What I am referring to is if the RCC determines a need for SCAADL, the RCC will brief the Marine and the family on the benefit. That isn't what I was aware of, unless that is a change or that is a mistake by being in there. That seems to be that the RCC is the first hurdle. If the RCC determines, then --

COL BUHL: That is a miswording. Obviously, the RCC -- the uniformed leadership

has the final say in everything. I sign off on the SCAADL applications on behalf of Deputy Commandant for Manpower and Reserve Affairs and our Commandant. But the RCC is often that -- not often. The RCC is that campaign the Comprehensive Recovery Plan architect.

LTCOL KEANE: Sir, just the way it is worded.

COL BUHL: Yes.

LTCOL KEANE: It looks it is a hurdle. If the RCC determines, then you will brief the Marine.

COL BUHL: No, it is uniformed leadership. And in terms of eligibility, that is a medical providers determination and we cannot -- no one influences that. That is a doctor's determination. But in terms of eligibility, once a doctor has identified that an individual appropriately rates it, the assistance, then we sign off on it.

You want to add to that, Paul, anything?

MR. WILLIAMSON: Just again, when the RCC is engaged with that Marine and family, part of that checklist is the various benefits that they may be eligible for. And if there is the slightest indication that there may be an entitlement to SCAADL, the RCC will help that Marine and family initiative that application for that. And as the Colonel mentioned, it proceeds then on to the medical provider who will complete the critical evaluation, then to the Unit Commander for the certification of line of duty entitlement, and then on to the Regiment for processing.

COL BUHL: And if I, airing the Regiment's laundry, so to speak, if there is an area I have had challenges with in that regard, one earlier when the numbers were much larger, the doctors across our Navy, I don't think we have had a uniform education on what SCAADL was. And we had to follow-up to inform our providers about what it is and how it works, et cetera. I think we are there now

but perhaps earlier we had some challenges with that. Not perhaps -- we did.

And too, that chain that Paul just described, so a service member is identified as a probable recipient, potential recipient, we push immediately the evaluation to the provider, then it goes back through the chain. Making it move through that chain quickly has required command-level focus, particularly at our outlying detachments where the administration might not quite be as -- isn't as robust and not quite fully responsive. So, we have addressed that during my tenure as well. I am very comfortable now that we move these applications quickly through the chain. The numbers are small. We know who they are.

CO-CHAIR CROCKETT-JONES: So, the non-concur would be on -- do you have a position on the exemption from taxes and the AHLTA access? Can I hear you talk about those just a little?

MR. WILLIAMSON: Well the AHLTA

access issue is just a difficult technological issue. And it is not that -- again, we don't have -- the Marine Corps doesn't control AHLTA.

COL BUHL: We don't.

MR. WILLIAMSON: We don't have any providers. But if it can be done, by all means.

The tax exempt piece, that was one of the questions we had initially posed is how is it that the VA caregiver stipend is going to be a tax-free benefit but the SCAADL benefit is not. And it was at that point that I don't want to say we were rebuked but we just said that anymore entitlements that were subject to tax-free benefit are well beyond the Marine Corps' capability to influence.

CO-CHAIR CROCKETT-JONES: Yes, but we can try.

MR. WILLIAMSON: Yes, ma'am.

CO-CHAIR CROCKETT-JONES: I just want to know if you had a reason that you felt

it should stay within a taxable lane and the answer is no. It is not that there is a reason to keep it there. Okay, that was my question.

COL BUHL: Next slide. With regard to resourcing behavioral health, the Wounded Warrior Regiment concurs the best possible care is provided to our Marines and families. But in terms of staffing and manning, behavioral staffing billets, we are going to defer to the DoD. The Wounded Warrior Regiment is part of Marines and Families Division in Manpower and Reserve Affairs. We have the Behavioral Health subsection of that division in Marines and Families. But again, we are deferring to the DoD really for the billet specifics in terms of numbers.

As a regimental commander with a staff consisting of active duty, mobilized reservists, GES civilians, NAF civilian, government workers, and contractors, I

understand very well, I believe, the ongoing challenges of manning to the appropriate level, commensurate with needs. That is one of my great daily challenges.

So, we are standing by for DoD guidance. We defer on that with Behavioral Health.

If I felt that I had an area that was insufficiently met or staffed, I absolutely would address that through my chain of command.

CAPT SANDERS: So, while I have got you on that point, Colonel, one of the other services talked about the reduction in some permanent staff in different levels because of reductions in active duty for work. And I am curious to know, is a great number of your staff augmented by Reservists brought on active duty? And have you been able to POM for those to be permanent? And are you using those people and is it impacting your ability to do your job?

And you don't have to answer me now.

COL BUHL: No, that is a great question. I will field it now. And I will suggest that it rolls into the overall way ahead, the way forward of the Regiment.

And the answer is over 80 percent of the Wounded Warrior Regiment's uniformed staffing is mobilized Reservists. And in many cases at our detachments, in particular, it is near 100 percent and we are working through the POM process as the OCO, the contingency operational funding diminishes exponentially. It is being halved every year.

Our Commandant, my general officer chain of command is very well-informed. The Navy Department knows this. We are watching this closely. We believe that we have sufficient resources through the remainder of this fiscal year and the next. And so we are looking at the year beyond as a first real critical year. And we are exploring ways to

move to the baseline budget to continue what we are doing. And I am confident that we will find a solution for that. Our leadership will find a solution for that.

CAPT SANDERS: Thank you.

COL BUHL: Yes, sir. Next slide.

The USMC concurs with the recommendation and we have the resources in place, I believe, to ensure that our reserve component, wounded, ill, and injured Marines and Sailors joined to the Regiment receive case management identical to their active duty counterparts.

We continually strive to ensure that our Reserve Component Marines who are wounded, ill, and injured Marines who are away from our bases and stations are made aware of the Regiment and its care coordination capabilities. And accordingly, we have several key initiatives established and/or underway to specifically support this population.

Lieutenant Colonel Ted Wong at the table here with you was assigned as the Regiment's Liaison Officer to Marine Forces Reserve in New Orleans last spring, particularly, to address this area of reserve support. He is the connection between our staff here in Quantico and the MARFORRES staff in manners related to care and support of active and reserve wounded, ill, and injured Marines and families assigned to MARFOORES units. Ted's roll-up every month is substantial. He is busy. He has a lot of work to do. He is engaging in a lot of cases and he is educating a lot of people.

We have established relationships that allow for briefings at training events hosted by Marine Forces Reserve, including their annual I&I conferences, their IRR musters, their PME education for the Marine For Live Program, and others. We are very embedded and invisible across Marine Forces Reserve. And as I just answered in a question

just now, 80 percent of my command are mobilized Reservists. So, there is a lot of interaction. I am able to hire and populate my leadership through the Reserve network that we have. It is very important. We are embedded. We have got good relationships and I don't see them changing.

Our RCC program has been trained on reserve-specific subject matter to assist our Reserve Component Marines and their families. We have integrated into the RCC training.

The Wounded Warrior Regiment has begun sending a personalized letter to every Marine on MedHold or in a line of duty status, informing of the resources available through the Regiment. So, we are sending out a direct letter to everybody in that regard.

Our communications program has developed a reserve-specific tool kit, which provided access to policies, forms, fact sheets, common definitions, and a checklist

that we have created geared toward our reservists and their families.

The RMED Section, Reserve Medical Entitlement Section continues to oversee all cases of wounded, ill, and injured reservists who require medical care or referral into the disability evaluation system for service-incurred ailments. And we all met last time at the Sergeant Merlin German Call Center. Of course, I've got an active, what we think is the best outreach program, in terms of follow-ups with direct phone calls to every wounded, ill, and injured service member. It is powerful. It is active. You saw it for yourselves, when you visited us last.

So, that is how I have attacked that challenge.

Okay, next slide. Thank you.

In Recommendation 20, family member involvement, we are going to defer, again, to the DoD for the official response. But it is our practice to, of course, highly

encourage family member participation in the recovery and transition process every step of the way.

We have a robust protocol for contacting family members that starts with, as we spoke at lunch, aggressively encouraging Marines to provide consent to communication for family members with that family contact authorization form. I believe it has been cited as a best practice by the Task Force.

CO-CHAIR CROCKETT-JONES: Yes, we do say that methodology is an active voice versus a passive voice. And I have been harping on this for the past two days.

One of the things that I want to throw out to you, the reason why the IDES process became a touch point for us is because it is not a medical process. It is an administrative process which has a time line. And I use this example because I think it is one that easily goes unseen. A family member has an EFMP status, a child. And perhaps the

spouse is well aware of all the subsidies and programs that being in that EFMP program entails. But maybe the service member, because they have deployed a lot is less aware of how urgent that program support is and how necessary it is. And when that person hits that DD214, the EFMP stops.

And the primary caregiver who has been monitoring that child in an EFMP status has to find alternate support, subsidy, programs, whatever, in the area where they are going to come to reside. Those things generally take time. Frequently, local service provision requires all kinds of documentation and approval processes. And these can be difficult to get into. They sometimes have waiting lists. There are all these concerns for this person.

If there isn't an awareness of the time line and we know it is going to be, we have an idea, everybody has an idea of how long IDES is going to take, if we don't bring

that person in, that primary caregiver in, at some point, to say you know you have got about 200 days and you have got to take care of this, they are really left out in the cold. And that is totally separate from any medical, other concerns that you rightly want to protect the privacy of that service member.

And so, there are plenty of stuff, as you have demonstrated, there are plenty of methods that are short of mandating that can encourage someone to get the people who needed the information they need.

And we do use your methods and the active voice you have taken, we use that frequently as an example to others on how they can use a perspective change without actually changing much in the way -- there is no mandate but the active voice creates better outcomes.

And so, this is a touch point in the process that is important. Some families it is extremely important to, this kind of

planning, long-term planning, transition. So, this is why the recommendation featured this point was because really there is a lot that changes and the time line becomes a significant contributor.

COL BUHL: I wish, Ms. Jones, I wish you would have been -- recently we had a caregiver luncheon during the trials out in Camp Pendleton because we had so many family members from across the Regiment gathered and a lot of resources there. This specifically came up, the EFMP. And our Family Readiness Offices are very read into that and so are our RCCs, who are really charged with informing.

And I couldn't agree with you more. And I have an EFMP son. My wife knows more about the program than I do or she did. And we have the EFMP Section in the Marines and Families Division also in the division I work and of course Marine Corps.

We also address this, I am on a little role to say that I was pleased to see

this addressed carefully and thoroughly, at our EAS Boot Camp that I attended down in Camp Lejeune about a month ago with Battalion East. We had almost a hundred families in a very large hall and this was an area that was covered. And a lot of the families were, it was husband -- it was Marine and spouse in the room together. So, we are on it.

And I will say over and over again, we can never be good enough at this. But it is an area that we address. We address it proactively.

And I will add just another thing. I think often it is family members that give us the greatest challenges, in terms of making sure we get them everything that they need. The Marines, most of the time, come right in line, but most of the time, and comply. It is the members we want to make sure we are not missing something with or that are more complicated.

We, in nearly all cases, the

Marines actually do welcome their family member involvement in their recovery and transition planning. And in our recent Care Coordination Survey, 97 percent of the Marines that responded stated that involvement of their family members in the CRP enhanced their recovery and transition. So, we absolutely believe that family members have to have visibility on that Comprehensive Recovery Plan.

We actively promote the use of our social media tool, including Facebook and our App as an immediate tool to access all these important benefits and entitlements information. And that App, I can't speak enough about it. It is so easy to use. It lays every entitlement out very clearly for them. It walks them through it. It is easy to understand, easy to use, and it is not the KIAT handbook in a giant binder. It is right on their telephone.

This month, we focused, as I

mentioned in my opening remarks, on a caregiver information push. And our Facebook site, as I said, has had some exponential increases in the recent months, that big number I told you about, 20,000 in the last few months. So, I am confident that this is a viable platform to get important information out and to stay in contact with our families.

And I have already spoken of it but I will one more time say that regular contact with our Marines is maintained systematically through the Sergeant Merlin German Call Center; 119,000 calls last year; six to one outreach to input last year. We are actually increasing that. It is over six to one. It is a big powerful outreach. Nobody does it like we do it.

We are participating in the DoD Warrior Care Policy Initiatives to create joint policy and processes to support caregivers. We are going to continue to identify innovative ways to encourage family

member involvement. And as I said, we could never be good enough at that.

Next slide, our patient population, patient census trajectory. If, and I will tell you I think it will, but if the population continues to track consistently with the history that we have seen over the course of certainly the past two to three years but over the course of the Regiment's history, we do not anticipate any significant fluctuations in patient numbers for the next two years.

Our recent Care Coordination Survey, 67 percent of the population reported that they are receiving care for a head injury; 62 percent of our patient population, our recovering Marine population have post-traumatic stress. While this is based on self-reporting, personally, based on my experience, and all the input that I get, I believe this is an accurate portrayal of the demographics of our current population.

Anecdotally, my battalion commanders are telling me that their patient population is changing. And as you would expect, the kinetic injury numbers have gone down significantly but the behavioral health challenges are on a rise. And I can speculate a bit on that, give you my professional opinion but as the op tempo has lessened, people are now, as the units are not going back to combat, and as people are transferred, Marines are transferred to follow-on assignments that are not necessarily any less stressful, recruiting duty, drill instructor duties, et cetera, they are raising their hands and coming forward with PTS issues.

Also, the education, in terms of identifying TBI cases, has continued apace. And we are discovering people with TBI that might not have been identified earlier for whatever reason. And so we are seeing a spike, a steady increase in those Behavioral Health cases.

And with the complexity associated with supporting those, that on its own is a challenge. But with a large force, we are drawing down a bit but we are still not quite 200,000 uniformed Marines that are training in austere environments, very challenging combat training. We are going to have injuries out in training. And of course, there is the steady flow of automobile and motorcycle accidents and people get sick.

We had a number of cancer patients competing in our trials, two of whom the doctors' prognosis is that they would be terminal. You know, Marines want to beat the odds under every circumstance.

So, people are going to continue to get sick. They are going to continue to get injured in training off-duty. And about half of our population right now are ill or injured outside the combat zone. So, we see a steady state for the next two years.

You can see the numbers on the

graph there. The recovering Marines and Sailors on the active roles slightly decreasing over the past years but the number of Marines that are receiving recovery coordination care, being supported at their commands, which is our Commandant's intent, just slightly increasing, resulting in a steady state of support.

Okay, next slide. Long-range vision. I think the answer is written up there in the box for you. We see a steady requirement, an enduring requirement to care for those Marines and Sailors who have been ill or injured in training or on and off-duty. We believe that we will continue to see lesser numbers coming from combat, as we transition there in Afghanistan.

We also this flow of Behavioral Health issues steady for the next couple of years. I don't know how far beyond that we are going to have cases like this but we have been at war for a dozen years and it is often

a tour or two, and sometimes three, after the combat action that these signs manifest themselves. It is often in events that occur, potentially misconduct, et cetera. But sometimes it is two or three tours later.

So, there is an enduring need here. We have never done it before like the Regiment does it. And people ask us, our Commandant has said I cannot imagine not having this capability going forward, where we have one command that is dedicated, organized, trained, and equipped, so to speak, to care for the wounded, ill, and injured in the Marine Corps.

So, what we see is our detachments, the peripheral detachments being reduced to liaisons with Recovery Care Coordinators to continue to ensure that we have sentinels out at the periphery of some of our installations but also, those sentinels are out in a positive outreach to the local commanders and their bases and stations.

Those RCCs are there to provide that support for the Regiment at the outlying sites. And then if we identify people in need of being joined to the Regiment, for whatever reason, we then move them to Centers of Excellence. We have five identified: Walter Reed, Camp Lejeune, San Antonio, Balboa, and Camp Pendleton. And the two battalion headquarters that you are well familiar with on each coast of Camp Pendleton and Camp Lejeune are the centers. And there, we will continue to staff robustly what we need to take care of our Marines and Sailors and their families.

And we don't think this is just a downsize approach. This make sense that we can get people where they can get all the resources in one place, the best of everything, where we have the hospitals, the barracks, the headquarters, all of that, the Hope and Care Centers all in one location.

CAPT SANDERS: Just a comment.

The other services all projected 48 months' out a rise in their client population, as opposed to a steady state. So, I just had that as a note of difference in thought.

COL BUHL: Dare I speak for the other services, I won't. But I will say that, again, it is our Commandant's intent that our Marines and Sailors, wherever possible will heal in their parent commands, with their brothers and sisters who they are serving with on a day-to-day basis.

So, if there is a high acuity hospitalization, for example, extended appointments more than a unit is capable of supporting, things of this nature, then we are going to join that Marine or Sailor to the Regiment and give him or her the care they need with us.

But otherwise, we are going to continue to support them through RCCs and remotely at their units and provide all the backup and expertise of an in-depth regimental

headquarters. And those battalion headquarters, I mentioned. So, if I am answering your question --

CAPT SANDERS: It was more of a comment than a question but thanks for the answer anyway.

COL BUHL: Right, okay. Yes, we are going to take care of them but our numbers should remain, I think, constant for the next two years.

MR. REHBEIN: If I may, for a moment, sir. You touched on a couple of points here that piqued my interest a little bit. One, about the probability that two or three tours later some of these behavioral health problems come to the surface. And then you also mentioned something about having some sentinels out there.

We all know that, quite often, behavioral health problems manifest themselves as behavior problems. How do you envision those sentinels interacting with unit command,

to determine whether a particular behavior problem in a Marine is really a behavioral health problem? How do you make that connection?

COL BUHL: Like for example, anxiety disorder versus post-traumatic stress, et cetera, et cetera. Of course, I nor any uniformed member, aside from the Regimental Surgeon and the Battalion Surgeons are doctors. So, we rely on our medical professionals to make those type of assessments.

But where we have behavioral issues manifesting themselves that come to the attention of a commander, we are hitting it again in multiple ways. One, at the commander to commander level, we are informing every group of commanders at the lieutenant colonel and colonel level that are going out to the Fleet Marine Force. Every class, we speak to them and provide a full brief and going to questions of this nature with the commanders.

We are doing that for our senior enlisted seminars as well.

The liaisons that are out at, for example, Twentynine Palms, staff NCOs experienced, will provide briefs routinely for the base and will go to commands on request and we tell our commanders, as they go out to the fleet, ask for the briefs for your people. We will provide them at any time. And we do. We are very busy.

We are also in the staff academies. And I attended a briefing out in Okinawa when I was there last for all the staff NCOs that were in the academy there in III MEF at the time.

So, a lot of outreach. And in terms of these manifestations that we see emerging and occurring in the years forward, there is a great deal of discussion across the Marine Corps about this because probably first and foremost legally, we are seeing legal challenges. But you know the health of the

force and certainly suicide prevention and other domestic abuse, sexual assault prevention, et cetera. Everything is inter-related in terms of behavioral health.

And so I don't think this could be any further at the forefront of our commanders, our leadership.

Did I answer your question?

MR. RECHARDT: You did because commanders out there are going to be faced with the situation is this particular drinking problem better handled through the normal disciplinary channels or better handled through behavioral health channels.

And as long as they are given the training and have the judgment that they could make that decision intelligently, yes. And I think what you described to me is the basis of forming that kind of judgment.

COL BUHL: Yes, sir. And I would also add, regarding your remarks, it is both. Both work in conjunction and we ensure that we

are taking into account a Marine service record. And when you start -- for example, just notionally, two DUIs in a 30-day period and you look and this individual has had two meritorious promotions on the battle field to corporal and sergeant and suddenly he is in trouble, potentially, being administratively separated and you start looking back at his combat record and you see that he has made five deployments to Iraq and Afghanistan. Okay, and then we start digging a bit.

MR. REHBEIN: Out in the civilian sector, we are very often finding that those kinds of combat veteran behavior problems are better handled through special courts, where there is some extra sensitivity given there, --

COL BUHL: Absolutely, sir, veterans court.

MR. REHBEIN: -- that there is potential behavior --

COL BUHL: And our DISCs are

District Injured Support Coordinators, who I know the Task Force is familiar with, we have 31 of them across the United States are very involved in caring, assisting in our veteran population in cases of that nature are occurring. And that is exactly the path we use.

Yes, sir?

CSM DE JONG: Sir, if I may?

COL BUHL: Yes.

CSM DE JONG: I know we are about to close this out. I am probably going to hit a nerve here. So, I was waiting until the end in case I get a microphone thrown at me.

I know it is the Marine Corps' stance --

COL BUHL: I will just have Ted elbow you.

CSM DE JONG: Okay.

COL BUHL: No.

CSM DE JONG: I know it is the Marine Corps' stance and it is the

Commandant's stance to leave a lot of injured Marines within their formations, their line units.

COL BUHL: I understood what you meant.

CSM DE JONG: Okay. What we continuously have heard over the last three or four years is that it doesn't work. But when we talk to a group of Marines and we ask the pointed question of while you were receiving care in your line unit, was it working, and the resounding answer is no. The resounding answer is why couldn't I just get to the Regiment earlier so I could focus on my recovery, focus on healing and continue to be a Marine?

So, when we hear that it doesn't work, where can the Regiment help leverage where is the right place for a Marine to heal?

COL BUHL: I will tell you that the greatest challenge I have had as the Wounded Warrior Regimental Commander is with

peer commanders explaining why a Marine either should be joined to the Regiment or should not be joined to the Regiment. That is the art of command. It is a great challenge and we carefully review everything, particularly the medical piece, the doctors' recommendations. And we believe that because of the high percentage of people, we leave an outlet for every -- there is a lofty goal of extended permanent limited duty where our comment on is said if you are injured in combat, we are going to find a place for you if you want to stay and continue to serve. And we are doing that but the numbers are very small. But the opportunity exists.

But the percentages say that if you come to the Wounded Warrior Regiment, you are probably going into the IDES and you are probably going to find yourself with a medical retirement.

And so, we want them to continue to serve. And sometimes we take people TAD,

TDY for 90 days. Sometimes we extend that and try to get them back to their units. But we have found that the union cohesion says that if they leave their parent commands, their line units, their formations, that they will probably not remain in the service. And that probably is at the epicenter. And so is it perfect? No, it isn't. It is the art of command. And I am engaged with commanders to convince them one way or the other. Those are the toughest conversations that I have.

CAPT SANDERS: Would that, as a philosophy, are you taking on from internal to the Regiment a way to try to reverse that process and trend so that automatic movement to the Regiment means you are not going to be a former Marine in short order?

COL BUHL: Well again, the art is that you will return -- the intent is that you will return to full duty. That is our goal for every Marine. In some cases, it is just not going to be possible for whatever reason,

usually medically. A lot of times, Marines decide in their families, they make conscious decisions based on their illnesses or injuries that they will have to move on. Sometimes, it is out of their hands.

CAPT SANDERS: And I fully understand that and have seen it in the past. But I guess get somewhat troubled by the concept that if the thought process for leadership is that when we get to the Warrior Regiment, more than likely you are not going to get back to a line --

COL BUHL: We don't believe everyone who joins and say guess what, 94 percent you may be in the 94th percentile here. No, of course not. And in fact, everything is positive and focused on healing, recovery, return to full duty.

Our motto, the Regiment's motto is Etiam in Pugna, "Still in the Fight." And everything that we do along the five lines of operation, mind, body, spirit, family, medical

is focused on returning that individual Marine back to full duty or to the best full life that he or she can look forward to ahead. And I am not going to stand up as a propaganda here in front of you. I am just going to say, a lot of these -- I just went rock climbing last week with a group, a couple of more amputees and most of them had never been rock climbing before. I had only been once or twice in my life. A lot of these young men and women are doing things in their lives that they never would have imagined that they would do before, specifically because they found themselves in the Wounded Warrior Regiment, while creating a lot of avenues for achievement and fulfillment in their life ahead. The goal is to get them back to full duty. The reality is most of the marines that are joined to the Regiment that reach that level of high acuity are probably going to be medically retired.

MS. DAILEY: Ladies and gentlemen,

we really need to kind of wrap here.

COL BUHL: Yes, ma'am.

MS. DAILEY: If you have got questions, let's put them on the table quickly. We would like to get to the survey. If she moves quickly through it, we can bring Colonel Buhl back. I saw a red button.

Okay, we might have time. It depends on how fast April moves.

COL BUHL: Okay. April is much more efficient than I am. And I don't think she is any less passionate than I am but she is very efficient.

So, April, do you want to -- I will remain on deck with no rush or hurry if anyone out in the grand audience or at the table here wishes to speak to me about anything related to anything I have said.

MS. PETERSON: Okay, good afternoon.

So, I am standing in for Erica Osain, who is our Assessment Survey Analyst,

who I know that you have heard from before. But Colonel Buhl and I will try to live up to her expectations of us.

So, the first slide, our Annual Care Coordination Survey was conducted in December of 2013. And over the past few months, we have been analyzing our data. You guys should have the survey instruments in your package. We did make a couple of changes this year which really proved to be positive for our survey efforts. One, we ended up taking up a random sampling of our population by doing a census which we have done the last couple of years. And second, we put proctors on-site at our battalions and detachments to give the surveys to the population. And what happened was we got a 100 percent response rate. So, for us, I think this year was our best year for data, in terms of being able to use it for trends and being able to site recommendations for improvement.

Any questions?

Second slide. So, as always, we have been doing the Care Coordination Survey for three years now and we always look at the same elements. So, Section Leaders, RCCs, DISCs, Call Center, and our Contact Center Staff. So, we have got three years' worth of trend data which you can see there from 2011, 2012, and 2013.

You can see in almost all areas that our satisfaction levels have increased or stayed pretty steady.

Next slide.

COL BUHL: The areas that we have most encouraging results, staff, and I would say for myself, across the force, there is no more blessed duty in our Marine Corps than serving in the Wounded Warrior Regiment. No more blessed duty and everybody feels that way. And I think a good number of the Marines that are in the Regiment, particularly the mobilized Reservists, they have had options over this last period of war to serve across

the Reserve Force and they actively seek to serve in the Wounded Warrior Regiment. It is almost a missionary, a sense of duty.

Transition, we have a lot of positive feedback on transition --

DR. STONE: How do you correlate that with the fact that 80 percent of your staff is Reserve Component, if, in fact, this is considered by the Marine Corps to be sacred duty, why isn't it balanced better between the components?

COL BUHL: Because we are a total force, like all the services. It doesn't matter whether you are a Reservist or you are an active duty Marine. And I have served both as an enlisted Reservist, an Inspector Instructor --

DR. STONE: So, Colonel, as you move through the reduction in your wartime funding and are forced then to use your active component Marine in this work, are you comfortable that the Marine Corps will view

duty and assignment of a young marine to this in the same manner as they would a line assignment for future promotion and evaluation?

COL BUHL: Absolutely, sir. I have sat on two promotion boards: the Wounded Warrior Regimental billets were briefed well; the Lieutenant Colonels Board two boards ago, very solid. I wondered if it was because I was sitting in the room as a brand spanking new Regimental Commander in the room with other peer colonels. Very strongly viewed.

One of my battalion commanders out on the West Coast is a Colonel Select at the junior enlisted level. The NCOs, we have had consistent meritorious promotions at Quantico and other places. We just had our recent awards with the Marine Corps Association Foundation for Civilian and Uniform Caregivers leadership awards that are recognized. There were 13 general officers in the audience there. So no, I think the duty is prestigious

in that sense and meaningful. And there is no more active proponent and advocate than the Commandant of the Marine Corps for it and he presides over my change of command, himself, personally, and he doesn't do that for three-star generals.

So, I do believe that it is, sir.

With regard to transition, I think that our transition cells at our battalions, and at some of the detachments as well are significantly above what the Marine Corps' fine standards are. We say transition on steroids. In saying that, we are continuing to refine the efforts that we have ongoing. We are trying to ensure, and your help here is important that we continue to harness the sea of good will. As the shooting wanes, we don't want to forget about our wounded, ill, and injured, and our ill and injured in the Marine Corps.

We are continuing to leverage resources and we are providing employment

paths and careers and education opportunities for people. So, I feel good about that.

The focus on recovery, I think I said enough about this just now but it is not just physical healing. It is spiritual. It is mind, body, spirit, family. It is all interrelated. It is not just getting better, your wounds are healing up. And a lot of times it is the inner wounds that are the most challenging.

We have built a structure of support and we have an enduring requirement. And we think that this structure now, as it has been refined over seven years can be -- it can be modulated, God forbid that we should have another major crisis.

So, I believe answering the question about promotions, we have institutional buy-in and that the Regiment is going to endure and continue to be supportive.

Next slide, the challenging areas. Staff coordination. I think communication is

the toughest thing that we do. It just is. And it is tough internally and it is tough between staff and recovering Marines and it is tough between their families as well. And so it is an area that I have emphasized, especially recently in the wake of these surveys and we use these results to drive home the point that we have to get better at that.

We have just, finally, it took me 18 months to get Section Leader training standardized and onboard but our uniformed "squad leaders" are now formally trained. We have an established process and we are seeing immediate results from it. It took too long but it is working. It is going now. And we are getting great feedback on that.

I already talked about the 31 DISCs in terms of handoff to the VA, warm handoff and continued support. And that is the number one thing we see on the Call Center in terms of areas of being addressed, when people call in to the Call Center.

And so like I just said, at the end of the day, communication is our toughest challenge. It is identified there.

MS. PETERSON: The next slide speaks to our Reserve response rate. You can see that at the time of the survey there were 42 reservists joined to the regiment. 22 of those reservists completed the survey for our 52 percent response rate. But still with such a low number, we reported the percentage and the aggregate and 95 percent were satisfied with the services provided by the Wounded Warrior Regiment.

COL BUHL: Are we eight minutes over our time? Okay.

MS. DAILEY: Did April finish already?

MS. PETERSON: Yes.

COL BUHL: We hustled for you, ma'am.

MS. DAILEY: Well you are over-achieving. You are 20 minutes' ahead of time,

actually.

So you all don't have any more questions about the survey program for April or Colonel Buhl?

I am sure if you give Colonel Buhl one more question, I bet we could make up these 20 minutes.

(Laughter.)

COL BUHL: Well, I can talk as little or as long as you wish. I am very passionate about what we do. We have never had anything like this. And for the senior ladies and gentlemen in the audience who remember, who have lived through the last generation, we never had anything like this for our people. Nothing. They came home and the nation turned their backs to them. Never again.

And so that is what our senior leadership believes right down to the men and women who are living through this last ten years of war.

DR. STONE: Colonel, if I may ask one question.

COL BUHL: Yes, sir.

DR. STONE: You were in the unique position in the Marine Corps as being a consumer of services, rather than provider, much different than the other three services that we have heard from in the last three days or the last two days.

What is it that you don't have that you feel you need in order to serve this population better?

COL BUHL: Well, I think that my greatest challenge, aside from those one-on-one conversations with peer commanders in terms of joining, my other greatest challenge is the same challenge that is shared by all of us in the force. And there is a constant battle to get people onboard, stabilized, and serving. We are constantly challenged with manpower. And by extension, as the support structure across the military, across our

bases and stations is adjusted, so to speak, based on budgetary constraints and stuff, we feel second and third order effects from that.

Is it affecting our ability to take care of our people? Not yet. Not yet. I believe that we have been fenced, if you will. We are getting what we need to do what we need to do. But I worry about it. I am concerned about it in the future years that we will feel those second and third order effects across, whether it is mental health counseling for family members that we might have talked about here, other things, services that affect us indirectly, if you will.

So, my big challenge continues to be getting people but we are getting what we need. We are getting what we need right now.

MR. REHBEIN: Let me ask you to speculate for just a minute on something that intrigues me. Ninety-four percent of the folks that joined the Regiment go into IDES and leave the Corps.

COL BUHL: Approximately.

MR. REHBEIN: How much of that is because of the acuity of the health problems? Is there something about being in the Regiment that tells Marines it is time to leave the Corps?

COL BUHL: I think it is always personal, individual. Every case is unique. Every individual Marine in his or her situation, their families are unique, whether it is the injuries, their age, their time in life, their career progression, what have you. But the answer is that in nearly all cases, it is the medical determination which drives everything.

Marines have sometimes confounded their doctors and healed and functioned better than -- they beat the odds. They beat the statistics and I like to say there is a separate category in that medical book for Marines. It is another chart.

But it is usually the medical.

Medical drives this, sir.

MR. REHBEIN: We struggled with, I personally, have struggled with the concept of is it better to leave wounded, ill, and injured with their line unit as much as possible or is it better to move as many as possible into something like the Wounded Warrior Regiment or a Warrior transition unit in the army and wondered effect being in a strictly medical recovery unit has on the psyche of the individual Marine or soldier as to whether or not it tends to tell them that maybe their time in the uniform is coming to an end, just by being in that unit.

Questions you can't answer. Questions no one can answer definitively.

COL BUHL: I understand what you are saying.

MR. REHBEIN: As we are setting up or not setting up these kinds of units and assigning people here or there, depending on what may be best for them, that is something

I think needs to be kept in --

COL BUHL: It is a careful, individual, very personal, specific. We don't have a process. We have a relationship with every Marine and Sailor and their families. And it is a family decision in many cases but it is driven predominately by the medical situation. We celebrate every success and return to full duty. We celebrate it, we recognize it. We meritoriously promote. We did not have meritorious promotions during my time in command with those who come online. And we tout these and show others what can be realized. You can come back. Our motto is "Still in the Fight" and at every level that is emphasized.

So, the mindset is you are a Marine. You are going to stay in the fight. You are going to keep pushing. You are going to come back to full duty. And in so many cases, it is a deep, powerful, hurtful emotional conclusion that they cannot remain

in active duty in their uniforms and continue to serve and sew these trials and games and other things that we do to tie our veterans back in to continuing to stay a part of the Regiment and a part of the Marine Corps are so important and get so much emphasis in and beyond our command.

This Saturday, I was in Camp Pendleton. Rob Jones, a sergeant who lost both is legs in Afghanistan in 2010, a combat engineer, rode, finished a 5,100 bike ride that he started in Maine, rode down the Eastern Seaboard and then rode across the country, six months, 30 miles a day, through the winter, blown off his bicycle, specially modified prosthetics so he could ride upright. And I was at the finish line there and his family was there. His little brother who graduated from high school drove a box truck all the way up from Maine to San Francisco and his dad did the final stretch down to Camp Pendleton. I mean, he is keeping them, us, in

the public's eye. I mean I am just giving it as a quick example, a personal, how important it is.

So, that is what we want. That is what we strive for. And that is what we celebrate.

MS. DAILEY: Did you all get the last tasking? Sir, you had sort of tasked the other services to talk about their post-DD214 requirements. Did you pass that to them while we were --

Okay, we will do that. We do have a mental requirement for you to answer. What you are identifying is the what is your requirement for post-DD214 services?

DR. STONE: Just to state it, it is a for the record. You can respond later. All the other services are going to come back with it. We have recognized the fact that in your post-discharge connection of a Marine back to the Regiment or to the Corps, you extend certain services beyond retirement.

Why do you feel the need for that? What are the gaps that you see? And what are other organizations not doing for your Marines that you feel need to be done?

MS. DAILEY: And we don't need the answer right now.

COL BUHL: And I will just say that I think I have given the answer in Rob Jones' story and what we say how important it is to keep our veterans connected to the current active duty population. We want to show them what life can be for them that the best is yet to come. It is important to keep that connection going and to assist our Marines to know that they have reach back that they are still part of a unit. They still belong. Yes, they are retired but they belong. They still have a regimental headquarters there for them. It is important to us. It is all about our motto, Semper Fidelis.

MR. WILLIAMSON: Sir, if I may, I

think the thing that we have noticed in our contact with our Veteran Marines through our Call Center is the gap is many of them don't ask for help. And our ability to reach out to them and encourage them to do so through our DISCs, being able to, literally, take them to a Veterans Integrated Service Network and bring them to that facility, to start receiving the healthcare that they need is a very important piece.

It is the Commandant's intent that we keep faith for our Marines, the fact that we still care about them, that they know we care about them and we are interested in them receiving the services and support that they deserve, even if they don't want to ask for them.

COL BUHL: I will add a very short addition and say that from the years approximately 2003 to 2007, we didn't have and in the first year to two that we grew the Regiment and formed what we have today, we

missed people. We didn't give them all the thorough reviews of their injuries and their illnesses and we have been steadily making up for that over time. And many of these are identified by the Call Center, the Sergeant German Call Center.

MR. WILLIAMSON: One of the best things that I have heard as being part of the Regiment is the father of one of our Veteran Marines who is also a Veteran Marine, I can't tell you how proud I am to have been a part of an organization that now takes care of my son the way that they didn't take care of me at the end of my service. Very powerful.

MS. DAILEY: And we are going to pass that to you guys as a formal request and circulate it back to us.

And then I did want to ask just one thing, April, on your slide, your survey results. And then any last questions and we will wrap here.

Is it concerning to you all that

the Call Center, although very high ratings, is the lowest of your high ratings? Your Call Center is getting 87, 89, 88 percent. Great number but there is a lot of resources going into your Call Center. A lot of money going in there. Would you not expect something higher in those percentages?

MS. PETERSON: You know I think when we out-briefed the Call Center on those results, a couple of things came out of it when we spoke to the manager. One, when we released the survey, that goes out via an email, with a survey link.

So, the type of people that choose to take those surveys are slightly different than the ones with the joint population when we do a sampling.

So, I think that accounts maybe for a slight difference. Two, the call center, oftentimes, depending on the severity of need, makes one phone call a year vice our care manager's population who are there every

day holding the hands of our Marines.

So, it is just a slightly different type of population. For us when you consider that they are making one phone call a year and we have got satisfaction ratings, this high, meaning Marines, recognize the services that they are providing and they are satisfied. To us, sure, it gives us an area to work on. It wasn't as concerning as if we had seen that like in 2011, when we had 88 percent for an RCC, that put us on a mission to make improvements in our RCC program.

MS. DAILEY: And what is the difference between a Contact Center and the Call Center?

MS. PETERSON: So the Call Center is the Sergeant Merlin German, Wounded Warrior Call Center. That supports a primarily veteran population. Our contact cells are located at both of the Hope and Care Centers at Camp Lejeune and Camp Pendleton. Those contact centers support a primarily active

duty population. So, they are supporting our external Marines.

And in the cases of the contact centers, oftentimes they are right there face-to-face with the Marines that they are supporting at Lejeune or Pendleton. So, there is a higher touch than say the Sergeant Merlin German.

CO-CHAIR CROCKETT-JONES: If that is the last question, then thank you all very much again.

COL BUHL: Thank you. Thank you very much.

CO-CHAIR CROCKETT-JONES: Thank you for being our final briefing, the most exciting.

And this is the end of our April business meeting. See you all in May.

MS. DAILEY: One last thing, we did have someone leave something, a very expensive and sentimental pen. If anyone has picked up a pen that says Happy Retirement

Colonel Phillip Thornton, please bring it over to this gentleman here. Did you find it? Oh, great! Great!

All right. Yes, see you all in May. You have a homework assignment for Tuesday, please. Review of the members' observations.

(Whereupon, at 2:55 p.m., the foregoing meeting was concluded.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Task Force on the Care, Management and Transition of Recovering Wounded

Before: US DoD

Date: 04-17-14

Place: Arlington, VA

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

Neal R. Gross

Court Reporter