1
U.S. DEPARTMENT OF DEFENSE
2
DEPARTMENT OF DEFENSE TASK FORCE
3 ON THE CARE, MANAGEMENT AND TRANSITION
OF RECOVERING WOUNDED, ILL AND INJURED
4 MEMBERS OF THE ARMED FORCES

5 (the Task Force)

6 Washington,

7 D.C.

8 Tuesday,

9 February 22, 2011

10 U.S. Department of Defense

11 Embassy Suites, DC Convention Center

12 900 10th Street NW

13 Washington, DC 20001

14
APPEARANCES:
15
Non-DoD Task Force Members Present:
16
Dr. Karen S. Guice, M.D., M.P.P., Non-DoD Co-Chair
17 Mr. Ronald Drach
Dr. Russell A. Turner, M.D.
18 Dr. Steven Phillips, M.D. Mr. David K. Rehbein Ms.

19 Suzanne Crockett-Jones DoD Task Force Members

20 Present: Lt. General Charles B. Green, DoD Co-

21 Chair Major General Karl R. Horst Major General

22 Richard S. Stone, M.D. Master Sergeant Christian

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1 S. MacKenzie Commander Timothy A. Coakley, M.D.

2 Lt. Col. Sean P. Keane Staff Present: Denise F.

3 Dailey, PMP, Executive Director Larry Nisenoff,

4 MBA, PMP, Director of Operations James B. Wood,

5 Records Manager Ryan Heist Lakia Brockenberry

6 Philip Karash Stephen Lu Bella Gonzales Joseph

7 Jordan, Events Manager Cassandra Grey Edward Hsieh

8 Masheva King
Randolph Wagner
9 DeQuetta Tyree

10
Research Team Present:
11
Suzanne Lederer, ICF
12 Jessica Jagger, ICF
Allen Bediako, ICF Brad Booth,
13 ICF Cathy Hanna, AECOM

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

16 MS. DAILEY: Good morning, ladies and

17 gentlemen. My name is Denise Dailey. I'm the

18 executive director for the task force. I would

19 like to remind everyone if you would, we are

20 recording, we have a transcript of this event.

21 Consequently for us to capture all of the

22 information, you will need to speak into your

1 microphones in front of you, please. That will be
2 very helpful for my transcriptionist, who will
3 raise their hand and make all sorts of hand
4 signals if he's not getting it. We have throughout
5 your agendas notes that will help you move through
6 the briefings for the Army, questions you may want
7 to ask if you are if you want to probe a little
8 deeper. So our agendas are outlined with a
9 methodology for you to ask questions and to keep
10 the conversation going for the Army though I think
11 the Army will probably have a good job of that as
12 is. The other thing I would like to mention is
13 that we have had some administrative changes with
14 the Task Force. We
15 do have a new member who's not here, Lieutenant Colonel Keane. He has been appointed and when he gets here,
16 ma'am, I have all your red we might want to wait until we get him here his introductory information.
17 The other point I'd like to make is Master Sergeant Hightower, our National Guard representative, was
18 successfully retired by the disability evaluation system, so we have nominated and have a new nomination for the
19 National Guard position and we will have that individual on board by our next meeting. So at this point, I'd like
20 to turn it over to our co-chairs. Thank you, very
21 much.
22 MS. GUICE: Good morning. And welcome to

1 the second business day of the recovery task
2 force. I'm Dr. Karen Guice, the non-DoD chair.
3 Before we actually begin the business for today,
4 go around the table and have the task force
5 members introduce themselves.
6 MR. DRACH: Ron Drach, recently retired from
7 the US Department of Labor, veterans' employment
8 and training service.
9 MR. MACKENZIE: Master Sergeant MacKenzie;
10 US Special Operations Command and Care Coalition
11 Liaison, taking care of the special ops of the
12 wounded, ill and injured.
13 MR. REHBEIN: Dave Rehbein.
14 MR. STONE: Rich Stone; Deputy Sergeant General,
15 mobilization and readiness of reserve affairs.
16 MR. HORST: Carl Horst, I command a military
17 district of Washington, joint force headquarters,
18 National Capital region.
19 MR. PHILLIPS: Steve Phillips; I'm at National
20 Institute of Health.
21 MR. TURNER: Russ Turner. MS. CROCKETT-JONES:
22 Suzanne Crockett-Jones.

1 MR. COAKLEY: Commander Tim Coakley; Deputy
2 Sergeant for
3 the Navy Expeditionary Combat Command.
MR. GREEN: I'm Bruce Green, your co-chair.
4 MS. GUICE: Thank you. One of our members, Mr. Justin
Constantine, couldn't be here today. He had a work
5 obligation he had to attend to. Today's meeting is
around a series of presentations from the Army and I
6 think we should go ahead and get started with that and
our first presenter is Brigadier General Williams.
7 MR. WILLIAMS: Okay. We'll see if this works. There we
go. I've got one administrative note. I found some
8 spectacles by somebody who was near, that's you,
9 by my own guy. I wanted to make sure it wasn't --
10 I'm sorry. Well good morning everybody. I know
11 that after a three day weekend and no football on
12 for some of you football lovers out there, it was
13 a tough weekend but I brought my team together and
14 I'm honored to be here. So let me introduce a
15 couple of my folks. I've got my Command Sergeant
16 Ben Scott back there. And then I've got the Army
17 wounded warrior director, Colonel Greg Gadson
18 also. Apart of my team here as well as many
19 others of my team will be presenting today. The
20 Department of Defense co-chair, Lieutenant General
21 Green; Department of Veteran Affairs co-chair, Dr.
22 Guice, and Executive Director Ms. Dailey. Members

1 of the task force, I'm Brigadier General Darryl
2 Williams, Commander US Army Warrior Transition
3 Command and Assistant Sergeant General for Warrior
4 Care and Transition. I'd like to take a few
5 minutes and give some opening comments about what
6 you're going to hear today; set some stage and
7 then give you opportunity to ask questions of me
8 and my team. I'd like to thank the task force day
9 to spend the day with you presenting some of the
10 work the Army has been doing over the past four
11 years to develop what we refer to as the Warrior
12 Care and Transition Program.
13 As you all are likely aware, the Washington Post has published a series of articles beginning February 18,
14 2007, critical of the care, living conditions and support wounded ill and injured soldiers at Walter Reed Army
15 Medical Center are receiving while assigned to the medical hold and medical hold over companies at the
16 Army's premier medical facility.
At the conclusion of our presentation today, I believe
17 you'll see that the Army has not only made the commitment to correct the inadequacies mentioned in the Washington
18 Post articles, as well as in the reports of the
19 review in the 2006 by the Department of the Army
20 IG concerning the Army physical and disability
21 evaluation system. The independent review group
22 commissioned immediately following the Washington

1 Post articles, the Dole-Shalala commission, as
2 well as others, but has developed a robust, re-
3 sourced and enduring program to meet the needs of
4 soldiers and families in this era persistent
5 conflict that she talks about all the time. I
6 mentioned that the Army in February in 2007 began
7 developing a response to the findings of the
8 Washington Post articles. This response engaged
9 every activity the Department of Army that anyway
10 had impacted the lives and well-being of wounded,
11 ill and injured soldiers and their families, as
12 well as reaching out and teaming with the
13 department of veterans' affairs. The result was a
14 development of the Army medical action plan, which
15 was formalized as Department of the Army,
16 Executive Order 11807; healing warriors. And
17 published June 2nd, 2007, the same time the Army
18 established an initial operating capability of 36
19 warrior transition units and nine community-based
20 transition units. That installation is across the
21 United States, as well as in Germany and Puerto
22 Rico. Well the purpose of providing a robust

1 support capability

2 that also allowed soldiers to recover as close to home as possible. I would be remiss if I did not recognize

3 further the confluence of events that help make possible what the Army has been able to create since 2007. I have

4 already mentioned the various inspection reports and reports of commission, all of whose recommendations have

5 been and continue to be incorporated into the AMAP or as the Army refers to it today, the Warrior Care and

6 Transition Program.
I've already mentioned the Department of the Army report

7 on the Army physical and disability evaluation

8 system. As a result of this report successful

9 efforts were undertaken to decrease the paperwork

10 requirements involved in the determination

11 process. Today, Colonel Hobbs from the office of

12 the Sergeant General, informed me of the US Army

13 medical department's ongoing efforts to make the

14 medical evaluation process more efficient. The

15 integrated disability evaluation system has in

16 many ways closed the gap between medical

17 separations from the Army. By developing a

18 concept whereby VA benefits and care, as well as

19 Tricare network of other coverage of on-going

20 medical therapy and care needs are prearranged so

21 that the transition is as seamless as possible.

22 However, as you will hear from Colonel Cassidy

1 who's the Deputy Director of the Army physical and
2 disability evaluation system, there still remains
3 much to be done to shorten significantly the
4 length of time required to complete the medical
5 evaluation board and physical disability
6 evaluation system. There remains much to be done
7 to shorten significantly the length of time in
8 these processes. I asked Commander of the Warrior
9 Transition Command and I am privileged to be
10 working with Colonel Cassidy and the Department of
11 Army G-1 these past several months. I've only
12 been in command for a few months.
13 To develop under the direction of Chief of Staff, the
Army a proposal that would create just such a
14 stream-lined system. Until this is accomplished, there's
no question that the soldiers and families who find
15 themselves tied to a lengthy DES process, Disability
Evaluation System process, will continue to be less than
16 satisfied. I used the term confluence of events a moment
ago to describe the considerable energy and opportunity
17 which the Army was able to take advantage.
Aside from the findings of various commissions, Congress
18 passed the Wounded Warriors Act, as part of the
19 Public Law 110-181, the National Defense
20 Authorization Act for fiscal year 2008. This
21 legislation encompassed many of the legislative
22 priorities that the commissions and the Army

1 identified as being needed to take wounded, ill
2 and injured service member care to where it has
3 come today and to guide where it will go in the
4 future. Funding for the construction of the
5 Warrior Transition Complexes began in 2008 and is
6 beginning to come to fruition as soldier family
7 assistant family centers, administrative space and
8 accessible barracks have been either completed or
9 are currently being built which will provide
10 convenient and accessible campuses where wounded,
11 ill and injured soldiers or as we refer to them in
12 warrior transition, and their families, can go
13 about the businesses of healing, recovery and
14 planning for the future. You will hear today from
15 various presenters about the comprehensive
16 transition plan. Begun at the time of the mission
17 to a warrior transition unit, this process today
18 fully automated followed by goal setting,
19 rehabilitation planning, then critical pre and
20 post- transitional stages. For the individual
21 warrior transition and his or her family, the TCP
22 in a very real sense represent their

1 pathway to a productive future. This process has made it possible to bring together all elements of care planning,
2 goal setting, monitoring of progress and communication of the vision for the future.
3 Each warrior and transition has, along with the necessary steps identified and tracked that will enable each
4 soldier to step forward confidently with a plan for their future.
5 As Colonel Mozden will tell you in her presentation, the comprehensive recovery planning process used by recovery
6 care coordinators was modeled in large part by the
7 Army's comprehensive transition plan. The Army's
8 proud of its contribution to this statutorily
9 mandated program and I believe it to be a fine
10 example of the cooperative and transparent manner
11 the in which Army continues to work with other
12 agencies to ensure this grateful nation does do
13 all that it can for service members and their
14 families. To be truly effective, the Warrior Care
15 and Transition Program must become fully
16 institutionalized across the Army to ensure that
17 every Army activity along with our partners at the
18 Department of Veteran's Affairs, Department of
19 Labor, and others to do everything possible to
20 help put our brave men and women back in the game
21 either by recovering and returning to duty or with
22 a clear plan and direction with all the support

1 possible to reenter the civilian world as
2 confident, capable and prepared contributors to
3 society. Since the beginning in June of 2007,
4 Warrior Transition units have cared for and
5 supported over 34,000 soldiers and their families.
6 Just over 10,000 of that number are currently
7 being cared for in 29 WTUs and 9 CBWTUs. Of the
8 other 24,000, 47 percent or more than 11,000
9 soldiers have recovered and returned to duty,
10 either in their previous skilled areas or were
11 possible retrained into
12 another skilled area they can more easily master. For the more severely wounded, ill and injured, the Army
13 Wounded Warrior program is there to provide advocacy and assistance while the soldiers are recovering and
14 continues to support the soldier and his family as he moves to veteran status. It would be unrealistic to
15 think that with the Army, even with the tremendous support and cooperation we enjoy from the Department of
16 Veterans' Affairs and the Department of Labor and Congress, could particularly at the grass roots level
17 accomplish, the goals of the warrior care and
18 transition program without the strong support of
19 private organizations. Through our community
20 support network we have developed a vibrant
21 network of nearly a two hundred organizations
22 which support our soldiers and veterans with

1 everything confidence building activities,
2 tuition, and other support for education, home
3 improvements and a list of support activities too
4 long to list here. These caring organizations
5 provide their support at no cost to the soldiers
6 or veterans. They represent the very best of the
7 citizenry of the United States as they each in
8 their own way do what they can to express their
9 appreciation and support for those who have
10 sacrificed so much to maintain the freedoms they
11 and all Americans enjoy. Established in 2004, the
12 Army Wounded Warrior program currently provides
13 support to over 8200 soldiers and veterans. As
14 you will learn from Colonel Mozden, commands the
15 Warrior Transition commands a clinical support
16 division, and Colonel Greg Gadson of the Army
17 Wounded Warrior Program, a wounded soldier himself
18 whose incredible campaign to recover from the loss
19 of both his legs, set an example for others to
20 emulate has received national attention.
21 Advocates who make up the back-bone of AW2 are
22 detailed to WTUs, to assist the triad of care that

1 manages each warrior and transitions and care in

2 the

3 planning and preparation to transition to Veterans status, those soldiers who as a result of their combative

4 wounds and injuries represent those who are the most severely wounded. It is the Army's position that the

5 combination of the primary care manager, nurse care manager and squad leader, along with the AW2 advocate and

6 the entire multi-disciplinary team that cares for and supports each severely ill or injured soldier and the

7 comprehensive transition plan developed for each soldier accomplishes and surpasses the requirements of the

8 recovery coordination program established in DoDI

9 1300.24. Colonel Katherine, Kathy Mozden will

10 draw you a more detailed presentation on the

11 subject during her briefing on the non-clinical

12 nurse case manager aspects of the warrior care,

13 non-clinical case manager aspects of the warrior

14 care and transition program. Another key

15 component of the Warrior Transition Care, Warrior

16 Care and Transition Program establishes a part of

17 the DAX order 118.07 for the non-clinical support

18 of warriors in transition and their families are

19 the soldier family assistance centers. Operated

20 by the Army's installation management command.

21 These centers bring together many of the programs,

22 and experts warriors in transition need to provide

1 assistance with everything from child care and
2 lodging to arranging from VA care and benefits.
3 Mr. Christopher Watson is support specialist for
4 the SFAC program as we refer to it will brief you
5 in more depth about the tremendous support this
6 income provides soldiers and families as a means
7 for making it easier to focus on recovery and
8 preparing for the future while having many of the
9 needs of the present made easier to accomplish.
10 As you can imagine with over 10,000 soldiers and
11 families being cared in our WTUs and CBWTUs, along
12 with more than 4200 CADRE and staff members caring
13 for them as well, as XVAC staff and the 82,000 AW2
14 soldiers
15 and veterans being supported by more than being 172 AW2 advocates, plus AW2 support personnel, communication is
16 of vital importance. To accomplish this, the Warrior Transition Command is established and is in the process
17 of a major expansion of its strategic communication capabilities. Today, Warriors in transition and their
18 families can receive up-to-date information on Warrior Care and Transitions and programs. The Disability
19 Evaluation System, AW2 support and a variety of available care and support information on the Warrior Transition
20 Command website, www.wtc.army.mil. They can also
21 read about developments in the Warrior Care and
22 Transition program as well as hear from and

1 communicate with experts and those who have been
2 through the recovery process and have helpful tips
3 to provide by visiting a WTC blog,
4 www.wtc.armylive.mil. Beginning March 1, 2011,
5 Warriors in Transition and their families will
6 receive real-time information about developments
7 that impact them from the WTC Twitter site that
8 will be located at http://twitter.com/us.army.wtc.
9 For AW2 staff and clients, there's an AW2 section
10 available on the WTC website, as well unique AW2
11 blog located at www.awt.armylive.live.mil. Also
12 coming, March 1st for the AW2 soldiers and
13 veterans is the AW2 Face Book page, which will be
14 located at Facebook.com/usarmy.aw2. Here will be
15 find real-time information of interest as well as
16 an opportunity to communicate directly with AW2
17 soldiers and veterans, as well as with AW2
18 advocates and staff. Soldiers, veterans, and
19 families will find links to other agencies that
20 can provide assistance, as well as such as Army
21 One Source, Military One Source and the National
22 Resource Directory. To ensure soldiers and

1 families have as many means as possible available

2 to them to seek and obtain help for their

3 concerns, the Army established the Wounded Soldier

4 and Family Hotline: 1- 800-984-8523.

5 The Warrior and Soldier Hotline has been operated the US Army medical department's medical assistance group or MAG
6 since March 2007. Since April 2007, this hotline has handled over 24,000 cases and help resolve nearly 29,000
7 issues for soldiers and families including warriors in transition. The hotline is aided in this effort by 61
8 ombudsmen, nearly of whom are located Army Installations with military treatment facilities. Callers are either
9 helped immediately by the trained and professional staff that answer these calls, or receive assistance from an
10 ombudsman within three business days of placing

11 the call.

12 I had mentioned already the tremendous support

13 Congress

14 has provided the Army as we have been developing

15 the Warrior Care and Transition program. The

16 members and staff of the House and Senate Armed

17 Services Committee along with the in House and

18 Senate Appropriations Committee and House and

19 Senate Veterans' Affairs Committee watch with keen

20 interest and concern what is going on in the world

21 of care of for and supporting for wounded, ill and

22 injured service-members, veterans and their

1 families. To keep them informed, I provide
2 quarterly and on-going updates to the professional
3 staff members and council of these committees.
4 I've done two since I've been in command. Another
5 key element in preparing soldiers to transition to
6 civilian life is educating in employment and
7 access to the many programs that is available to
8 these transitioning soldiers. As commander of the
9 Warrior Transition Command, I have established
10 three pillars of excellence that I will emphasize
11 during my tenure. These are: Training of those
12 who support and care for wounded, ill and injured
13 soldiers and veterans - the CADRE; education to
14 help soldiers prepare for the future, and
15 employment - jobs. CADRE training must remain
16 relevant and up-to-date. To this end, the initial
17 training course for WT CADRE is
18 being revised to include a track for primary care
managers. This course has been updated several times
19 since its creation in coordination with the US Army
medical department center and school. In addition to
20 what has been learned from third party reviews of the
Warrior Care and Transition Program, these updates draw
21 from the best practices identified during the
approximately 23 operational inspections of WTUs and
22 CBWTUs B that my staff augmented by more than a dozen
subject-matter experts from across the Army conducted on

1 an annual basis. As an example, in November 20 of
2 2010, the Department of the Army IG published 56
3 recommendations, generated from a six-month
4 inspection of the Warrior Transition Unit and
5 Community-based Warrior Transition between January
6 and June of 2010. I am the Army lead of a task
7 force that is implementing these recommendations.
8 The WT CADRE training course will also be the
9 beneficiary of this effort, which will -- was
10 conducted with the full support and cooperation of
11 Warrior Transition Command as a means to ensure
12 transparency in the way the Warrior care and
13 Transition Plan is executed. In addition to the
14 operational inspection program, the Army IG
15 findings and other sources, Warrior Transition
16 Command is fortunate to have the insights of
17 numerous visits by Congressional delegations and
18 Congressional staff delegations, which also ensure
19 both transparency, an additional valuable source
20 of identifying areas for improvement. Warrior
21 Transition Command through the Army Wounded
22 Warrior Program also participates in the ongoing

1 efforts of Army senior leaders to improve the way
2 that the Army takes care of soldiers and families
3 through the Army family action plan process, AW2
4 conducts a rigorous annual symposium where scores
5 of recommendations received from soldiers and
6 veterans and families are examed --
7 examined, debated and ranked in order of priority. As a result AW2 and the Warrior Transition Command have
8 successfully championed through this process a number of improvements, which Army leaders have embraced to improve
9 military family life. Earlier this year, utilizing much of the same process WTC and AW2under Greg Gadson's
10 leadership, sponsored the first form for soldiers who otherwise determined due to their injuries to be unfit
11 for continued service. Having remained in the Army's continued active duty, continued reserve program,
12 COAD/COAR, these are truly courageous and
13 patriotic individuals who have many challenges to
14 overcome daily as they continue to serve. In an
15 Army focused on fitness for duty and combat, there
16 are areas in which more needs to be done to make
17 it possible for such brave men and women to
18 continue to serve in uniform. From this first of
19 its kind symposium, senior Army leaders have
20 received six recommendations, all of which are
21 being pursued at the highest levels of Army
22 leadership. These include, ensuring COAD/COAR

1 soldiers remain competitive with peers for
2 promotions. Improve throughout the Army for the
3 effective distribution of information about
4 COAD/COAR soldiers; develop improved procedures
5 for the procurement, sustainment and maintenance
6 of durable medical and adaptive fitness equipment
7 required by COAD/COAR soldiers; Provide assistance
8 with the coordination of ongoing care COAD/COAR
9 soldiers require; explore creating a stipend for
10 extra expenses directly associated with service-
11 related injuries; and then finally, Develop
12 advanced education programs for enlisted COAD/COAR
13 soldiers. Another example of the determination
14 and the resilience of soldiers can be found in the
15 area of adaptive sports and competition. The
16 Warrior Transition Command is working with the
17 United States Olympic Committees, US Paralympic
18 program to develop
19 adaptive sports and fitness programs for Warriors in
Transition. This ongoing program is designed to enhance
20 the service member's rehabilitation, improve their
physical fitness and generally improve their quality of
21 life. The program focuses on getting soldiers back into
a healthy, active lifestyle. With a number of activities
22 being offered, multiple days per week at each
installation. Activities can include basketball,

1 swimming, sitting volleyball, spinning, archery, walking, running and strength and conditioning. The program
2 utilizes a train the trainer's model to teach
3 local leaders and CADRE members to implement
4 ongoing activities and communicate a variety of
5 opportunities to ensure service members and their
6 families' -- opportunities to injured service
7 members and their families. The value of
8 competition as a motivator of injured soldiers,
9 service members is behind the premier event in
10 this program known as warrior games. The second
11 annual warrior games will be conducted at the U.S
12 O.C. training center in Colorado Springs,
13 Colorado, May 16th to 21, 2011 with the offer
14 invitation to the panel. In preparation for this
15 event the Army has conducted a series of training
16 camps for Warriors in Transition and AW2 veterans.
17 Culminating as recently as February with the
18 selection of the army's team of over 90 athletes.
19 These athletes have been training hard in the
20 particular sports venue, whether it's shooting,
21 swimming, archery, track and field, cycling,
22 sitting volleyball, and wheelchair basketball. The

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1 transforming power of sports and competition
2 demonstrated at last year's games leaves little
3 doubt as to the worth of adaptive sports and
4 competition. Through this program we have seen a
5 number of soldiers picked themselves, train and
6 through competition realize they are capable of
7 doing more than previously thought possible. The
8 WTC and the Army have teamed with the
9 Department of Labor to pursue opportunities for soldiers, such as though available through the veterans'
10 appointment and training service. For example, beginning tomorrow, the Army Wounded Warrior Program is hosting the
11 wounded warrior federal employment conference at Fort Beltwar. Where the transitioning service members from
12 all services will receive practical training in how to successfully find employment. There is yet much to do in
13 this area and I look forward to achieving considerable success in this area over the next year or so. Before I
14 conclude my remarks I must mention the tremendous
15 program, the medical care, the Army has developed
16 under the direction of Lieutenant General Eric
17 Schoomaker, my boss. Advancements in protective
18 measures and military medicine have contributed to
19 the more than 90 percent survival rate of soldiers
20 wounded or seriously injured in the conflicts in
21 Iraq and Afghanistan. In addition to the
22 extraordinary success in burn care and management,

1 the Army's Institute of Surgical Research
2 accomplishes everyday as they continue to expand
3 the Army's ability to severely burn injuries; the
4 Army has developed cutting-edge cab abilities in
5 the area of high-tech prosthetics. Perhaps no
6 greater challenge presents itself today that
7 provide in the comprehensive behavioral health
8 care returning soldiers require. Since 2007, the
9 Army has increased by more than 1700, the number
10 of behavioral health providers caring for soldiers
11 and family of soldiers who experience a post-
12 traumatic stress disorder, and the effects of
13 traumatic brain injury. New techniques to
14 minimize the impact of PTSD and even to avoid many
15 of its effects of a robust program of resiliency
16 training have been established across the Army.
17 The side effects of these conditions have included
18 homicidal and suicidal tendencies, efforts to
19 escape the torment of pain and painful memories go
20 beyond success,
21 go beyond suicide to efforts that self-medicating with alcohol, experimenting with different combinations of
22 prescription medication, as well as the use of illicit drugs is presenting an increasing challenge to Army

1 leadership. You will hear from Colonel Stasinos and
Major Goldman about efforts of Army medicine to treat the
2 psychological effects of war through the establishment of
the comprehensive behavioral health system of care. You
3 will learn about the intense focus this program has on
providing behavioral health care and support towards
4 transition. I am confident you will come away
5 from this presentation with an understanding how
6 seriously Army medicine is addressing this ever
7 burgeoning reality of the psychological effects of
8 war, multiple deployments and prolonged conflict
9 have on our fighting men and women. In closing,
10 you will not doubt in this hearing and in all the
11 work that you do, be concerning what success looks
12 like for the soldiers in the Warrior Care and
13 Transition Program. I can think of no better
14 example than of a staff Sergeant who was cared for
15 by the staff of the Fort Houston for Wounded and
16 Transition Unit. This soldier returned from Iraq a
17 broken man; both physically and emotionally.
18 During a routine appointment, at the family health
19 clinic, the soldier was seen by a physician who
20 recognized that he was examining a wounded warrior
21 in need of urgent care. Once in the Warrior
22 Transition Unit, the soldier received the

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1 professional behavioral health care he needed.
2 Contemplating suicide at the time as he recalls
3 today, the Warrior in Transition began working
4 with his nurse case manager, who helped him set
5 weekly goals to attain the long road to recovery.
6 Over time, the triad of care addressed this
7 warrior's issues one by one. Where surgery was
8 called for to heal his broken body he received
9 that surgery. Along the way, the soldier
10 received the treatment and therapy he needed to help him heal and manage the pain he endured. His medications
11 were prescribed and tracked to ensure they were working and if not change until a successful combination of
12 treatment was found. Things did not always go well and there were challenges to meet and overcome. Notably,
13 there were battles with Tricare to make sure this warrior in transition received the appointments, procedures, and
14 equipment he needed. Every step of the way, the triad of care was there assessing, acting, evaluating, and
15 reassessing. As a WTU team helped him develop a
16 clear and attainable path to recovery and his
17 future, adjustments and lifestyle had to be made.
18 The WTU staff made sure that the right mix of
19 counciling sessions, educational sessions, finance
20 sessions, therapy sessions, rehabilitation
21 sessions and family sessions were accomplished.
22 Along the way a network and friendships developed

1 both with the staff and the other wounded warriors
2 in the Warriors Transition Unit. His squadron
3 became as close to him as his brother. He was
4 there for every surgery and recovery. He was
5 there any time day or night whenever his help was
6 needed. The fog of despair was lifted and this
7 wounded warrior began to find purpose in his life
8 with his new found friends and brothers in arms to
9 thank for much of his recovery. His wife sums it
10 up best when she says that the medical
11 professionals and the Warriors Transition Unit
12 saved her husband's life. That is what success
13 looks like in the Army's Warrior Care and
14 Transition program. Thank you for this
15 opportunity and I know you will learn a tremendous
16 amount about the Army's Warrior Care and
17 Transition Program today from the experts we have
18 who will appear before you. At this time I
19 welcome any questions you might have before I turn
20 it the briefing over to Colonel Kathy Mozden.
21 Thank you sir, ma'am.
22 MS. GUICE: Thank you sir. Are there any questions?
MR. REHBEIN: Can I make a couple of comments to the

1 General?
MR. WILLIAMS: Yes, sir.
2 MR. REHBEIN: Actually, one is a comment and one is question.
3 MR. WILLIAMS: Yes, sir.
MR. REHBEIN: And I, this first comment I don't have any
4 better idea. I want you to understand that. You referred to the business of healing. And I wonder
5 sometimes out there in the rest of the world,
6 business refers to eight, ten, twelve hours a day,
7 five days a week and I know that Sergeant
8 MacKenzie and Mr. Constantine can tell you that
9 healing is not that kind of thing. It's a
10 24/7/365, where I can go home and take a couple
11 days off from my business and forget about it.
12 They can't. So I don't know if there's a better
13 terminology that we can use to help the people out
14 there in the world understand what our wounded,
15 ill and injured are going through. That's just a
16 comment I hope we can all think about. And
17 regarding the community based transition units, I
18 hope today we can hear somewhat of how the
19 decision processes runs whether or not someone
20 should be assigned to a CBWTU and if that decision
21 process what reevaluation is involved there. It's
22 got to be very difficult to be out there a long

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1 ways from, trying to communicate by telephone. I
2 can understand how that could really, really begin
3 to weigh on an individual but would maybe do a
4 better job healing inside the WTU.
5 MR. WILLIAMS: Yes, sir. Sir, thank you for
6 your comment and your question. With respect to
7 your comment, we'll take that to heart. I mean, I
8 have a lot of experts, starting with my Army
9 warrior could provide insights maybe about that.
10 I understand what you're saying. It's more than
11 just an on-off sort of proposition. It's a
12 24/7, and it's holistic whole and healing is something
that happens not just when you come in, it happens all
13 the time. Sir, we'll take a look at that. With respect
CBWTUs, you will hear how we work through that. I'll
14 tell you that at the high water mark, the idea that you
heal closest to home, that's the idea behind the CBWTUs.
15 You'll hear a little bit about and I can follow-up later
if you don't, if it doesn't get addressed for you, but
16 we're in the process of transitioning from a 29 WTUs and
nine community-based warrior transition units to 29
17 warrior transition units where and even more so in
18 this concept of remote care. So we have soldiers
19 who active guard and reserve, primary guard and
20 reserve, who have the opportunity to heal closest
21 to home. And it's very much how they communicate;
22 it is telephonically, and it is visits and there

1 are challenges associated with that. But, so
2 you'll hear more about that later in answer to
3 your question.
4 MR. MACKENZIE: Morning, sir.
5 MR. WILLIAMS: Good morning.
6 MR. MACKENZIE: I had the unique experience
7 of being a liaison at Walter Reed during this
8 transition in 2007. I noticed we had a lot of
9 challenges at times because very few people were
10 volunteers and very many people were assigned. As
11 the volunteers and the people eager to be the
12 CADRE, increased the care for the warriors
13 increased.
14 What I don't hear, although we are focused on the
15 wounded warrior, what I don't hear or see is where
16 is the reward for being the best WTU? Where's the
17 competition? The things that make everything about
18 being a military man or woman great are that
19 competition yet it seems like these unsung heroes
20 go unrecognized. This a unique challenge, it's a
21 unique position competition and try to be a CADRE
22 and take care of wounded warriors do it, it's more

1 than just out of the kindness and the caring of an

2 individual. I was wondering any special opportunities, like we call it in the Air Force special assignment where

3 these guys are getting these recognition being that special CADRE.

4 MR. WILLIAMS: That's a great question. The CADRE members are compensated. They get special pay and so if

5 you remember back to my three main points, CADRE, CADRE, CADRE, whether it be Greg's CADRE or the WTC. So we are

6 incentivizing to be the best team, the best team of group of sergeants, to be the best battalion and awards to

7 recognize in front of everybody. That's one

8 piece. The sergeants are currently given a

9 stipend for being on there. Some of the things,

10 full transparency that I found is I don't think

11 the training is enough, which is why they are

12 relooking at it. Currently, they get a two-week

13 training cycle there. You've got an armor guy, an

14 infantry guy, an artillery man like myself who's

15 asked after two weeks, enabling to be this wing

16 man, to be this battle buddy, or somebody who is

17 potentially older than he or she. Not only, the

18 inventiveness of making it special to be an Army,

19 we're looking at things like, do we put something

20 on a uniform; some sort of recognition, some sort

21 of scrolls where you are recognized as a CADRE

22 member, that you're just as important. I really

1 think though, back to the training. So two weeks
2 currently we have and you'll hear some of that.
3 What I want to do is I was a deputy director for
4 before I came here and what I have found is, both
5 anecdotally and by science, we train 3,000 Army
6 sergeants, to use my terms, master gunners to
7 improve their resiliency in their formations. And
8 by extending the course by two weeks and the other
9 requirement that I told my, what I've found, we
10 have sergeants who are serving in these positions
11 who have not been through the training. You have
12 to have gone through the training; you have to
13 have gone through this extended
14 care in terms of the training. So I'm making a big deal
out of that advocate or that Army Sergeant who's in AW2,
15 both in terms of training, both in terms of
incentivizing, and both in terms of the benefits they get
16 right now. We're going to make a big deal of that.
We're working with the senior commanders, I tell them
17 that, when I go talk to them. In fact I'm heading out
there later today to talk to the precommand corps, all
18 the EMTF commanders all the new WTC commanders and I'm
going to talk about all these programs. So does that
19 answer your question?
20 MR. MACKENZIE: It does, and that's a lot
21 because of my unique experience. There are those
22 soldiers where you look at and go man, where did

1 this person come from? They are awesome, and yet
2 you never hear anyone talk about them the way we
3 do. It's going to be very encouraging to see if
4 you do come up with something along those lines.
5 MR. WILLIAMS: I appreciate that. One last
6 piece, the senior Army leadership, once a quarter,
7 in fact we have our session in about two weeks,
8 they ultimately own the picking of the leadership,
9 the triad leadership I was talking about. So if
10 you find that the other piece of this, kind of
11 like the other side of the coin here, if you find
12 soldiers or sergeants, the triad, you know you've
13 got the nurse, the surgeon and the doctor, if you
14 find squad leaders out there who aren't meeting
15 it, then you have an obligation to change it. So,
16 you own the policy, you get them trained, make
17 sure they get there at the right time, and Senior
18 Mission Commander, you make sure you've got the
19 right athlete. So that's kind of the Army's
20 position.
21 MR. PHILLIPS: Thanks. General, thank you
22 very much. I appreciate those comments. The WTUs

1 have an incredible mixture of injuries from combat

2 injuries to psychological

3 problems. It's my understanding that the number, the percentage of the combat injuries are very low in the
4 WTUs and I was just wondering, and perhaps someone else will address this are there any plans to begin to
5 differentiating those? I'm a physician and I can only treat certain things, and be able to address those
6 specific differences within the WTUs?
MR. WILLIAMS: Sir, your question is very timely. There
7 is actually a movement by the Department of Defense to look at that very point. As of last Friday, if you look
8 at 10,020, only 1297 were battle-injured of that

9 group. So it's a small percentage of those, about

10 ten percent we say. The official Army position

11 right now is we do not want to do this, just to be

12 perfectly transparent. I put together some things

13 for the vice and the senior Army leadership. I

14 queried the field. I asked my commanders out

15 there, the ten commanders; I asked the wounded

16 warriors, I asked folks out in the field, what do

17 you think about separating the wounded, ill and

18 injured. But first I must say that I am wounded,

19 ill and injured commander; that's my first

20 position. But having said that, would we want to

21 segregate potentially, what I got from the field

22 was, no, now I'm a soldier, and we are working now

1 Dr. Woodson and Dr. Stanley and I was in the sock
2 last week. There is a movement afoot to do that
3 very point at full transparency. And so we are
4 looking right now at how to do that. It's course
5 of action deep right now, so I guess the answer to
6 your question is yes, sir, we are looking at that.
7 But the official Army position is that we would
8 not do that, but I think it's more, let me paint
9 it another way, we think the things I talked about
10 between the enhanced access care, the stuff they
11 get with respect to installation, the SFAC, the
12 support, we think they are special, the whole
13 population and to differentiate that population we
14 think is
15 potentially problematic. I mean, how do you get the air
borne or range infantry man who has been deployed six
16 times and with no issues, but on his seventh time while
preparing for training, fast ropes in and hurts himself
17 and we say that potentially not he's in the wounded, ill
and injured club or we're going to make you, we're going
18 to separate the folks who are wearing a purple heart
because they were wounded, you're going to make a
19 differentiation there. Right now we're working through
that. It's very, in the beginning stages, developing a
20 strategy. I know that the Department of Defense
21 is working on that. Just in the last week, I
22 mean, it's really, it's really, really timely. We

1 are prepared -- so having said that, we're
2 prepared to work on that if that's the case. We
3 think, and especially what we do with the WTU in
4 total, we think that if we gestalt that we are
5 already giving soldiers a lot of special, that are
6 both wounded, ill and injured a lot of special
7 things and anything over and above that, would be
8 viewed as somewhat problematic. Does that help,
9 sir?
10 MR. PHILLIPS: Thank you very much. One
11 thought that comes to mind respectively is that
12 perhaps we can differentiate between those never
13 been deployed within the units and those who have
14 been deployed.
15 MR. WILLIAMS: Yes, sir. Very well said.
16 MR. GREEN: Can I just ask for some
17 clarification on the last answer?
18 MR. WILLIAMS: Yes, sir.
19 MR. GREEN: So for the folks that are
20 basically ill and injured, when they are put in
21 the Warrior Transition Unit, are they taken off
22 the books of the unit where they were assigned?

1 And so that allows the field unit to be get a
2 replacement.
3 MR. WILLIAMS: Yes, sir. That's the nuts
4 and bolts, yes, sir. They belong to that
5 battalion. They are taken off
6 the books, yes, sir.
7 MR. GREEN: So is that the primary reason why the field is so unfavorable of keeping the Warrior Transition Unit; it keeps their books basically filled with deployable
8 assets?
9 MR. WILLIAMS: Um, no, sir. There was about six that was one of the low ends. There was a list. The biggest reason is that's my battle buddy and so the perception of
10 that would be problematic. From the high end perception piece of, of their buddy mate to the low end, some of the
11 things that you just talked about. We had like
12 six criteria and I can give you those later, sure.
13 MR. GREEN: Can you clarify one thing
14 further for me? So is the Warrior Transition Unit
15 numbers, are those numbers on the books for
16 strength of the Army?
17 MR. WILLIAMS: Yes, sir. Yes, sir, they're
18 part of my command.
19 MR. GREEN: Okay. I have one other question
20 if I may have. Sorry, since I took the microphone,
21 I apologize. Are you assigned members currently in
22 the Warrior Transition Unit processes as CADRE?

1 MR. WILLIAMS: Do we reassign them, sir?

2 MR. GREEN: Right. In other words, can they

3 be in the process of their disability evaluation

4 and also be assigned to CADRE to support others?

5 MR. WILLIAMS: Sir, we have -- the short

6 answer is no. We have a lot of CADRE, increasing

7 number of CADRE who were once wounded warriors.

8 So that's what we have. Like for instance,

9 Lieutenant Colonel Danny Dudek at Fort Louis, a

10 single, I'm sorry, a paraplegic is a battalion

11 commander. We have my commander; Hanes down in

12 Fort Knox is an amputee. So we have smatterings

13 those are high level, those are soldiers were

14 CADRE. Also that has recovered from PTSD. So you

15 can not be in the program but you can be an ex-

16 member.

17 MR. GREEN: So in other words, if a determination has
been made they are either returned to active duty or
18 places in a civilian position and support thereof.
MR. WILLIAMS: Yes, sir.
19 MR. GREEN: Okay. Thank you.
MR. WILLIAMS: Yes, sir?
20 MR. HORST: I'd like to follow-up on Master Sergeant
MacKenzie's comment about incentiveness servicing CADREs
21 at the WTU. Beyond recognizing the best squad leader in
the WTU, from an institutional standpoint, the Army needs
22 to recognize that serving on a WTU CADRE is career

1 enhancing for a non-commissioned officer. A non-
2 commissioned officer that is down range
3 consistently traditionally tends to be promoted at
4 a higher rate than a non-commission officer who
5 has not been down ranged. With the D. A.
6 Secretariat needs to do in their instructions to
7 promotion board is to give careful consideration
8 to non-commissioned officers serving in Warrior
9 Transition CADREs for consideration for promotion.
10 That will cautify that WTU is important when it
11 has demonstrated through promotion results.
12 That's how the word gets out to the rest of the
13 Army that being a member of the CADRE is both a
14 rewarding experience, but it's also a promotion
15 rewarding experience, as well.
16 MR. WILLIAMS: Yes, sir. Sir, thank you for
17 that. Spot on. My commands are back there is
18 working on that very effort. I apologize for not
19 mentioning that. In working with human resources
20 command, and Major General Farrisee, we're in the
21 developing embryonic stages of doing exactly what
22 General Horst just talked about. Recognizing from

1 their N. C. R. O., this is a big deal. And I've
2 had a number of conversations with the Sergeant
3 Major of the Army about this. He thinks that this
4 is the right thing to do. We did the same thing
5 in the last program I was in. The instructions to
6 the board must say that this is
7 a big deal, like we do in the Army with our drill sergeants and other career sorts of enabling and
8 enhancing jobs. So, sir, spot and thank you for that.
MR. PHILLIPS: Very quickly General. Does the CADRE have
9 other responsibilities besides the WTUs?
MR. WILLIAMS: No, sir. That is their sole
10 responsibilities.
MR. DRACH: General, thank you for your comments. You
11 said a lot of things that really make me happy based on my forty-two years of experience working with Wounded
12 Warriors and disabled veterans. Two things that I
13 didn't hear and I may be premature in bringing
14 these up because it may be covered later. You
15 didn't mention, at least I didn't hear anything
16 about DoD's cap program, the Computer Electronic
17 Assistance Program, which provides assistive
18 technology and assistive devices to the wounded,
19 ill and injured that they get to keep. It's a
20 very marketable, it's a very useable thing because
21 when they leave they can take that with them and
22 they oftentimes take their reasonable

1 accommodations to the workplace with them. And
2 the other is the DTAP program, the Disabled
3 Transition Assistance Program which is part of the
4 overall transition assistance program. I think
5 the WTUs are in a unique situation to enhance what
6 is currently DTAP, which is currently only a two-
7 hour add-on to the other programs because you sort
8 of have a captured audience and it can build on on
9 what DTAP does right now.
10 I also was very pleased to hear you talk about
11 the
12 sports program and the adaptive sports program.
13 But you mentioned, I believe you mentioned that
14 you are going to provide adaptive fitness
15 equipment. When I think of adaptive fitness
16 equipment, I think something different that
17 adaptive sports equipment and often that adaptive
18 sports equipment is really for fitness, such as
19 the monoski and I know that there's a gap between
20 VA and DoD
21 because VA can provide certain items but not to the
person still on active duty. I think you know what I'm
22 talking about. Have you ever given any thought to the
possibility of DoD or the services being able to provide

1 the adaptive sports equipment?
MR. WILLIAMS: Greg Norman is, Greg is itching to talk,
2 so sorry. The short answer is yes and I'm going to let
Greg talk a little bit about it.
3 MR. DRACH: That's okay, I've got it. Thank you.
MR. WILLIAMS: Thank you, sir.
4 MR. GADSON: Sir, in terms of the CAP
5 program, I want to say it's alive and well. I've
6 actually been able to take advantage of the
7 equipment that it provides. Primarily one of the
8 things I had damaged was my arm also, and I don't
9 have fully use of my right hand, and so the Dragon
10 Speaks software when I have long emails, or some
11 long typing I can do I normally put the Dragon
12 Speaks on and I'm able to use that to dictate long
13 emails or long correspondence. So, we are, we
14 have that program and take advantage of that. So
15 I would say that. I think you struck a nerve with
16 the adaptive sports and fitness and equipment. I
17 personal think it's a major issue and it's
18 personally affected me. And as you said between
19 the VA and the DoD, we have not come to a solution
20 on this. I think we're kind of pointing at each
21 other in terms of whose responsibility it is.
22 There are some that believe that the VA and some

1 that think the DoD and Tricare and it's really
2 about Tricare should provide the adaptive fitness
3 equipment and I think there's some that believe
4 that the VA could do it also. I think that's, I
5 mean, I'm not here to pick a solution. I know the
6 VA knows how to do it and I think ultimately and
7 have the systems in place to do it, those service
8 members that are in this position are ultimately
9 become veterans at some point in their life.
10 There are pros and cons, but we are
11 collectively kicking the can on this issue and some that are also related to those policy gaps between those
12 service members that stay on active duty and can't take advantage of some of their veteran's benefits because of
13 their situation.
MR. DRACH: Just a comment and I appreciate what you're
14 saying, but it seems kind of interesting that a wounded amputee at Walter Reed can get a sports prosthesis, but
15 not the sports equipment.
MR. GADSON: Yes, sir. I think that's accurate and not
16 to put Walter Reed on the spot, but it's really
17 inconsistent in terms of its application. I'm a
18 double, bi-lateral amputee. It's much more
19 expensive to outfit me with adaptive equipment
20 than a single BK. So even amongst amputee you see
21 inconsistencies and what DoD is willing to provide
22 or not provide.

1 MR. DRACH: Thanks.

2 UNKNOWN SPEAKER: Okay. General Williams, I

3 wonder if we can come back to General Green's

4 question on the ability of commanders to move

5 soldiers who are not medically fit into the WTC in

6 response to preparation for deployment or to

7 maintain their unit readiness. I wonder if you

8 can discuss the effect of the FRAGO 3 or FRAGO 4

9 on those admission criteria.

10 MR. WILLIAMS: Yes, sir. So sir, we saw a

11 precipitous rise right before, you'll see this

12 later, they'll talk a little bit about that. So

13 FRAGO 3 established the entry criteria for our

14 population. I believe it was summer of 08, if I'm

15 correct, a real rise in the number. We topped out

16 at about 12-5, 12,500. And so we started to look

17 at ourselves and say, look who's going to get in,

18 who meets the criteria for an entrance into a WT.

19 So, FRAGO 3 primarily addressed the active duty

20 component. And it had a dampening effect, and I

21 think Kathy's going to show you a slide that shows

22 you that. You'll see the

1 dampening effect of the movement of the population. And
then FRAGO 4, we missed the reserve component, shame on
2 us, and so FRAGO four speaks to the entry requirement
associated with the compose 2 and 3, the guard and
3 reserve. That's kind of where we are right around. We
are now right around, like I said, right around ten
4 thousand. We think as I mentioned earlier, after four
months in command, total transparency here, I think many
5 of the things that require, that cause us to be this big,
and have this latency, because the Warrior Translation
6 commands, because I'm an artillery man, about
7 creating thrust, they move through the process
8 quickly and move on to something. It's not a
9 place where you're going to hang out and you'll
10 see some of that when you go around.
11 You'll see folks that have been there for a while
12 and
13 you'll start asking yourself why you are here for
14 so long. I think the inefficiencies of the
15 disability evaluation system, folks waiting on a
16 MEB or getting their med MEB process and as you
17 know, the Army, and Kathy is going to talk a
18 little bit of this also actually bigger than the
19 Army. The DoD has got this I dash process where
20 we're trying to improve the integrated disability
21 evaluation system where it's actually taking
22 longer. The acute time for an average soldier,

1 once he or she has been declared medical, the M.
2 R. D. P. has been met, whether or not he's going
3 to stay in and has been declared that he needs to
4 be MEBd or PEBd, it takes on the average 260 or
5 270 days for this process. So those two FRAGO's
6 establish the criteria for the WTC and help shape
7 us.
8 MR. GREEN: Can we get copies of those two
9 FRAGOs so that we can understand?
10 MR. WILLIAMS: Sure. MS. CROCKETT-JONES: You said
11 that training for CADRE member consisted was
12 another two weeks. Is there any
13 sustained training that goes on, considering, I'm specifically thinking about things, like the way
14 resources change, programs that are available for specific illnesses and change and so, and then how is
15 that perhaps that training passed to soldiers in WTUs? There sometimes seems to be a lot of soldiers having to
16 almost find programs themselves and then bring that back and sort of train their own CADRE to be updated on what's
17 available out there, is there may be something to sort of transmit information a little more clearly?
18 MR. WILLIAMS: Yes, excellent
19 point. That's what I found and that's why my
20 second priority is the education piece; that's
21 specifically what we're talking about. Not this
22 sort of ad hoc, sort of catch us if you can sort

1 of way. I would say at the high end, we have a
2 training conference at WTC in April, this year,
3 third week in April, and you're invited to come to
4 that also, where we bring in all the CADRE down in
5 Orlando this year to talk this very thing. What's
6 changed in the last year? Here are the, from the
7 CTP changes down to what's new in advanced and
8 what you just spoke up. I also talked about our
9 web sites and how we update folks. So that's our
10 principle at the strategic level. I talked to the
11 commanders all 29 of them every quarter and I just
12 recently, we used to do it, all 29 on and each to
13 throw on a comment. I said this is a waste of
14 time so now I've broken them up into regions where
15 I spend an hour, a full hour and a half with of
16 the regions. I don't know, you'll see this on the
17 map that I'll show you later. But in terms of the
18 four regional medical commands that the Sergeant
19 General has, Hawley Bowland, the south, the west,
20 the east and Europe, I talk to them about the
21 latest trends. That's how it gets back to the
22 soldiers, through that formal process. That's how

1 we do it up here. Our annual conference, our web
2 sites, my quarterly
3 updates, I talk to all the commanders when they come through PCP, that's what I'm doing tomorrow down in San
4 Antonio. I talk to the installation commanders, and I talk to the senior Army leadership's concerns about the
5 process. It's a top down piece. Yes, ma'am.
MS. GUICE: I'd like to go back to a follow up question
6 about the population you have and the WTUs and if my memory served me correctly in my notes, you said about 47
7 percent had returned to duty. Of the remaining I'm assuming, they are all in a disability evaluation system,
8 acknowledging that we have two, the legacy and
9 IDES, what's the average length of time those
10 individuals spend, because you've some track
11 record with some of the people in there. What's
12 the average length of time in either one or both?
13 MR. WILLIAMS: Right. Slightly longer, I
14 don't want to guess. Ma'am, the bottom line IDES
15 is about 30 days longer, I think it's 227 for the
16 legacy and about 30 days for the integrated
17 disability evaluation. But I don't want to guess,
18 the exact number will be shown to you later. The
19 bottom line is what we've found in these 16 sites
20 that were selected it's a little longer in terms
21 of time processing. But we have that exact number
22 so I can get it correctly, but it's longer. And

1 Dan Cassidy, who's going to tell you about the
2 efforts the Army doing to get duel adjudication,
3 some of that kind of stuff.
4 MS. GUICE: When you talk about length though, I'm
5 assuming that this means to the time of the DD-
6 214 or is it the full, all the way to VA
7 compensation payment?
8 MR. WILLIAMS: It's the full thing. The
9 latter, ma'am. So once you've been declared
10 medically unfit and once you get the compensation,
11 so that whole continuum.
12 MS. GUICE: Because with certainly
13 disability, the legacy system, I mean
14 traditionally, we quote the number about 600 days
15 to get to the VA compensation. So I just want
16 to make sure that we're comparing apples to apples and we know what timeframe we're actually referring to and I
17 look forward to that information later. Thank you, sir.
MR. WILLIAMS: Yes, ma'am. Okay, I think we probably, I
18 should transition to some other briefs unless there is any other questions. And I'll be here for most of the
19 day. But, thank you. Kathy will be next and tell you a little about the program in more details. Thank you
20 sir/ma'am.
COLONEL MOZDEN: Just because I'm kind of shorter.
21 GENERAL WILLIAMS: Yes ma'am. There you
22 go.

1 COLONEL MOZDEN: Thank you, sir.
2 Morning Sir, Morning Sir, Morning Ma'am. Members
3 of the task force, ladies and gentleman, I am
4 Colonel Cathy Mozden. I am just going to give you
5 a -- kind of a set the stage here for an overview
6 of Warrior Transition Command and what we are all
7 about. Much of this I am sure will be quite
8 familiar to you, so I expect we will just go ahead
9 and move through these slides fairly briefly. And
10 then, we will move on with the rest of the
11 presentations. This is our agenda that we are
12 going to be covering today. After I do the
13 overview for you, then we are going to move on to
14 Dr. Gliner who will be providing the statistics
15 and some of the metrics on our Soldier
16 Satisfaction Surveys. Colonel Scott and I will
17 then be coming back to talk about non-clinical
18 aspects. We will move on to the SVAC briefing and
19 of course, we do give you a break in here. Short,
20 but we will give you a break. Then we will move
21 on -- Colonel Scott will come back and talk about
22 the clinical aspects of our program, then we will

1 hear Dr. Stasinos brief on TBIPTSD, and then end
2 with Colonel Hobbs and Colonel Cassidy reviewing
3 the MEDPEB and the IDES. Warrior Transition
4 Command -- this command is subordinate to the U.S.
5 Army MEDCOM. The mission of our command is
6 to successfully transition soldiers and their families back to the Army or to civilian life as we have been
7 discussing. The key to mission accomplishment is our comprehensive program of medical care rehab, professional
8 development, and personal goals, which we will be touching on several times today.
9 You will see that we do not have command and control over our units. Those are nested within the regional medical
10 commands within MEDCOM. The Army Wounded Warrior Program, some of you may recall that we had different
11 entities out working. The Army Wounded Warrior
12 Program was with Human Resources Command. When
13 the Warrior Transition Command was stood up, all
14 of those resources were brought together under one
15 command -- our current commander, General
16 Williams. The AW2 program supports both active
17 duty and veterans, and they do that in partnership
18 with the Veterans Administration and they are
19 engaged with our soldiers or our veterans for as
20 long as it takes. This slide demonstrates in a
21 very condensed format the sort of then and now of
22 warrior care in the Army. As commented on in

1 2007, Army took a hard and we think ultimately
2 very productive look at the way we were supporting
3 our recovering wounded, ill, and injured soldiers
4 and their families. Moving quickly, to resolve
5 those concerns, the Army stood up our Warrior
6 Transition Units within MEDCOM under the command
7 of individual MTF's, thereby creating a safe-
8 haven for recovering soldiers of all compos. Some
9 of you may recall that prior to the stand up of
10 the W2U's, we had what we would call Retention
11 Processing Units. That was primarily a program
12 created for reserve component soldiers. The
13 active component soldiers were managed through
14 MEDHOLD which was done individually within each
15 MTF structure. So by creating the W2U's, we
16 developed a program and a
17 structure that would support all compos of soldiers who were going through this recovery, rehab, and transition
18 process.
To build these, to structure these, to staff these, Army
19 looked to their Senior Mission Commanders on installations. In addition, our reserve component
20 partners in the guard -- the reserve contributed cadre as well. We now have all compos serving as cadre as well as
21 civilians.
We also developed through our partners over at
22 Installation Management Command. You recall one of

1 the big issues was the housing -- the types of
2 barracks -- the housing that the soldiers were in.
3 We have now moved to where we -- I don't know if
4 any of you have had the opportunity to go out to
5 Fort Riley, where we have been able to open our
6 first actual built from the ground up comp, uh,
7 campus, if you will, for our recovering soldiers.
8 But it is very exciting to see that come to
9 fruition. So, our barracks were improved -- the
10 housing for the soldiers -- and then the SVAC's
11 were developed, bringing all of the existing Army
12 personal family, administrative support functions
13 that were on the installations -- bringing them
14 together with the SVAC. You will be getting a
15 briefing on that later, so that it was convenient
16 to the soldier and his family. This is our current
17 population as General Williams discussed with you
18 earlier of just over 10,000 warriors. This slide
19 gives you a picture of where our Warrior
20 Transition Units are located and in addition,
21 where our CBWTU's are located. The CBWTU's
22 historically were referred to CBHCO's and those

1 are actually pre-existing the development of the

2 WTU's. They were stood up in 2004 when we still

3 had the MRP Units on Installations. Again, this

4 was targeting that reserve component soldier, most

5 of whom -- not all -- but most of whom really

6 prefer to

7 be at home for their healing process. We can speak more about that -- the CBWTU program in a little bit.

8 You know this is the Army, or this is the government -- we love metrics, right? We count numbers all of the

9 time. Well, you have probably seen this slide, many of you. This gives us a population over time look at who

10 all we have had in these Warrior Transition Units and what the impact of some of our decision points have been.

11 So, for example, you will see on the left hand side -- the establishment of the WTU's. The WTU's, when we first

12 structured them were based on an anticipated

13 population of about 5500 because that is what we

14 had in the system at the time. We had about 1000

15 active component soldiers, and we had 4500 reserve

16 component soldiers. You will see that beginning

17 spike. That was when the decision was made to

18 move all of the soldiers going through an MEB,

19 into the Warrior Transition Units. The blue is

20 capturing your active component personnel. The

21 green and the pink are your reserve components.

22 You will notice that they have been a fairly

1 steady state across time. The big boles was in
2 our active component soldiers as they were moved
3 into the Warrior Transition Units for a number of
4 reasons, but certainly all of those going through
5 a board. So then we had FRAGO 3 published. FRAGO
6 3 took a close look at eligibility criteria and
7 looked at "what soldiers do we really need to
8 provide this enhanced command and control, this
9 complex case management"? And, the determination
10 was made that we wanted to target those soldiers
11 who needed that additional care and had the
12 complicated cases that were going to take at
13 least, we believe, six months of, of rehab before
14 they would be ready to move on. And that soldiers
15 that were going through board, just as an example,
16 a soldier with a severe hearing loss, did he
17 need to go into a WTU and receive all of those same
things as a soldier who had a long-term complicated
18 recovery process in front of him.
After the implementation of FRAGO 3, you will see that
19 the numbers came down. Now FRAGO 4 had a number of
components in it, but one of the key features of FRAGO 4
20 was to address the reserve component soldiers who
actually, we'd had that MEDCOM policy all along, but this
21 kind of gave more teeth to it if you will -- that for the
reserve component soldier, his location of choice
22 normally, as I mentioned, is to be home during his

1 healing process. So FRAGO 4 was saying "unless
2 that soldier had significant medical needs and was
3 going to need a number of specialties to take care
4 of him; then let's have him go home, heal at home,
5 be in his own community, and receive his care
6 through the Tricare network or by the MTF if he is
7 within a catchment area. You will see in our
8 Satisfaction Surveys that those soldiers, again
9 not for everybody, but the vast majority of our
10 soldiers in the CBWTU's are very happy that that
11 program is there for them. They really did not
12 want to be hanging out on the installations. They
13 really did want to go home and be with their
14 families and in their communities and have a
15 position there where they could provide a good
16 "duty day" within a Title 10 capacity, but not
17 have to stay on an installation during that time.
18 We can certainly take more; have more discussion
19 about that later. The FRAGO 3, again, was
20 reviewed. The commanders, the MEDCOM commanders,
21 all concurred that they felt that FRAGO 3 -- the
22 criteria for eligibility were good as written and

1 we did not make any change to that at the time.

2 You heard General Williams -- I'm sorry.

3 GENERAL GREEN: Can, can we just...For

4 clarification,

5 just so we understand -- and it will help when we can see 3 and 4. But for instance, when you include

6 non-deployables, all non-deployables, that would include people that in our system in the Air Force would be code

7 C, non-deployable for medical reasons, and so HIV positives. So do you put all of your non-deployables

8 including people such as HIV positives into the WTU's? COLONEL MOZDEN: No, sir. The non-deployable do not go

9 into the -- the straight non-deployable do not go into the WTU. And we can --

10 GENERAL GREEN: Okay.

11 COLONEL MOZDEN: -- address that further

12 with you, but they are not a part of that WTU

13 population normally, sir.

14 GENERAL GREEN: So, you still have another

15 process of some kind that identifies people with

16 what we would call a Code C that identified them

17 with specific -- retained on active duty, but

18 having a medical issue.

19 COLONEL MOZDEN: Correct. Correct. Yes, sir.

20 GENERAL GREEN: Okay. Thank you.

21 COLONEL MOZDEN: General Williams described

22 to you our triad of care. In the early days when

1 AMAP was first being developed and folks came
2 together and brainstormed this out, "what is the
3 best way to take care of our soldiers and their
4 families, how do we need to structure this, what
5 is that going to look like"? The determination
6 was made that -- or the concept I guess if you
7 will -- that developed was one of the triad, where
8 we would bring the medical folks together in
9 support of that soldier. We would also be bring
10 the C2 folks together in the person of the squad
11 leader within the WTU or the platoon sergeant
12 within the CBWTU, and they would work together in
13 an integrated manner to bring the services and the
14 support that that soldier and his family would
15 need.
16 The PCM would develop the treatment plan, coordinate the
work with the very specialty providers -- those of you
17 who have had multiple medical conditions, you know what
it is like when you have the Orthopedist over here, the
18 Neurologist over here, and by the way don't forget the
Psychiatrist. Who pulls that together? That is the job
19 of the PCM -- that Primary Care Manager -- within our
WTU's to bring that together and help translate that to
20 the soldier and what the impact is and how these things
are working together.
21 The Nurse Case Manager who works with our soldiers
22 sees them on a weekly basis or more often

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1 assessing his health care needs and monitoring his
2 process during the recovery, and the squad leader
3 who would provide the military continuity, chain
4 of command and then support, for the soldier and
5 his family and addressing all of their non-
6 medical issues or concerns. That triad of care
7 then became the cornerstone of the soldier's
8 recovery effort. Multiple healthcare providers,
9 Army and other support services and programs, were
10 brought to bear in supporting the soldier and his
11 family. But all through that nexus of the triad
12 of care, we will have people say "What do you
13 mean- triad? There is a lot more people
14 involved". Of course there are many more people
15 involved. And that's where we get into our multi-
16 disciplinary team or some refer to as the recovery
17 team. All of those players come to bear but we
18 feel that the cornerstone for that is the triad
19 for that soldier, so that he has a small group
20 that he is interacting with on a regular basis who
21 know what's going on with him.
22 DR. TURNER: Can I ask, uh, interject one

1 question here. This is-this is good. Where is the
2 decision made to, or is this the group that
3 decides whether the individual is transferred from
4 his unit to the um, let me get the words right,
5 the transition command? At what point is the
6 decision made to -- apparently, maybe I misunderstood -- but the, these ill and injured are transferred to the
7 Warrior Transition Command, right? At what point is that decision made, and who makes it?
8 COLONEL MOZDEN: Actually I have a slide that addresses that very thing.
9 DR. TURNER: Yeah.
COLONEL MOZDEN: But to answer your question, the
10 decision to bring a soldier into a WTU is not "Hi, I am here and I am kind of lost so I think I will come to the
11 WTU", at least that is not how it is suppose to
12 happen. There is a triad of leadership that works
13 with that soldier, and it varies on installation,
14 but it is normally the Senior Mission Commander,
15 the MTF Commander, and the W2 Commander. There is
16 a packet that that soldiers' unit puts together
17 with his medical situation and they review that
18 and they make a determination if, does this
19 soldier need to come into the WTU, or can he stay
20 with his own unit while he heals?
21 DR. TURNER: So it is initiated by the
22 individual's commander?

1 COLONEL MOZDEN: Yes, the soldier we're in
2 the Army -- every soldier has a commander, that
3 commander is the person who initiates that
4 referral process. Now I'm talking COMPO 1 for
5 right now, and we can address the COMPO 2, 3 --
6 there is also a triad of leadership. It is a
7 little bit different. Okay, any questions on the
8 triad? You'll see it's slightly different for the
9 CBWTU but it is very much the same concept. They
10 have the same standards, they have the same
11 mission. Although in the CBWTU, the physician --
12 and we have a physician in each of our CBWTU's --
13 he or she are not doing hands-on medical care,
14 they are doing the medical management oversight of
15 that treatment plan that is being executed out in
16 the community by the
17 Tricare PCM and the specialists that are in that
community. Now, if at any time the physician in the
18 CBWTU is concerned about the soldier's progress or, are
there other things going on that we need to take a closer
19 look at, they certainly can send that soldier, and we do,
back to an MTF and ask that the military physician review
20 their case or have them seen by a military specialist.
GENERAL STONE: I wonder if I could provide just a little
21 bit of context since we keep coming back to how, how do
we decide to admit. Clearly, in 2007 when the stand up
22 of the Warrior Transition Command occurred, there

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1 were areas of the Army in which every broken
2 soldier was admitted to the Warrior Transition
3 Command. And, uh, the response of demanding that
4 there be a sufficient complexity of care required
5 in true case management required is what the --
6 really input us towards FRAGO 3 and 4 was -- that
7 we were admitting soldiers to this command that
8 needed complex medical case management. As such,
9 since 2007 we have monitored the number of non-
10 deploying members of the military, or of the Army,
11 in our brigade combat teams. Now the basic unit
12 of employment of the Army in combat arms is the
13 brigade combat team. That team is about -- and
14 put up with me Darryl for this, I am not a combat
15 arms guy -- is about 4000 soldiers. And as we've
16 tracked those 4000 soldiers, we have tracked since
17 2007 the number of non-deploying at the deployment
18 date, what we call LAD. And, we have grown from
19 10 percent of that 4000 in 2007 to about 14
20 percent non-deploying in 2010. And, that's all of
21 our brigade combat teams. Now of that 14 percent,
22 which is about 600 soldiers, approximately 190 to

1 200 are medical problems. These are not soldiers
2 in the Warrior Transition Command; they are
3 soldiers non-deploying. Now, part of the reason
4 they are coming to the deployment platforms is the
5 FRAGO 3 and 4, which blocks their
6 ability to be placed into the Warrior Transition Command. Now, if I break down that 190 to 200 soldiers, about 130
7 have short-term medical problems blocking their deployment and they eventually join their unit. About 60
8 to 65 soldiers have more complex medical problems that don't necessarily require their admission to the WTC, but
9 do require that they stay with the rear detachment of their unit and heal. And, uh, when I s. we divide them
10 in our classification and one of the frustrations that our civilian colleagues will have is the fact that Air
11 Force uses a little different term and the Navy
12 uses a little different term. We call these 3A
13 for short-term and 3B for, it takes more than 90
14 days to repair the soldier. Now, those soldiers
15 are still returning to duty at very high rates.
16 But to provide further context, let me remind you
17 that this ground war for these 10 years, we have
18 had over a million man years of deployment in the
19 Army -- over a million man years. Today we are
20 looking at a 10,000 population in our WTC which is
21 less than 1 percent of our 1.1 million man Army.
22 But, it should be our goal is that it be our most

1 complex medical management regardless of cause of
2 injury. And you heard General Williams say we
3 don't accept in the Army this effort to say it
4 should only be the Purple Heart. I would ask us
5 to go back to our basic concept of wounded, ill,
6 injured on our logo. We are about wounded, ill,
7 injured and we don't discriminate based on source
8 of injury. We do discriminate based on providing
9 a single level of care based on complexity of
10 care, and I apologize for jumping into this but I
11 want to provide some of that. Now FRAGO 3 and
12 FRAGO 4, as we obtain those for the task force --
13 and I thought we had them already in our initial
14 packet, but maybe we didn't. FRAGO 3 and FRAGO 4
15 define
16 admission criteria to make absolute assurance that we are
not "dumping" into the WTC people that a commander may
17 not want. But, the medical care delivery system and the
administrative commands, as well as the line chain of
18 command, all agree that this soldier deserves complex
medical care management. So, and I apologize to the
19 committee for taking so much time describing that.
DR. PHILLIPS: May I ask a quick question of that switch?
20 Of the very small number that you mentioned, the 60 or
50, are they, is that related to recruitment issues or is
21 that --
22 GENERAL STONE: Some of it relates. And,

1 and I will tell you in the next month I'll have a
2 way better view of the 2010 data. But, some of it
3 relates to new onset medications; some of it
4 behavior health; some of it anti-hypertensive's;
5 some of it reflecting various medications that are
6 used as part of just medical care management in
7 providing the ongoing follow-up in a garrison
8 based environment versus a field environment. We
9 are unable to monitor in a deployed environment
10 many of these medications effectively to provide a
11 safe environment.
12 DR. TURNER: Colonel Mozden, just for
13 all of us concrete, aviation kind of thinkers, if
14 I could maybe get you to take, walk me through an
15 example obviously. I got an e-mail from some
16 concern parents of an Army soldier, who their son
17 was put in a civilian psychiatric institute in
18 Georgia for PTSD, or even treating this after
19 multiple deployments in the theater. Could you
20 walk me through the example of using -- you know
21 how, how the Army makes sure that this guy is not
22 lost in the cracks and how he is followed to make

1 sure that, you know, he gets the care he receives

2 once he's put in a civilian care system?

3 COLONEL MOZDEN: How did he get into

4 the civilian care system?

5 DR. TURNER: He was referred there I am told.
COLONEL MOZDEN: By?
6 DR. TURNER: An Army doctor.
COLONEL MOZDEN: Okay and he is not in a WTU currently?
7 Is that true?
DR. TURNER: Not that I am aware of.
8 COLONEL MOZDEN: Okay, but he is assigned to an
installation somewhere?
9 DR. TURNER: Yes. He's active duty.
COLONEL MOZDEN: Okay. That's fine.
10 DR. TURNER: Walk me through the example of,

11 the (inaudible).

12 COLONEL MOZDEN: Oh right yeah. Um, we, we

13 have a lot of partners in the medical system. The

14 Army, the Army doesn't have the capacity to take

15 care of every issue to the degree that someone

16 might need a specialty. So, we often will turn to

17 the civilian sector to support us in that

18 treatment plan for the soldier. But, whenever a

19 soldier is under that care of medical, the

20 military treatment facility and he is referred

21 out, there is a process under our Personal

22 Administration, or PAD folks, where they always

1 will be tracking what they call the Absent Sick.
2 We have a soldier but he's over, he's located in
3 this hospital over here, but we're car -- we know
4 he, he's there. We're tracking him on our books.
5 So, there isn't a loss of, there should not be, a
6 loss of visibility for that soldier. And
7 ultimately of course, his command -- he is in a
8 unit, his command will know where that soldier is
9 being cared for.
10 DR. TURNER: Is there some kind of quality
11 check? I guess I have more faith in military
12 psychiatrists, um infamously more than I do, no
13 offense on that. I guess intuitively you would
14 hope that a military psychiatrist will at least
15 review the case of someone who is seen for PTSD
16 because I feel very strongly that they are the
17 best
18 to see these guys. Is there any kind of quality control?
I guess the Primary Care Manager would review the case
19 as well? He is still governed by this triad I guess?
COLONEL MOZDEN: Yes. Well, if the soldier is in
20 a WTU. Now remember, I'm describing a soldier assigned
to a WTU. But even within the military care system,
21 aside from this, that soldier is going to be working with
a physician and he is going to have, have been most
22 likely, those behavioral health specialist on the
installation, who are making that referral to that

1 civilian psychiatrist because they know that that
2 is a program that works well for their soldiers.
3 And I guess, just to kind of stir the pot a little
4 bit, I would have to say I don't think the Army
5 owns all of the expertise in PTSD because
6 certainly the VA has been out in the forefront in
7 many of our residential treatment facilities that
8 have done a very good job with our soldiers.
9 GENERAL GREEN: But if I could bring
10 us back to your briefing --
11 COLONEL MOZDEN: Oh, good.
12 GENERAL GREEN: -- so, in the same case -- so
13 basically it is determined based on the treatment
14 he receives downtown that he is not going to be
15 able to return to duty immediately. He may need a
16 medical board, and his commander would, then,
17 basically would make a recommendation and he would
18 sit down with the hospital commander and the WTU
19 commander to decide if they were going to put him
20 into WTU. Is that the way it works?
21 COLONEL MOZDEN: Yes. That would be a very
22 good example of that. Yes, sir.

1 GENERAL GREEN: Okay, thanks.

2 COLONEL MOZDEN: Okay, going right along.

3 This was a, this is part of a briefing that we did

4 for the WWCTP last January. We briefed this at a

5 Winter Conference. We mentioned we have a

6 conference each year. The MDA 2008

7 and you are all familiar with that, required a variety of things to address the needs of wounded, ill, and injured.

8 The soldiers have care and support throughout the recovery process, addressing both medical and non-medical

9 concerns. That there would be medical case managers, non-medical care managers, and the larger recovery team,

10 is the DoD language that would be working with that service member.

11 Army along with other service representatives, and some of us are here in the room were involved at that time,

12 sat down and put together and really developed

13 that Recovery Coordination Program that ultimately

14 came out in a DoDI 1300.24. That DoDI came out in

15 December of 2009. Our WTU's, as you know, were

16 stood up in 2007. So when this came out, we said

17 "Okay, we need to look at this and make sure. Are

18 we taking care of business here the way the DoDI

19 is instructing that we do"? "Are we covering this

20 within our Warrior Transition Program?" So a

21 crosswalk, if you will, was developed and when we

22 finish with that, Army's position is that in fact

1 we do meet those requirements and in fact exceed
2 those requirements based on the program that we
3 had already established within, with our WTU's and
4 CBWTU's. The next cou, these couple of slides, I
5 am just kind of giving you as an example of what
6 the DoDI language is and then how we're
7 implementing that on the Army side of the house.
8 Is um, I think pretty straight forward but just to
9 highlight a couple of things -- where we talk
10 about continuous care, continuous clinical care.
11 We have enhanced access to care standards within
12 MEDCOM for our soldiers that are in the WTU with
13 certain levels of requirement for them to have
14 their appointments, to really facilitate and
15 hopefully expedite any MEB process that they might
16 be involved with, as well as addressing any of
17 their medical needs.
18 The DoDI talks about a recovery team. The terminology we
use is more often that the triad that we have and then on
19 the follow-on slide I will show you also, the rest of our
players on this multidisciplinary team that we bring to
20 bear within the Warrior Transition Program.
The Recovery Care Coordinator, this is to help that
21 soldier and his family with the non-medical issues. Well
in WTU land, that, the point person for that is our squad
22 leader, our platoon sergeant, that command side of the
house that is supporting the soldier -- that is concerned

1 about the soldier and his other non-medical kinds
2 of issues. Then, he in turn brings in the
3 specialist that are going to address those kinds
4 of issues; whether it be the SVAC personnel
5 working with financial concerns, or housing
6 issues, and so forth. The Medical Care Case
7 Managers, the DoDI language, those in the Army are
8 our Nurse Case Managers are and Colonel Scott will
9 be briefing this later and telling you more about
10 the rule of our Nurse Case Managers in the WTU's
11 and CBWTU's. The non-medical, again, this is
12 addressing the role and involving the role of the
13 squad leader and then working within the triad and
14 then for those who are most severely injured --
15 our AW2 Advocates are involved and we will be
16 talking about them a little bit further.
17 Additional recovery team members, again, that is
18 reflecting our multidisciplinary team, whether
19 that be our Behavioral Health folks, our
20 Occupational Health, Physical Therapy, the MEB
21 Docs, Chaplains, and so forth. The Comprehensive
22 Recover Plan um, we were, when we first started

1 developing this as part of the line of action 3,

2 the Case Management line of action 3 and

3 addressing that, we brought in the service reps

4 including folks from Army, Navy, Air Force, VA,

5 and in developing that we were using a lot of the

6 tenants that we had already moved out with in

7 terms of our Army Comprehensive

8 Transition Plan, which initially was called our Comprehensive Care Plan, but as we were moving through

9 time and we had the medical stuff down pretty well -- but what we needed to help the soldier with now was his

10 transition. Because we can get him healed up, but then what? If that soldier did not know where he was going, or

11 what he was going to be doing or what was going to happen to him next, then we were not being successful in our

12 work.
So, we changed this to the Comprehensive Transition Plan

13 so that even in the title we are demonstrating

14 what our goal is as we work with the soldier and

15 his family. The next slide talks about the Triad

16 of Leadership, with the discussion we just had

17 earlier actually, about how a decision is made to

18 bring a soldier into the Warrior Transition Unit.

19 I did not know if there were any additional

20 questions on that, or are we -- When the soldier

21 comes in, if the determination is made that he

22 probably doesn't need to be in the WTU, he can be

1 managed in his unit -- that is not a one-time only
2 request. If he is managed in his unit and they
3 find that actually it is not going well or he has
4 had additional complications, he is not recovering
5 as we thought he would, they could always bring
6 this back and request admission into the WTU for
7 management.
8 GENERAL WILLIAMS: Full transparency on
9 this -- I want to make sure that this triad of
10 leadership, you will find variance when you go out
11 there. Some Senior Mission Commanders do this
12 very, very well. They are very actively involved
13 with the MTF Commander and the WT Commander, do
14 all of the meetings, so this is the ideal -- this
15 is the way it is supposed to work. But, in my
16 four months of going around, we have variance. So,
17 I don't want to give you a pipe dream here. There
18 are Senior Mission Commanders who are plugged in
19 and do
20 this very, very well. I talk to them, like I mentioned before, and that is the reason why the Army has a General
21 in this job because I can talk to the Deputy Senior Commander or the Commander, but I also talk down to Jimmy
22 Keaton -- Jimmy Keaton at Ft. Carson, Colorado who is the MTF Commander. And I already told you I talk to all of

1 the WT Commanders once a quarter, so this is my -- this is for me where it talks about center of gravity, this is
2 where I push. I touch these buttons. If I want to make stuff happen, back to your point ma'am: how do you make
3 sure that they're most relevant and they are
4 getting the stuff? These are my pressure points
5 right here.
6 COLONEL MOZDEN: This is a pictorial
7 if you will, of our Comprehensive Transition Plan
8 and we have actually -- we came to this point from
9 another point and I am sure we are going to move
10 to a slightly different look in the future. We
11 have decided, for example -- well let me just take
12 you through this first and then I will come back
13 to the changes. The Comprehensive Transition Plan
14 we see as the blueprint, the road map if you will,
15 of the WTU's future -- that soldier's future. The
16 soldier when he first comes into the unit, this
17 Comprehensive Transition Plan process is begun
18 during the first thirty days. During that time,
19 the soldiers meeting with his squad leader; he is
20 meeting with the OT; he is meeting with the social
21 worker; he is meeting with the Nurse Case Manager;
22 with the physician. He is meeting with a number

1 of different people who are providing -- they are
2 taking information from him and then they are
3 going to work to assist him as he develops his
4 plan or his way forward, because really the
5 Comprehensive Transition Plan isn't for us. It is
6 for the soldier and his family. And so, if he
7 doesn't own it and doesn't feel a part of it, as
8 it's being built, then we are less likely to have
9 the success that
10 we would like to see.
The soldiers receive goal training, goal setting
11 training. They also work with an Occupational Therapist,
who I am sure many of you know that is one of the things
12 Occupational Therapist do. They work with people to help
identify work related, future, jobs that they might go
13 into, what kinds of functional limitations they may or
may not have that will impact their future.
14 The soldier -- a key part of our Comprehensive Transition
Plan is that the soldier does a self-assessment of 18
15 different areas when he comes into the program.
16 And, pretty much covers all the areas that we
17 would think a person would be concerned about. We
18 look at his medical care. We ask him about his
19 pain level. We ask him about his support system.
20 We ask about substance abuse. We ask about your
21 housing, family issues. We ask that soldier to
22 tell us on his time, in his words, if he has got

1 concerns in any of these areas. He then meets
2 with his squad leader -- remember getting back to
3 the triad -- and his Nurse Case Manager and they
4 develop an action plan on how they are going to
5 address any concerns that that soldier has
6 mentioned in his self-assessment.
7 GENERAL GREEN: Any questions? MS.
8 CROCKETT-JONES: I'd like to ask a
9 question about that process. Is there at any
10 point a directive for the um, either the squad
11 leader or the case manager to have any, establish
12 any communication with family members or spouses?
13 There seems to be some, you know, more than a few
14 soldiers in let's say PTSD or TBI whose self-
15 assessment ability might not be up to par and
16 especially when they are being asked to discuss
17 substance abuse issues or family situations. They
18 might not be giving very good assessments to the
19 folks. And I know that there are more than a few
20 spouses who would wish there was some
21 communication here where they could feel
22 reassured that what their soldier in recovery is taking
to the people that he is working with reflects reality at

1 home. Is there any directive for squad leaders to make that initial contact, because a soldier might be not
2 promoting that contact --?
COLONEL MOZDEN: Sure. Sure we do.
3 MS. CROCKETT-JONES: -- or family support at home because of the issues that are coming up.
4 COLONEL MOZDEN: We try very hard to incorporate the entire family in that Transition Plan for the soldier
5 because for any of you that are in any clinical
6 kind of setting, you are aware that if you are
7 only dealing with the patient -- the identified
8 patient -- you may often be missing some very
9 important history or information on what is really
10 going on at home or what is really going on when
11 the soldier is not at his duty location. So we do
12 reach out to those family members. We encourage
13 their participation. We would love to have them
14 come and sit in on what we call our "scrimmages",
15 when we sit down with that soldier and talk
16 through all of his issues and how we you know,
17 "what's the plan ahead and where are we going"?
18 The Nurse Case Managers and the social workers in
19 particular spend quite a bit of time with family
20 members.
21 So, certainly we do not view the soldier as in a
22 vacuum

1 and the clinical team would want to know any
2 information that the family would want to -- you
3 know, could and is willing to provide us to give
4 us the most complete picture that we could. Master
5 Sergeant?
6 MASTER SERGEANT MACKENZIE: Yes, Ma'am. That is
7 unfortunately -- at times we find that concept
8 very, very flawed. The reason for that is, and I
9 have dealt with this personally -- where a spouse
10 goes into a room with her husband, the last thing
11 she wants to do is make him look bad. That joint
12 meeting thing doesn't work, number
13 one.
Number two, at the very beginning it has to be
14 established that the spouse is an integral part, in other
words, these separate meetings. "What do you see, what
15 are your concerns?" separate from the soldier, so you
establish that baseline where it is already intuitive.
16 As he is starting to recover and become more aware, this
surprise meeting with his wife is not some major issue.
17 This is an ongoing thing.
Encouraging their support doesn't work. It has to be
18 part of that mandatory briefing type deal, because
19 a lot of these families you find come from areas
20 where you find the wife does not speak out, or may
21 not speak English very well, or other areas in
22 that realm. If it is not saying "Hey we need your

1 input, we've got a meeting for you on this day",
2 and it is not with the husband sitting there
3 looking of your shoulder, it is not anything else.
4 It is "What are your concerns, what do you see at
5 home"? And I think that needs to be actually an
6 active part, not an encouraged part of the
7 treatment plans.
8 COLONEL MOZDEN: Mm mm-hmm. Thank you.
9 GENERAL GREEN: This would be a good place
10 for us all to understand -- do you have any idea
11 of what percentage of the folks in the WTU's are
12 within a 50 mile radius of the families? In other
13 words, I am just trying to get an idea -- Is the
14 reason you have 29 so that you are basically
15 dealing with local units and therefore local
16 families and the only place they would be
17 distanced is reservists? Or, are they being moved
18 more often than not?
19 COLONEL MOZDEN: I don't have a number for
20 that sir, but we can certainly get it for you.
21 GENERAL GREEN: Okay. I would appreciate that.
22 GENERAL WILLIAMS: Sir, that is what I

1 was going to say. I'll try to get that by the end
2 of the day, if you can. I can probably get that
3 number for you today. My
4 guys can work it. Back to the other point that you just made Ma'am, and Master Sergeant, thanks for that because
5 that is a focus. I have only been in the saddle for a while. I have seen this come up and I said "Why aren't
6 we taking the whole family approach to this?" So, some units do it really, really well and some don't do it so
7 well. I can give you bumper numbers if you need them later. But it is -- remember my second bullet --
8 education, education, education. So, it was more than just for the soldier. It is for the family. You are
9 going to heal as a family. That is the way it is
10 going to work. You all know that better than I
11 do. So, it is a big focus for me. I am really
12 kind of at the point where I am kind of seeing
13 what is. What is the delta? Some units who talk
14 to me once a quarter do this very, very well. It
15 is a point of emphasis. It probably needs to be a
16 strategic emphasis on my point to make sure, so
17 thank you for that. And sir, we will get you that
18 data.
19 COLONEL MOZDEN: Just to finish up on the CTP, the
20 soldiers' self-assessment, along with their chosen
21 career track, form the basis of what we refer to
22 as our CTP scrimmages. When the soldier comes

1 into the unit, and that's why I was saying, we
2 will continue to tweak this I am sure -- what you
3 see on this slide here is that there is what we
4 refer to as tracks. The soldier may return to
5 duty, the soldier may have a change to his
6 specialty within the military but still be in the
7 Army, or the soldier will be transitioning from
8 the Army. What we have now determined is that we
9 really actually have two tracks, don't we?
10 Because we have the soldier that we are going to
11 be able to retain in the military, in one capacity
12 or another, or we have the soldier who, because of
13 his injuries, is going to be separated from
14 military service and become a civilian. During our
15 CTP scrimmages, the soldier and their
16 multidisciplinary team who assist that soldier in developing a strategy map with both short and long-term
17 goals that encompass the soldiers' six dimensions that we've, that we work with identifying strengths that they
18 may have and this is in accordance with the Comprehensive Soldier Fitness Model that perhaps some of you are
19 familiar with that looks at physical, emotional, social, family, and spiritual areas or realms for that soldier.
20 And, in addition, we have career as we feel that is a very important piece to this as well.
21 The CTP is a living document. It is not something
22 that is printed and put in a drawer somewhere.

1 This is a blueprint. It may change over time.
2 The track may change. The soldier may say "I want
3 to stay in the Army no matter what", and then he
4 may because of the way his recovery is going, it
5 may be determined that he probably is going to
6 need to go through an MEB/PEB and become a
7 Veteran. So, we work with this over time. It is
8 reviewed on a regular basis quarterly, or more
9 often, depending on what is going on with that
10 soldier.
11 GENERAL WILLIAMS: Cathy, did you cover the
12 automated stuff? Did you talk about the automated
13 aspects?
14 COLONEL MOZDEN: I have not, but I can
15 certainly sir. You will be hearing more about that
16 later as well, but the -- our CTP process has
17 actually been under way for some time, but during
18 this past year, we have been able to fully
19 automate that process. That has helped our
20 commanders both at the senior level at the Warrior
21 Transition Command, as well as down at the unit
22 level to be able to see what is going on with

1 their soldiers and make sure that things are
2 tracking accordingly. The soldier is able to work
3 alongside his squad leader reviewing his self-
4 assessment. There is a variety of tools within
5 this program, and then we, in turn, can capture
6 information out of the system to tell us what is
7 going on across the command in terms of concerns that soldiers are having. For example, how many have housing
8 issues as an example. Or, how many are self-reporting PTSD type symptoms or need behavioral health referrals.
9 So, we will be able to pull a lot of information out of that system without the burdensome calling out for an RFI
10 down to the unit on an every week basis. Balanced Scorecard -- the Warrior Transition Command
11 Balanced Scorecard -- the organizational objectives and the metrics are all nested with the MEDCOM Balanced
12 Scorecard. In November, shortly after General
13 Williams came on board, he conducted an off-site
14 with his senior staff members to critically
15 analyze our particular Balanced Scorecard and
16 further refine and synchronize our efforts. As a
17 result of that, we have an updated Balanced
18 Scorecard and metrics that we will be tracking.
19 This is a new product and it is going to be
20 briefed to the Surgeon General actually on 21
21 March of this year for his approval. Once
22 approved, that Balanced Scorecard will be part of

1 an ongoing cyclical process where metrics will
2 drive our organizational inspection program visits
3 that we are going to be telling you more about
4 later. The data received and analyzed during
5 those OIP visits will lead to programmatic changes
6 and improvements which will be reflected in
7 updates to the Balanced Scorecard. We will
8 continue to discuss the metrics and the program
9 feedback as we go through the course of the day,
10 but I would like to move on and introduce Dr.
11 Gliner unless the panel feels that perhaps because
12 it has been a while, you might prefer to have a
13 break at this time.
14 GENERAL WILLIAMS: Just give me 20
15 seconds before -- you know having the last few
16 slides and kind of commanders speak and
17 commander's intent -- for those of
18 you who are familiar with those sort of constructs. So, having somebody else talk about it -- When I came in last
19 fall I thought, I looked very critically at what we were doing, where we were going to go, and I challenged our
20 staff. Questions like "Where are we in 2020, and 2015?" "Why a Warrior Transition Command?" "Is 29 and 9 the
21 right stance?" That's what you saw the last few slides that Cathy covered. That is how we communicate
22 strategically up and down and out to our command up to the Surgeon General and out, and really getting at the

1 business of metrics which is what Doc will talk
2 about here in a minute. How do we know if we are
3 having a value? How are we measuring and seeing
4 our self? We have got these objectives. They
5 look really good on a PowerPoint slide, Williams,
6 but are you making a difference?
7 So, that is the process we are undergoing right
8 now.
9 Very deliberately, I am going to go back to the
10 Surgeon General, say "Sir, we have looked at this,
11 I have kind of put it in combat arms ease, and put
12 it into some basic buckets". Things like
13 education, training, and then how do you measure
14 those things? What tools are we doing to go after
15 that? -- To see if we are having the affect that
16 we think we are having on this population. So,
17 that was the three slides that Cathy talked about
18 there. So, now I just turn it back.
19 COLONEL MOZDEN: I think I got the high sign
20 that we should take a break so I appreciate your
21 attention. Ma'am?
22 DR. GUICE: Let's just make sure -- are

1 there additional questions? I actually have a few
2 requests for information and then we will take a
3 break, so that it seems like a natural separation
4 there. The, the first, I am going to ask you a
5 couple of questions about AW2. You mentioned that
6 -- I picked up
7 on a little change in philosophy. It used to be that AW2's said that it was five years after the retirement
8 from the service, but the philosophy now is for as long as it takes? Is that correct?
9 DR. GADSON: Ma'am, that is actually in transition and that's something I spoke recently about with the Surgeon
10 General. My concern with -- and at the time when "for as long as it takes" came in, in that environment, our Army
11 Leadership believed that was kind of the right message to send to that particular population.
12 Since joining AW2 in July, my sense and my
13 recommendation to the Surgeon General, my boss, is
14 that "for as long as it takes" really sends the --
15 in my opinion -- sends the wrong message. So, we
16 are in the process of developing a new motto,
17 slog, motto that essentially gets to the path of
18 independence. Now, it is not meant to undermine
19 our commitment to those soldiers, because there is
20 always going to be some exceptions. But, our
21 program is about empowering and leading folks to
22 independence, not creating dependency. So, I felt

1 uncomfortable with "for as long as it takes" and
2 we are doing some market analysis about what is
3 going to sell in this environment but that is --
4 the idea of a path to independence, is really
5 where we are going.
6 DR. GUICE: Thank you. I have one more
7 question for you.
8 On the slide, you have listed here the, the
9 Advocates
10 are located in WTU's and VA centers. What are the
11 criteria for placement of your AW2's outside of
12 the military installations?
13 DR. GADSON: Ma'am, they are not -- they are
14 in some VA centers, they are in National Guard
15 Armory and Reserve Armories, and some of them are
16 actually located in SVAC's and non-military
17 locations so it is really, where is the best place
18 to service the population? Now, we find that the
19 VA centers -- I would think that we would agree
20 that
21 our Advocates don't have individual resources but we are more of a coordinating kind of an element. So, for the
22 Veterans, the majority of our population at VA centers are very good locations to uh, where we can as an

1 Advocacy group share information with each other. It is
not just that we are coordinating with the VA but I think
2 that the VA coordinates back with us to make sure that we
have got our story straight and that we can work with the
3 Veteran to make sure that he is not playing both sides of
the fence.
4 DR. GUICE: So, could you just provide the
5 task force with the strategy and the criteria then
6 for your placement of advocates outside of the
7 military installations? I think that would be
8 helpful for us to kind of see a lay down of how
9 those decisions are made and the criteria.
10 DR. GADSON: Okay.
11 DR. GUICE: Thank you. And then I believe,
12 General Williams that you said you are going from
13 29 plus 9 to 29? So, on that lovely map you put
14 up with the cross country, can you just identify
15 those that are -- we can put a little circle
16 around?
17 GENERAL WILLIAMS: Yes. Yes.
18 DR. GUICE: It sounded like you were going
19 to decrease by 9, and that --
20 GENERAL WILLIAMS: Yes, ma'am.
21 DR. GUICE: -- and you have got all of them
22 on that one so --

1 GENERAL WILLIAMS: And ma'am we will give
2 you a map that can show that.
3 DR. GUICE: And then a time trajectory --
4 GENERAL WILLIAMS: Yes, ma'am.
5 DR. GUICE: -- of when you are going to
6 phase those out?
7 GENERAL WILLIAMS: Yes. It is phase conditions
8 triggered. We have some units that are already
9 kind of
10 moving forwards toward the remote care concept. So, the bottom line is we can give you that. We can give you the
11 future stance of what that looks like.
DR. GUICE: Great.
12 GENERAL WILLIAMS: I just want to make sure -- what Greg just talked about with respect to the hand-off in the
13 future. We have talked to the Vice -- that is all pre-decisional. So Greg has a huge conference next
14 month. He brings all of his folks in and this is one of things that he is going to try out with his leadership
15 because he is going to try to change the culture
16 here a little bit, to create that thrust I was
17 talking about. So, I want to make sure I don't get
18 in front of my Army leadership on this. So, it is
19 all pre-decisional. We are working it. I'll be
20 seeing myself looking at our organization, you
21 know, "Is this the right stance"? Greg is doing
22 the same thing in a very vibrant and dynamic way.

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1 I think coming out of that -- I invite you to that
2 conference also. That is the third week in March,
3 right Greg? 12/16?
4 DR. GADSON: The 13th through the 18th.
5 GENERAL WILLIAMS: The 13th to 18th, March,
6 in Dallas, Texas. Where he'll bring in all of his
7 advocates and they are looking at this very
8 question you just asked, and "what is the right
9 balance of that?" And actually on the one slide
10 that Cathy briefed -- Full Transparency. One more
11 like -- and Greg can talk about it on the break --
12 we are more like 1 to 50. It is not 1 to 30 in
13 our Advocates. Our Advocates to -- it is a little
14 higher. Based on the life cycle that Greg has --
15 and what I mean by that is -- so you have a bunch
16 of veterans out there who are being managed by an
17 Advocate, but they are in different buckets. Some
18 need a lot of contact time, some need less contact
19 time. So, he or she is able to manage a bigger
20 population. So, Greg does that characterize
21 that?
DR. GADSON: We are really kind of viewing more from a
22 caseload perspective.
GENERAL WILLIAMS: Workload; So, just a little bit of a

1 clarification.
DR. GUICE: I would really like -- I would also, if you
2 happen to have your, any ways that you are going to use
to balance that workload for your AW2's? If you have any
3 insight into that, I think that might be helpful too as
we really try to understand caseload ratios and how
4 wobbly those can be given the various

5 circumstances that the wounded, ill, and injured

6 face throughout their recovery. Colonel Mozden,

7 you had two things that you talked about.

8 Six months of rehabilitation in the WTU as a

9 criteria

10 for entry with the FRAGO 3 I believe it was. Do

11 you have data that actually can lay down that for

12 us? So, how many actually had required six months

13 of rehabilitation or longer with regards to the

14 population? And then you also talked about the

15 reserve criteria, the significant medical needs

16 and multiple specialists, a requirement for that

17 to be in the WTU's? I would assume that then you

18 have some way of tracking that and identifying

19 those individuals. Can you give us kind of a lay

20 down of the data and how that sorts out for your

21 reservists as well?

22 COLONEL MOZDEN: We can get that information

1 for you, ma'am. The part with the reserve
2 component is because we are trying to look at that
3 the same eligibility criteria regardless of compo,
4 but then for that reserve component soldier who we
5 need to take care of and he is going to be on
6 orders, then unless he has got such multiple
7 specialties where you'd would be going hither,
8 thither, and yon all over the countryside trying
9 to find enough specialists to serve that soldier,
10 it would make more sense and be better service to
11 him to stay on the
12 installation. But for the most part, if the soldier is able to go home, and that is where they prefer to be,
13 that is where they get their medical care. But we can work those metrics for you.
14 I just wanted to tag onto one thing on the locations. Your earlier question about the change in locations --
15 that is tied in with our remote care restructure. And it's, we currently have nine CBWTU's as you know. Well,
16 Puerto Rico is not going to go anywhere because it is Puerto Rico, you know? But the other units, we will be
17 merging if you will -- their cadre into locations.
18 We are going to expand our capability of
19 providing remote care but do it off of an
20 installation. Remember when we established the
21 CBHCO's and CBWTU's we did not have that structure
22 available to us. Now, we have an entire MEDCOM

1 wide structure of Warrior Transition Unit's to
2 support our soldiers. So, what we are going to do
3 is right now we have say, a battalion with two
4 companies. We will have a third company at that
5 location, Ft. Campbell. And that company will
6 provide remote care, just as the CBWTU's are doing
7 it now, but they'll provide remote care from the
8 installation and their footprint, if you will,
9 their catchment area will be smaller because we
10 are going to have more of them. And we will
11 provide -- we can certainly provide a map to you
12 that will demonstrate that. And just as General
13 Williams said this is a phased approach. We have
14 a couple of various -- for example, Ft. Riley, the
15 one that has the nice complex I was telling you
16 all about -- well Utah, where we currently have a
17 CBWTU, that cadre mix will for the most part be
18 moving up to Ft. Riley. Then they will be picking
19 up that remote care mission from that location.
20 But, in other areas -- Ft. Drumm -- already have a
21 detachment or a platoon I would say worth of
22 staff. They are doing

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1 remote care to assist the Vermont Guard and some other
Guard members up in the Northeast to make sure that we
2 were able to get those guys home and track them. Because
our CBWTU's after FRAGO 4, our CBWTU's which were
3 hovering around 1500 across the board for census, are now
pushing 23-2400. They are really getting up there. So
4 we are really trying to be able to move quickly to be
able to accommodate and still allow these soldiers to go
5 home.
DR. GUICE: And that leads to another question I had.
6 When these individuals are out getting their care

7 in the private sector under a Tricare provider,

8 how is that information about their treatment plan

9 and their treatment and their outcomes getting put

10 back into their military medical records so that

11 it can be available, for instance, when they go

12 through the disability evaluation system?

13 COLONEL MOZDEN: Sure. The Nurse Case

14 Managers and the CBWTU have the same access as --

15 they use ALTA. They use our regular electronic

16 clinical/medical record that the Nurse Case

17 Manager would that was sitting on the

18 installation.

19 DR. GUICE: No. If you are seeing -- let's

20 say you are seeing -- as far as the records from

21 the community --

22 COLONEL MOZDEN: Oh, how does the records

1 from the PU's or whatever?

2 DR. GUICE: Yes. How does that get back?

3 COLONEL MOZDEN: That is provided back to

4 the CBWTU for review by the PCM that is there and

5 the Nurse Case Manager and then our, the PAD

6 section scans that into their electronic medical

7 record. Sorry.

8 DR. GUICE: Then you also commented that the cadre

9 training is, meets the DoDI training standards for

10 the Recovery Care Coordination?

11 COLONEL MOZDEN: We are actually going to

12 spend a whole

13 section of a briefing on training --
DR. GUICE: Great.
14 COLONEL MOZDEN: -- so we can talk about that.
DR. GUICE: Great. I would like to have a little bit
15 more of a lay down about exactly how that matches up.
Then you mentioned a lot of case load benchmarks. Can
16 you just provide to us a schematic of your rational for
determining the caseload ratios for the cadre? You know,
17 it was a -- 1 to 10 and a 1 to 50, and a 1 to something
else? But could you just give us the rational? That
18 would be --

19 COLONEL MOZDEN: Sure. We had a, and that

20 came out of the USAMA work and they determined

21 that. So we, because it was a little bit all over

22 the map and Colonel Scott will be covering that,

1 because you know at the beginning some Nurse Case
2 Managers had caseloads of, you know, 1 to 50 and
3 that was clearly too much and so we did have the
4 USAMA organization go out and do a look at some of
5 our specified WTU's and they came back with the
6 ratio's that we are currently using at 1 to 10 for
7 squad leaders, 1 to 20 for Nurse Case Managers,
8 regardless of what type of facility they were in
9 and so forth. But we can certainly provide that
10 for you.
11 DR. GUICE: You also commented, you also
12 commented that the CTP is, it meets, exceeds the
13 standard of the CRP? And could you just provide a
14 lay down of that so that we can see exactly in
15 what dimensions.. Sure
16 DR. GUICE: the sea.. that works? And then
17 um, could you, uh, when you can, provide a little
18 bit more detail about the Balanced Scorecards. I
19 found it a little bit hard to read some of the
20 slides with the font size. That would be very
21 helpful I think as we are trying to look at the
22 effectiveness of what we do. Thank you.
COLONEL MOZDEN: Okay.

1 DR. GUICE: Any other questions?
MASTER SERGEANT MACKENZIE: The uh, can I touch on a few
2 areas simultaneously? But, I will say that the CBWTU is
an outstanding idea. There are just some problems I have
3 with it that I was curious on. It seems that the ratio
is less per individual as, you know, squad leader, or a
4 platoon sergeant? They have more people to care for, yet
a bigger area to care for, and you find a lot of times
5 that there is -- you know, I have dealt with guys
6 that say you know "I don't even know what my guy
7 looks like".
8 COLONEL MOZDEN: Yes Grant.
9 MASTER SERGEANT MACKENZIE: And there was no
10 formal introduction or anything else. Is that
11 part of this change over as we go to the, you
12 know, 29/9 to 29 is to create that in person
13 visit? To not only support the soldier but once
14 again, to support that family piece where you know
15 this person's wife or mom knows who they are
16 talking about.
17 COLONEL MOZDEN: Just a couple of comments
18 on that. Part of -- just to answer your question
19 in kind of are way ahead on this -- Currently in
20 the CBWTU we have the same Case Manger ratio, 1 to
21 20, as I just described. But you are correct.
22 The platoon sergeant -- we do not have squad

1 leaders in CBWTU -- but the platoon sergeant ratio
2 is 1 to 40. And uh, for some time the feeling has
3 been that that is a lot, even if the soldiers are
4 remote, that is a lot, because, we do have 100
5 percent accountability every day with the soldiers
6 by phone. We also have what we call Musters, and
7 they vary depending on the location but either the
8 CBWTU sends a team out to an area where we have a
9 number of soldiers living or the unit brings the
10 soldiers and their family members in for a Muster
11 weekend and they provide various briefs, DOL
12 briefs, VA briefs
13 and that sort of thing, has been very affective.
But you are right. It is a challenge, when they have
14 soldiers in there. Particularly if the soldier comes in
and in processes in the unit and that is when he meets
15 his commander and his first sergeant and his platoon
sergeant, and his case manager and his behavioral health
16 person and so forth. And then that may be the only time
that they see that person if they are able to have a
17 Muster opportunity. One of the things we are doing with
remote care with the restructure -- by having more
18 locations, so you have a smaller footprint that
19 you are responsible for geographically, then the
20 soldiers will come into their unit and see their
21 commander and their platoon sergeant on the
22 installation that in fact owns them. It is their

1 unit. So, we are hoping to address some of those
2 concerns in that remote care structure and go to a
3 1 to 20 ration on the platoon sergeants.
4 MASTER SERGEANT MACKENZIE: That was one of
5 the things I looked at. You have got the guy
6 right there next to you and it is 1 to 10 but you
7 got guys remotely and you are 1 to 40. I am
8 interested in -- it seemed a bit out of balance.
9 But, the other thing I had too, was that -- are
10 these community based docs actually communicating
11 directly with the PCM or are you relying on the
12 service member to remember to bring his records to
13 the PCM to get copies of?
14 COLONEL MOZDEN: It is a mixture depending
15 on what is going on with that soldier. The
16 physician in the unit may contact -- often times
17 it is the specialists that they will be talking
18 with in the community, but they also talk with the
19 PCM. But very often it is the Nurse Case Manager
20 that has that steady ongoing link. Whenever a
21 soldier goes out for an appointment, they are
22 talking with their Nurse Case Manager member every

1 week and they

2 are bringing those medical records or they are reaching out to the office. They have the office manager send the

3 medical records so that we are able to keep up with what is going on with that soldier. Because otherwise, their

4 triad there at the CBWTU would not have the information they need to make sure things are moving forward.

5 MASTER SERGEANT MACKENZIE: And then the other thing I had is -- you know I, working with, working with, across

6 the board -- all services. One of the things I find is that these guys are redoing appointments to redo medical

7 information. It is like "Okay, now I am in the

8 med board process, and all of a sudden I have to

9 redo all of this stuff". I mean, is there a -- I

10 mean, are we taking a look at some of this

11 documentation to go "are we really fulfilling the

12 need of six months to a year from now if we are

13 going to start a six month counciling deal and

14 when it is all said and done, is there any kind of

15 collaborative assessment to go "okay, your

16 paperwork is in order now for the med board if it

17 is needed". You know what I mean? Does it meet

18 the same response, or do we get down the road and

19 go "Okay now it is time to start the med boards,

20 now we have got to go through all these

21 appointments over again to get the correct

22 paperwork now that there's a med board started. I

1 just wonder if we are looking at that.

2 COLONEL MOZDEN: Well, I know that they will be

3 addressing some of that this afternoon in the med

4 board meeting. But you are absolutely right, it

5 is painful. I mean, I have been out there and

6 lived it with some soldiers, and it is painful

7 when they have to go back and get something redone

8 again.

9 GENERAL GREEN: The likely issue is that the

10 consultations have to be within six months for the

11 medical board to consider them and so it is not

12 that it is not adequate if they were done earlier,

13 it's that it has to be done within a six months or

14 else has to be re-accomplished or get an update to

15 it to say that the information is still current.

16 That is true across all three services.

17 COLONEL MOZDEN: Yes. Ladies and gentleman, unless it is compelling, can we all take a deep breath here and close

18 for a fifteen minute break? Okay, fifteen minute break, please? Thank you.Ladies and gentlemen, you're still in

19 Tab B and this is where the Q slide on row we're starting. It should be right behind the balanced

20 scorecard slides. If you need assistance, one of my able staff will be on their feet and on your shoulder to

21 assist you. Are we all there? Excellent. Doctor

22 Gliner.

1 DOCTOR GLINER: Thank you. I assume you can
2 hear me okay? Okay. I am Melissa Gliner and I
3 work in the Decision Support Center section of the
4 Director to Plans Analysis and Evaluation at the
5 Army Surgeon General's office in Falls Church,
6 Virginia and I'm going to talk about, as the slide
7 says, WTU Satisfaction and I'm not sure how much
8 anyone is aware of the WTU Satisfaction survey or
9 the satisfaction program which now includes MEB
10 Satisfaction. So I'll first just go over some of
11 the background issues with this and then I'll go
12 into some of the results and then show the way
13 ahead for this. Okay, people asked a lot after the
14 issues with Walter Reid came out. They said well
15 what did you all know at the time? So I'll start
16 back in 2002, then Surgeon General, General Peak,
17 who I'm sure a lot of you remember. He directed
18 the establishment of a survey program for
19 monitoring patient satisfaction with healthcare
20 delivered at our direct care facilities and we
21 found that patients were happier with care
22 delivered at Army MTFs versus civilian benchmarks

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1 and this trend continues, continues to go up; the
2 Army does, in patient satisfaction which is great
3 news and especially satisfaction with access.
4 Okay, moving on. What did we know prior to the
5 Washington Post articles?
6 Well Army leadership began serving medical holdover soldiers, meaning just Compo II and III, Guard and
7 Reserve, in 2006 and the results indicated that soldiers were very satisfied with medical care, case management
8 and were really satisfied with their providers. Now, of course, then people said did you know this was
9 coming and we said well we didn't ask about questions that were identified in the Washington Post article like
10 things about quarters and transportation and
11 access to care issues and also we did not ask
12 questions about the physical disability evaluation
13 system. So then in 2007, we modified the survey,
14 this was in response also to the Secretary in the
15 Army, to include active component soldiers and to
16 include other issues, especially non-medical
17 issues, such as those issues that were identified
18 in the Washington Post articles such as
19 transportation and finance and it became the WTU
20 Survey. Okay, methodology. It's a telephone
21 survey. When we started this, we started it as a
22 mailed survey but our response rates were so low,

1 there were just a lot of problems with addresses,
2 so we said, okay we've got to go to something
3 where we can really get hold of these people and
4 the idea was telephone and that was great because
5 they all have cell phones and in the file there
6 are three different numbers in which the
7 contractor can use to contact these soldiers and
8 so right now our response rate is over 40 percent
9 which is great news. With our regular
10 Satisfaction Survey, our response rates are just a
11 little over 20 percent so this is great news.
12 That's a very good response rate for a big survey
13 such as this and especially for this population
14 because we know that we get higher response rates
15 on our regular Satisfaction Survey from retirees
16 and family members. So we are very
17 excited about this and we can be more confident that this is a representative sample that we're getting.
18 Okay, so when do soldiers receive a survey? They will receive a telephone call following specific anniversary
19 dates. So after they've been in 30 days, 120 days, 280 days and 410 days. Also they'll receive an MEB Survey
20 towards the end of the medical evaluation board process and that's something that's very new, the separate MEB
21 Satisfaction survey. At first we just had MEB
22 questions on the regular WTU Survey then we

1 realized that soldiers were answering those
2 questions that may not have been in the MEB
3 process yet so we said okay, so you know we were
4 sure that they knew when they entered that process
5 but you know we had a lot of -- so we said we've
6 got to take these off and now in the data fields
7 we receive it says exactly where that soldier is
8 in the MEB process so that triggers us then to
9 give them an MEB survey and I'll show you results
10 for both of those. And then in summer of 2010, so
11 also just recently, we modified the survey to
12 include specific questions related to pain
13 management because there is a lot of -- you know
14 there's a big pain management task force out there
15 right now so that's also new and I'll show you
16 results with those questions on there but we don't
17 have a lot of trend data so it's sort of a
18 snapshot in time; the same with the MEB. All
19 right, bottom line up front. WTU Satisfaction has
20 remained really incredibly stable over the past
21 two years and fairly high. The longer active
22 component soldiers remain in the WTU, the less

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1 satisfied they become. The opposite is true for
2 Guard and Reserve soldiers which we're actually
3 surprised about. Access to care and satisfaction
4 with providers continue to be issues of
5 concern. The top driver of satisfaction in the WTU is satisfaction with your healthcare provider. There's been
6 a lot of talk about that PCM and that relationship so that's not a big surprise there. Soldiers indicate,
7 through recent verbatim comments, that pain management is an ongoing struggle but MTFs are developing innovative
8 methods to improve issues with pain management. MEB satisfaction remains low but and this was brought up I
9 think by a couple people the top predictor of
10 satisfaction with the MEB is knowledge of the
11 system and what I mean by that, and I'll show you
12 in the results, in the MEB survey we sort of not
13 really a knowledge test but it is really a
14 knowledge test that we put in the MEB survey but
15 instead of asking them is this true or false and
16 then trying to you know put in a trick question
17 here or there, we said we don't want to make it
18 that deliberate so what we put in were knowledge-
19 type questions but we ask them like please tell me
20 how much you strongly agree or disagree with this
21 and it asks things that are really -- you know
22 that there is a right or wrong answer such as you

1 have three days to contend this, if you're a
2 reserve component soldier there should be a
3 reserve component member on the board and I guess
4 it's exciting to see that you know the more
5 knowledge they have that the more satisfied they
6 are so I think that was brought up earlier about
7 education and the importance of education. Okay,
8 any questions so far about methodology, the
9 background of the survey before I go into the
10 results? Yeah.
11 DOCTOR GUICE: Actually a couple of
12 requests. First, could you give us a sample of
13 the survey tool and of the detailed methodology
14 and then the other question, hopefully you'll get
15 to it; use a lot of cross tabs so
16 that you're looking at not just the rate but the rate by the type of facility where they're stationed. Whether or
17 not it's related to the type of -- if they're wounded, ill or injured and what their clinical diagnoses are. In
18 other words, do the people who have PTSD respond differently on a satisfaction survey or those with a TBI
19 respond differently? So that might be --
DOCTOR GLINER: Okay. I'll try to -- you know a lot of
20 these slides -- that is a lot of those analysis we
21 have done in the past and we can do in the future
22 and I'll try to talk about them even if I don't

1 show the results so please let me know if I forget
2 to talk about some of those but absolutely. Right
3 after this I can provide you with a copy of the
4 survey or electronically to whoever and a copy of
5 the detailed methodology if that will help.
6 GENERAL GREEN: I know 40 percent is a good
7 result for surveys in general but related to this
8 issue, do we know why the other 60 percent didn't
9 respond? Do you have any comment?
10 DOCTOR GLINER: That's interesting.
11 Actually what I thought you were going to ask was
12 did you do a non-response bias analysis because
13 GAO did ask us to do that and we did and you know
14 the interesting thing though is that we couldn't
15 do the typical non-response bias analysis which
16 would be you call those up, the people that didn't
17 respond by mail, but since we were already calling
18 these as part of the survey, we said no we can't
19 call them again and say why didn't you respond the
20 last time we called you? So we did an analysis of
21 those who -- if there were any demographic
22 differences between those who responded and those

1 who didn't respond and we didn't find anything

2 significant. We found that except for -- we found

3 that we're getting a slightly older population

4 that's responding -- that's

5 more likely to respond than the younger population. Now that's just slightly meaning a few years so based on the

6 average age that responds. We were worried about that specifically because it's been known also in the civilian

7 sector that the older you are the more likely you are to be satisfied with your healthcare. Usually it's the

8 retirees that are -- and that's not just military because people say why are active duty so dissatisfied? Well

9 really it's an age issue because we see it also in

10 the civilian sector so we were worried about that

11 but the ones that are not responding, and I'm

12 trying to think back because we did look at that,

13 some of them you know just plain out refused.

14 They said -- also some of them -- I believe in the

15 contract they will try five different times so if

16 they don't get them after five times, they will

17 stop. It's you know contractually and other

18 times, bad phone numbers so that does happen too,

19 and let's see.

20 I'll fully admit that this is a population that

21 is so

22 over surveyed. It was kind of like be careful

1 what you wish for. You know after everything came
2 out people just wanted to you know -- DoD Health
3 Affairs has the survey of ill and injured soldiers
4 and we have this one and of course it's slightly
5 different populations but we know that they're
6 over surveyed and we try not to put you know the
7 burden on too much but it was you know after the
8 2007 issues, people couldn't wait to talk to these
9 soldiers and I think we kind of shot ourselves in
10 the foot a little bit because survey after survey
11 after survey came in for this population.
12 DOCTOR GUICE: I have one additional follow-
13 on question. With the responders, are they
14 representative of your population as a whole or
15 have you done that analysis?
16 DOCTOR GLINER: They're representative of the WTU
17 population. Was that the question basically?
18 Yes. We
19 found that they are. That there's no difference, so.
GENERAL HORST: Is there a reason why you haven't gone
20 online and go web based with your survey since 99 percent
of them have computers and some form of PDA?
21 DOCTOR GLINER: Right. You know we had talked about that
and that's a very good question because when we first
22 started it it was a mailed survey but they also had the
option of answering it online. The issue was, and we're

1 finding this out with other surveys too, that
2 people are more likely -- because we didn't see a
3 higher response rate and we thought what's the
4 deal? You know they have access, like you said,
5 to computers and we found that they will go online
6 if they're provided a direct link through their
7 email but if there's just something on the bottom
8 of the survey that says go to this URL, they're
9 less likely to go on and do it because it means
10 typing in something and so what we will look at in
11 the future is doing something through their AKO
12 accounts. You know we haven't done that in the
13 past with regular satisfaction surveys because
14 people said well a lot of retirees and family
15 members don't have AKO accounts but this
16 population -- I'm assuming everyone has an AKO
17 account, I would imagine, so that is something we
18 are looking at in the future definitely so thank
19 you.
20 MR. REHBEIN: Ma'am, this really isn't a
21 question for you, it's a question for the system.
22 But that last bullet point to me waves a huge red

1 flag. By the time these folks get to a medical
2 evaluation board, we're supposed to have been
3 supporting them for some period of time. Why are
4 they going to a medical evaluation board with a
5 low level of knowledge of the system? What's
6 happened to their support system preparing them
7 for that medical evaluation board and like I said,
8 that's not a question for you. That's a question
9 for some of our
10 other folks and I hope we can get some kind of answer to that because it sounds to me like we're letting them down
11 if we're letting them go to a medical evaluation board without knowing what's going to happen.
12 DOCTOR GLINER: Right and you know it gets even a little more complicated when I show you the results of the MEB
13 Survey because most soldiers indicate that they are very satisfied with their PEBLO. So I thought interesting you
14 know if that's the one that's guiding them along
15 and they're very satisfied with their PEBLO you
16 know, again, I don't know. There's a lot out
17 there that we can dig into there but thank you.
18 Okay, as I mentioned this is just a slide showing
19 overall WTU satisfaction and when I say
20 satisfaction, I mean on a five-point scale that
21 soldiers indicated four or five, very satisfied or
22 completely satisfied. And a quarter to FY10, that

1 is not just a zero percent satisfied, that was a
2 data glitch right there so I just wanted to point
3 that out. And we arbitrarily set a goal of 90
4 percent. That's what we have in our regular non-
5 WTU satisfaction and we've been a little over 80
6 percent but not huge changes month-to-month but
7 those are fairly high scores and we get a little
8 under -- about 1,500 returns back per quarter. Oh,
9 and one more thing I want to mention about this
10 slide as this was brought up about. These results
11 do not show the CBWTUs so there's one slide, later
12 on, that I will show you that does include the
13 CBWTUs but there was a question about their
14 satisfaction and their satisfaction is about 10
15 percent higher. So a lot of soldiers really like
16 being there and some of the comments that we see
17 as far as orders and stuff, they talk about, you
18 know I really want to be transferred to the
19 CBWTUs. So their satisfaction would be up around
20 here.
21 GENERAL STONE: Does that satisfaction level reflect since primarily that's Guard and Reserve, does that
22 reflect the length of time they're in the program? Is that time dependent? Is that where your second bullet

1 comes from in your -
DOCTOR GLINER: Well, actually that was -- thanks General
2 Stone because the next slide, I think this is what you're
referring to, the length of time in the program, so, but
3 yes, that's a lot of it. What we find, and this
4 was kind of a surprise, this left side -- if I
5 don't answer your question though please let me
6 know -- this left slide shows MEDCOM and this
7 includes the CBWTUs. So what this is showing,
8 these are the soldiers that have been in 30 days,
9 120 days, 210 days and 410 days and then each of
10 these lines represents COMPO. So what we see with
11 this blue line is that the longer COMPO I is in,
12 the less satisfied they become. The opposite is
13 true with the Guard and Reserve and over here this
14 is the same thing, but this is just an example. I
15 believe this was Fort Carson we were looking at.
16 I want to show an MTF example. They had some
17 Guard and Reserve in their WTU so that it wasn't
18 just those going to the CBWTU were more satisfied
19 but we saw, this is really pronounced, that why is
20 it that the longer the Guard and Reserve are in
21 the more satisfied they become whereas with the
22 active component, the less satisfied they are the

1 longer they are in the WTU? All right, did that
2 answer the question? Okay, thanks, sir. All right,
3 this just shows satisfaction with case manager
4 provider and squad leader and there's a clear
5 indication here that most people love their case
6 manager, they're fairly happy with their squad
7 leader but less satisfied with their healthcare
8 provider. Okay, satisfaction with medical issues
9 so this is
10 satisfaction -- this is the same one. Satisfaction with healthcare provider and then satisfaction with medical
11 care so as we would expect, they're about the same. Okay, satisfaction with non-medical issues and these were
12 a lot of things that were brought up in the Washington Post articles. So we see satisfaction with quarters
13 which is extremely high and I started this graft with Fiscal year '08, Quarter two, but we were much lower
14 before that so this is a very good news story that
15 we've really been able to improve on these non-
16 medical issues as far as quarters, transportation,
17 financial issues which is a little bit lower, but
18 all of these prior to this and I should have
19 expanded the graft but prior to this, these were
20 much lower so very good news story on these and we
21 can see in the verbatim comments and I'll show you
22 a sample of those that soldiers rarely indicate

1 problems with a lot of these things. Satisfaction
2 with access to care. We've taken a little drop
3 recently and a lot of this we're trying -- these
4 are lower than some of the other measures and we
5 mentioned earlier about how we put in those
6 enhanced access to care standards and now we're
7 really pushing to look at issues with specialty
8 care. You know if they can get in to those
9 appointments with their primary care manager then
10 how quickly can they get over to specialty care
11 appointments, to surgeries and to other things
12 they need and also satisfaction with counciling
13 which not any different than the other two but
14 satisfaction with -- I know we put in other
15 measures with enhancing access to behavioral
16 health. All right, let me explain this chart. We
17 found that as part of those non-medical issues, I
18 didn't show it on there, but satisfaction with
19 orders was always one of our lowest measures and
20 the Surgeon General at the time, says
21 why is that? You know that's such a broad question, satisfaction with orders, what does that mean? So we
22 added a check box on the survey that's, and they were allowed to check, this is just an example of one

1 facility. I just wanted to show you what the data looked like. So we added a check block and they were able to
2 check you know what issues with what type of orders and I know that's hard to see but this indicate -- this was the
3 most common response was transfer orders and then
4 in parenthesis it says, to the CBWTU or WTU
5 closest to your support network. Some of the
6 others, this one right here says PCS orders to a
7 new assignment to down here initial MRP orders but
8 this is now a great question so that the
9 facilities can go in each place, the commander,
10 and see what are the issues and this is at the
11 tactical level and take this and say what are the
12 issues with orders? Then the next slide asked the
13 nature of that problem? So okay, if it was
14 transfer orders, what was the problem with
15 transfer orders and the most common response was
16 timeliness. Although it's interesting, people have
17 asked you know are the Warrior Transition Units,
18 is that any different than the Army at Large with
19 orders? I said actually I do not know but that is
20 a very good question. You know is this population
21 any different with problems with orders because we
22 hear that a lot. All right, any questions on any

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1 of the grafts I've shown so far? Okay, now I'm
2 just going to show a sample of the verbatim
3 comments. What these are is at the end of the
4 survey, there's a blank box or actually it's on
5 the telephone since this is a telephone survey and
6 the interviewer says, "do you have any other
7 questions or any other things you'd like to
8 mention that we haven't touched on" and these are
9 directly transcribed by the contractor and
10 these are now pushed every month to the Warrior Transition, the commander of that WTU or CBWTU and the
11 hospital commander, so they get these every month and now I should mention, because people say oh gosh, what if
12 there's something hot that's mentioned? Now occasionally this happens and it doesn't happen very often. I would
13 say about once a month. A soldier will say something that may be urgent and the soldiers are told at the start
14 of the survey that this is completely confidential
15 unless you mention anything about suicide or
16 homicide and then confidentiality is gone. So
17 this happens about once a month and people are
18 surprised. They say wow, a soldier would just
19 tell a complete stranger on the telephone and
20 actually yes, they do. You know maybe that's what
21 it takes is a complete stranger. So we will get a
22 phone call within ten minutes of that survey from

1 the survey contractor and we directly contact the
2 Chief of Staff and that Warrior Transition Command
3 and they are able to get in touch with that
4 soldier within the hour of that survey so that has
5 been just -- I mean it's worked well every single
6 time it's happened in the Army. That we've never
7 had a case where we couldn't get the information
8 to someone who could touch that soldier within an
9 hour so that has been a great process that we have
10 in place and as I said, it happens about once a
11 month, just varying comments. It happens on DoDs
12 Ill and Injured Survey also and they will call us,
13 the Army Medical Command, and say it was an Army
14 soldier. So we're given the soldier's name, phone
15 number and where they're located and the nature of
16 the comment and you know occasionally it will be
17 something like I'm feeling suicidal and need help
18 right now and this survey -- we didn't expect that
19 we would be using this survey for that reason but
20 it happens and we have a seamless process in place
21 to get hold of
22 those soldiers when there's comments made like that.
Okay so, again, this is an example of the WT verbatim

1 comments. Also all these results that I showed are
online in a password protected website and anyone who
2 wants access can get access to this but all the cadre of
course and the WTC, they all have access. Case managers
3 can get access because we have results down to their
level. So it's fairly transparent that people can go in
4 any day. The results on the website are updated,
5 I believe, once a month so people can go in and
6 see those and see the verbatim comments for their
7 area. Okay, some of these comments are very
8 positive. The program is excellent, it's helping
9 me recover and some of them not as positive but
10 the great thing about these is it's the lowest
11 level you can go and it's a way to solve problems
12 right there. Okay, now I'm going to move on to --
13 yeah.
14 GENERAL GREEN: Have you done any
15 differentiation between wounded warriors, i.e.,
16 the folks who actually have wounds from the war,
17 and the ill and injured? Is there any variance
18 between the two groups?
19 DOCTOR GLINER: There is. I think we did
20 an analysis to see if there was a difference
21 between those who had deployed and those who had
22 not deployed. We found that those who had not

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1 deployed, I believe I'm getting this right, were
2 more satisfied than those who had deployed.
3 GENERAL GREEN: Did you carry that at all to
4 look, and probably I know the answer to this, but
5 to look at those who had not deployed versus
6 others that were not put in to the WTU? So in
7 other words, you've got another group out there
8 that are medically non-ready that are not in the
9 WTU undergoing similar processes. Did you look at
10 those two groups to compare at all?
11 DOCTOR GLINER: You know we didn't, sir, but
12 that's
13 actually something that we could do because we have our regular satisfaction survey, that if we could pull those
14 groups out, that is an analysis we could do but we have not done that yet.
15 GENERAL GREEN: And finally, is there any difference in the length of time for the deployed versus not deployed?
16 I would think that some of the injuries that we're seeing might have a much longer recovery time in a WTU for the
17 deployed and I'm wondering if you're seeing any
18 differences in the time of that. I wondered why
19 you stopped at 410 days I think? For some of
20 these --
21 DOCTOR GLINER: Well, we stopped at 410 days
22 because we were getting such small numbers after

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1 that point. We never wanted to be able to
2 identify anyone so that was the main reason at
3 least at the time when we started this and I'm not
4 sure, sir, you or anyone might be able to tell me
5 how many we've got past 410 days currently in the
6 WTU but that was really the reason for doing that.
7 GENERAL GREEN: Thank you.
8 DOCTOR GLINER: Thank you.
9 DOCTOR GUICE: Before you go on, one other
10 thing. You talked about the fact that when you
11 looked at what drives satisfaction and you said
12 knowledge about the system. What were the other
13 factors that you looked at in doing that analysis?
14 DOCTOR GLINER: Well, that drives MEB
15 satisfaction, certainly, but as far as the overall
16 WTU, what drives it really the healthcare provider
17 is the main driver and also satisfaction with
18 orders was a big driver and that's why we split
19 out that question, to look at specific reasons and
20 specific issues with orders and which types of
21 orders, so definitely the healthcare provider and
22 the orders.

1 We didn't find that case manager was a huge driver and a lot of that is there's kind of a ceiling affect there
2 when people are so satisfied with their case manager that there was not a lot of variance in that one. So really
3 the healthcare provider and to expand that, getting access to medical appointments.
4 Okay, now I'm going to show some results related to pain management and as I said, we recently added the pain
5 management questions based on advice from the Pain
6 Management Task Force and I just have a few of
7 these and again these are preliminary results so
8 we don't have a lot of trend data yet but we will
9 soon. The first question we asked related to pain
10 management is just that pain scale. Could you
11 rate yourself on a scale of 1 to 10 on how much
12 pain you're in and the most common responses were
13 a one and a four. Now this was fascinating to me.
14 What this shows, this blue line right here, and
15 these are the facilities down here on the bottom,
16 I don't think I included the CBWTUs, just the
17 WTUs. Then here, this blue line is the average
18 that the soldiers indicated on the pain scale.
19 This red line is actual acuity and this was an
20 acuity scale developed by someone at PA&E and what
21 we find is there's absolutely no relationship
22 between perceived pain and acuity and some people

1 said wow, how can that be and then other said well
2 of course, you know that's obvious. In fact, some
3 of our lowest acuity places, for example, I
4 believe the Heidelberg you know had the highest on
5 the average pain scale and we're still not sure
6 what to make of this but I thought it was
7 important enough to put up there. This just shows
8 average satisfaction with pain management and
9 responses on the pain scale. This does make
10 sense, the higher the perceived pain, the lower
11 your
12 satisfaction with pain management.
13 All right, I know these are hard to see but I just want to give a sample of the other types of questions we're asking on this. So this one up here asks, on the survey,
14 pain is my primary problem. Over here, my provider believes I'm in pain. Down here, I am confident that my
15 provider will be able to manage my pain. Then this last one, I'm able to control my pain. These are all broken
16 out by MTF and then we have the average score for
17 the MEDCOM and these were important to see as far
18 as dealing with expectations with pain management
19 and especially this one they thought was very
20 important. I am confident my provider will be
21 able to manage my pain. So it's not just --
22 because at first we used to ask just how satisfied

1 are you with pain management and we got such low
2 scores so we added these questions on. This last
3 slide with pain management shows what are your
4 expectations regarding pain management? That I'll
5 be pain free, that I'll have pain reduction, that
6 I'll have tolerable pain that allows me to perform
7 my activities, I have no expectation of
8 improvement and other. So the most common
9 response in this was that I'll have tolerable pain
10 that allows me to perform activities. Then last,
11 this just shows overall satisfaction with pain
12 management. Interesting, a couple of the lower
13 ones are launched on Bavaria over here and
14 certainly Bavaria, some of the lower acuity
15 soldiers.
16 DOCTOR GUICE: So what are you going to do
17 with this information?
18 DOCTOR GLINER: Actually, this goes directly
19 to the Pain Management Task Force so really they
20 are the ones that act on it. They ask us, then,
21 sometimes to do more of the analysis. Also the
22 Warrior Transition Command, I know, works with

1 them so they get these. But what

2 they've been able to do at the tactical level is to see sometimes what the soldiers are saying with this

3 especially what I didn't show on here, what is also included on the pain management questions, is the other

4 types of pain control that they would try such as acupuncture, biofeedback, massage therapy, there were

5 some others on there. Some of the MTFs and soldiers indicate that they've been able to do things to improve

6 or to try some of those other things that aren't

7 normally considered as part of the pain management

8 so they're actively using these data.

9 DOCTOR GUICE: So that task force or group

10 would look at the prescription patterns now and

11 overlay it with this information so there are --

12 DOCTOR GLINER: Absolutely.

13 DOCTOR GUICE: -- great differences in the

14 way pain was actually managed at Bavaria, for

15 instance, since it seems to be

16 DOCTOR GLINER: Absolutely, yeah, and that's

17 what's great because they do have access to all

18 those different data sets that they can overlay

19 that. MS. CROCKETT-JONES: I have a question about

20 the slide previous to this one. What is the green

21 line?

22 DOCTOR GLINER: Oh, the green line is the

1 MEDCOM average or actually -- you know what, I

2 take that back -- MS. CROCKETT-JONES:

3 [Inaudible].

4 DOCTOR GLINER: -- because that, yeah. You

5 know what, I take that back. Let me take that

6 back. Definitely on these two, I wonder if the

7 line, in transporting it on to this slide, may

8 have just gotten messed up. MS. CROCKETT-JONES:

9 Messed up?

10 DOCTOR GLINER: Yes. That's what I'm

11 guessing happened but you're right. That could

12 not logically be a MEDCOM

13 average there so thank you for pointing that out. I think that's what happened is that in transferring this

14 on, you know cutting and pasting the slide, that it got just moved up. Thank you.

15 MASTER SARGENT MACKENZIE: Does this pain management survey take into account people who are on pain meds,

16 people who are not on pain meds?

DOCTOR GLINER: It does not. It doesn't distinguish. In

17 fact, that's not even something that we ask but

18 that's a good point. There are a lot of comments

19 in the verbatim comments about pain meds and, in

20 fact, we used to have a question on the WTU

21 Satisfaction about satisfaction with getting pain

22 you know medication and it was always like so -- I

1 mean one of our highest scoring items and we say
2 well why is satisfaction with you know getting
3 pain meds so high but satisfaction with pain
4 management so low? So there was clearly that was
5 not the solution.
6 MASTER SARGENT MACKENZIE: The reason I
7 asked is because it seems like your charts would
8 all be skewed because you know if I'm on narcs,
9 I'm going to say my pain is a three and it totally
10 skews your chart right there because it -- now
11 I've given you my pain scale input based on being
12 on narcotics and it's not --
13 DOCTOR GLINER: We would expect -- I would
14 agree with you at that point until I saw the
15 acuity laid up against it because I thought if I'm
16 such high acuity, there's a good chance I'm going
17 to be on high pain meds I would think but we don't
18 necessarily see that and I thought that they'd be
19 -- General Williams.
20 GENERAL WILLIAMS: Kind of back to your
21 point, ma'am. What are we going to do with all
22 this? So here are the efforts to date of what we

1 have in terms of matrix. One of the stats that
2 was in the DAIG Report, if you've read
3 through that, was that 25 to 35 percent of WTs are addicted to some sort of pain medications or opiates. So
4 we have a weapon here in terms of seeing ourselves and we've done a lot of that and so we have information. The
5 Surgeon General, back in I believe '09, decided that Colonial Gallaway is the Pain Management Task Force so
6 Surgeon General set up a very deliberate sale and they've done a lot of great work and so pain management written
7 large across the population and then as it relates
8 to the WTs. What's the solar of all that? So
9 what I plan to do now is having some of this
10 information, having received some feedback from
11 the DAIG Report, is vector this weapon system on
12 and answer some of these questions. Back to the
13 metric piece I brought up earlier to help see
14 myself.
15 So that's what I'm going to do with it. I'm
16 going to
17 use all this great information, we're working our
18 way through it, and I'm going to kind of point
19 where it needs to go and confirm or deny some of
20 the things that were in the DAIG Report because as
21 I told the folks earlier, we're very transparent
22 about all this. If we've got issues with pain in

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1 our WTs and if we have soldiers -- for instance,
2 the Sole Provider Program where we have -- if WTs
3 are on more than four meds, they get a sole
4 provider. I don't really know what a lot of that
5 looks like. I know someone went out and looked at
6 our population and made some assessments about
7 pain and what the WT population is; some of that's
8 in here. So this is very, very recent stuff from
9 my perspective as the WTC Commander so I plan on
10 using a lot of those to go after these problems
11 that see myself. That's kind of where this all is
12 in context and space and time. Sir?
13 GENERAL HORST: Yeah, I'd like to follow up
14 on that someone made the comment about
15 differentiating between wounded warriors and ill
16 and injured warriors when
17 evaluating pain. As I look at the two WTs to use that I have Senior Command responsibility over, I find it
18 interesting that at Fort Meade, 65 percent say that pain is their primary problem yet, of that population of 190,
19 1.5 percent of that population is wounded and I happen to know that the psychological, PTSD, those sorts of things,
20 have a much higher representation in my two WTs yet 65 percent of them say that pain is their primary problem.
21 So I think we've really got to pull out the sharp
22 pencil and differentiate pain levels in wounded

1 population, pain levels in injured population,
2 pain levels in ill population to give you a better
3 representation of what we have.
4 GENERAL WILLIAMS: Yes, sir.
5 GENERAL HORST: And you don't even have to
6 go to those wounded in combat but if you just
7 break it in wounded, ill and injured, I think you
8 get a better data point. But I looked at mine,
9 it's 65 percent are in there and pain is their
10 primary problem yet 1.5 percent of them is really
11 a wounded worrier.
12 GENERAL WILLIAMS: Right, right.
13 GENERAL HORST: So I think the data is
14 skewed not because of how we collect it, just
15 because we haven't put a sharp enough edge on the
16 pencil that we're defining the parameters.
17 GENERAL STONE: Let me make some comment on
18 that. I think this is exactly why the Surgeon
19 General stood up the Pain Management Task Force.
20 You know the use of psychopharmacologics in
21 medical therapy came to be in the late 1950s and
22 grew up and we just took a look at some of the

1 Vietnam statistics and the Vietnam statistics
2 showed that almost 25 percent of soldiers deployed
3 in Vietnam were, this was a 1967 study, were on
4 psychopharmacologic agents. As we look at the
5 nonattachment of pain medicine
6 satisfaction to acuity levels, what I think is incumbent upon us as a delivery system in the Army is to really
7 move to a much greater level of provider training, understanding what the demand is for those agents and how
8 we should appropriately respond. By the same token, our sophistication with alternative delivery systems to
9 control pain and behavioral health modulation using either nontraditional, western modalities like
10 acupressure, acupuncture, other types of
11 modalities is where this data really begins to
12 have value and maybe I think over the four years
13 that this task force will be in session, I think
14 we'll have an opportunity to really talk to this
15 Pain Management Task Force and as the other
16 services come online with those task forces to
17 really see how we, as a military, respond to this.
18 By the same token, chronic pain is related to
19 traumatic injuries. This is a very unique
20 population and the escalating use of those agents
21 that effectively control pain have tremendous
22 addictive potential in a population that we may

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1 dealing with over a 70-or 80-year period and so as
2 we look at all of this, the Pain Management Task
3 Force leadership really should probably be in
4 front of us at some point.
5 DOCTOR PHILLIPS: Somewhat of a technical
6 question but I think it touches on the two
7 previous comments. A lot of this information is
8 in percentage and if you look at the pain scale on
9 your first slide, I'd be interested to know what
10 the actual numbers are because the percent
11 difference between say 10 and 14 percent could be
12 huge in population or it could just be a small
13 number, depending on the total population
14 surveyed.
15 DOCTOR GLINER: Right. Well, I guess we get
16 a sense of it if let's say we get -- this was from
17 about two months worth of data. So we can say
18 maybe about [inaudible] of
19 a thousand at the most, with this preliminary pain management data. So if that gives you any more of a
20 sense that you know 14 percent of those indicated one and that's going to be great with the trending in the future
21 to say what's happening with that pain scale and especially you know is it changing as overall
22 satisfaction goes up, is perceived pain going down or is it the perception of the outcome that's going up so,

1 yeah, good question.

2 DOCTOR PHILLIPS: You know I would say

3 because as this gets published, some nitpickers

4 might do statistical analysis and percent

5 difference is a lot different than raw data

6 analysis.

7 DOCTOR GLINER: Right, right, absolutely,

8 thank you. Okay, and then the last thing I want to

9 talk about is, and this is also somewhat new, MEB

10 satisfaction, and we had started this actually

11 awhile ago and we sent out the first surveys,

12 actually they were done by telephone, and what we

13 found as with a lot of surveys is that some of the

14 questions didn't quit pan out as what we had

15 expected to see so we revised the survey and now

16 we're looking at a lot of the results and what we

17 see, as I mentioned, this one first shows

18 satisfaction with PEBLA. Oh, and one thing I want

19 to mention, is that right now the MEB survey only

20 goes to those soldiers who are in a WTU. We know

21 there's a large population that are going through

22 an MEB that are not in a WTU. With the new survey

1 contract that hopefully will be awarded sometime
2 later this spring, the wording in there is that
3 all MEB soldiers will be surveyed and that will be
4 an interesting comparison to see the satisfaction
5 between those in the WTU and those not in the WTU
6 going through an MEB. Okay, so as I mentioned,
7 satisfaction with PEBLO is fairly high except for
8 this issue right here. That PEBLO
9 explained my appeal rights but other things like treated
you with courtesy and respect, overall satisfaction a
10 little lower and then these first two questions were just
I have been assigned a PEBLO or I have spoken to my
11 PEBLO. You know this is probably -- you know if we
looked at the actual data, it's probably 100 percent but
12 you know as far as what -- yeah?
DOCTOR GUICE: These are obviously a combination of IDEZ
13 and Legacy?
14 DOCTOR GLINER: Yes.
15 DOCTOR GUICE: And so what are the
16 differences between the two? Have you looked at
17 the difference?
18 DOCTOR GLINER: No, but we will in the
19 future. We'll put that on the survey.
20 DOCTOR GUICE: Because the other thing that
21 has been added to the Legacy is there's a military
22 service coordinator, as well, provided by the VA

1 and the PUEBLO and the MSC sort of work together
2 to explain information so it would be very
3 interesting to see how this changes with that
4 because that's not available in the Legacy system
5 and the other question, Dr. Phillips how many
6 people in this? You have percentages again.
7 DOCTOR GLINER: Yeah. This -- it's
8 definitely lower. I believe with this sample that
9 we're looking at right now, it's about 500
10 responses and again we'll have trending data
11 probably in the next month or so to at least see
12 how we're doing.
13 DOCTOR GUICE: The other thing that would be very
14 interesting, particularly as we do out site
15 visits, is to have this broken down by facility,
16 MEB facility, so that we could have that --
17 DOCTOR GLINER: Sure and I'm looking --
18 absolutely. Yeah, I don't show that in here but
19 definitely I've got that and especially because
20 there's a lot of variance so
21 thank you. This shows satisfaction with the process. As General Williams said in his opening speech, there's a
22 lot of changes in the DES so we're aware that some of these questions, overall satisfaction with the MEB, this

1 question asks the MEB takes the correct amount of time, I
think that's our lowest scoring one, the MEB process is
2 fair and the MEB is clear and understandable. So we know
we've got opportunities to excel on those, so. Then, as
3 I mentioned, the MEDCOM knowledge --

4 MR. REHBEIN: One question before you go on.

5 That last column, overall satisfaction with the

6 MEB, does that breakdown satisfaction with the

7 process versus satisfaction with the decision?

8 DOCTOR GLINER: No. But that's a very good

9 question. There is a question on here, which I

10 didn't show. It says when you are done you know

11 with the PEB, what percent disability do you

12 expect to receive and I didn't show that on here

13 but they're really based on -- it seems that most

14 of them either wrote 100 percent or 50 percent

15 which was fascinating in itself. So they fully

16 expect to either get 50 percent or 100 percent and

17 that's important when we come over here. There was

18 one question on the knowledge test that was

19 deliberately incorrect and we didn't want to --

20 you know I didn't write the question but it said I

21 must get 50 percent to have maximum benefits and

22 40 percent agreed with that and that's wrong so

1 that was interesting in itself. Then we say when
2 do you expect to get and either say 50 percent or
3 100 percent. So I thought I wonder if that goes
4 on to, you know, hey I think I have to get 50
5 percent, so good question. The other things with
6 the knowledge test, as I mentioned earlier, if
7 there's a reserve soldier being considered, there
8 must be a reserve component member on the board.
9 This question, I don't know the exact wording of the
question, but it's in the questionnaire that I'll give
10 you but it talks about what the Army looks at versus the
VA and this next one says the PUEBLO is my primary source
11 of information going through the process. Surprisingly
only 65 percent agreed with that. This had something to
12 do with three days for protesting and I know -- again, I
don't know the exact wording. Ten days for a PEB and
13 requesting a formal hearing. So those -- and as I
14 said, this was the top predictor of satisfaction
15 with the MEB was how well they did on the
16 knowledge test so more knowledge, higher
17 satisfaction. This will be so great for the
18 facilities to be able to look at this, broken out
19 by facility, to see where the training and
20 education is needed. Sir?
21 GENERAL WILLIAMS: I was just going to add
22 something. Are you done?

1 DOCTOR GLINER: Sure. I think that is it.
2 Just my contact information.
3 GENERAL WILLIAMS: So back to your question
4 again, ma'am, I just want to put some context on
5 it. So last November I came in and one of the
6 things -- one of the critical information
7 requirements that I need to see the organization
8 and then, more importantly, what are the questions
9 we got asked and go after. So that's really where
10 all of this is. We've had a DAIG Report; we've
11 had a Department of Defense IG Report which is
12 currently working at two locations, a number of
13 different issues that I mentioned in my opening
14 comments. So I have my own OIP that goes out and
15 looks at all these installations, routinely, and
16 kind of -- kind of -- surveys and asks these kinds
17 of questions so we have a lot of stuff that we're
18 working our way to say that this is information,
19 this is critical information, this is
20 information we don't really need to worry about and here's where I need more fidelity, kind of back to
21 General Horst's point about sharpen the pencil here a bit and provide more fidelity -- and provide the real
22 questions which are going to help us move forward. So in the context, Colonial Goodman's folks and Doc and other

1 have provided me kind of a general supporting role
ability to see myself. Now it's up to me and my command
2 to go back and figure out the precision on this
3 and that's where we are. We do not have precision
4 on a lot of these things and the questions you're
5 asking are kind of teasing some of that out.
6 Well, how do you know wounded, ill or injured and
7 we don't have that but I'm going to be asking
8 those questions here pretty soon. As I go back to
9 the Surgeon General and I go back to the Army
10 leadership, sir, here's where we are right now,
11 here's where I want to go because of this stuff
12 that we have measured for some time. There's got
13 to be some efficacy associated with it. Why did
14 you do this way? Well, sir, because we measured it
15 for six months and longitudinally we have this,
16 over here we've seen that. So, to me, all this
17 great work that Doc's done is great work but now
18 it needs to be tailored to our different
19 populations. Sir?
20 GENERAL HORST: Intuitively, I think we also
21 have to have a greater participation rate in the
22 surveys. Your pain management you've got about 10

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1 percent.

2 GENERAL WILLIAMS: Yes, sir.

3 GENERAL HORST: In the MEB process you've

4 got about five percent and so I think we have to

5 encourage, persuade, compel whatever to get

6 greater participation in these surveys to give you

7 that more refined data so that we can move

8 forward.

9 GENERAL WILLIAMS: It's a great point, sir, and I

10 actually to that for node. To me that's a word that I know you all -- it's leadership. I mean really back to

11 the education piece, I'm pretty sure I can be pretty persuasive in helping commanders set the conditions where

12 folks -- hey ladies and gentlemen, this is going to help you get better. This program is going to get better now

13 when you provide good data back to these -- and your point about the media, too, sir, spot on. So we have

14 some -- this is some area we have some work to do

15 here. I'm excited about the opportunity to go

16 after this, so. Sir.

17 GENERAL HORST: I mean at the end they're

18 all still in this -- they're still in the Army,

19 Navy, the Air Force, and the Marine Corps and

20 we're not a democratic society.

21 GENERAL WILLIAMS: That's right, that's

22 right and I appreciate that, sir. Thank you for

1 that. So I look for those opportunities to
2 influence that. Anything else Doc?
3 DOCTOR GLINER: No, thank you, and I will
4 get the survey and the methodology out. Are there
5 any other questions?
6 DOCTOR PHILLIPS: Excuse my ignorance but
7 what's the knowledge test consist of?
8 DOCTOR GLINER: Oh. I apologize. It's just
9 the -- let's see, it's a series of seven questions
10 right down here and it just asks them -- instead
11 of asking true or false, it says how much do you
12 agree or disagree with these issues and it'll say
13 things like I must get -- like this last one. I
14 just abbreviated here but this last question says
15 I must -- how much do you agree or disagree with
16 the following statement? I must get at least 50
17 percent disability to get maximum benefits?
18 Things like that.
19 DOCTOR PHILLIPS: I just may have missed it.
20 Are these anonymous or are these identifiable?
21 DOCTOR GLINER: Well, it's never anonymous
22 because we can

1 always track back you know based on, because we have the soldier's information, but it's confidential so that you
2 know as most surveys -- yeah, confidential unless they indicate suicide or homicide. Thank you.
3 GENERAL WILLIAMS: So the efforts that General Bostick and Gary Cheek -- General Cheek are doing to get at this
4 process. The G1 is -- so once you've met the medical readiness determination point, medical requirement
5 determination point, it now becomes an
6 administrative process for the most part after
7 that and what we found, I sit on this board for
8 the Chief, is that soldiers really only spend
9 about 11 days in that total 200 and X plus days of
10 contact time with their providers; they're
11 waiting. So they don't know where they are in
12 this process and that's really what this is trying
13 to tease out here and so we think if we could
14 provide more knowledge about where you are and
15 expectation management, it's going to create some
16 -- back to the thrust [inaudible], again, to get
17 folks through it. So let's fix high end. You'll
18 hear this latter this afternoon from Dan Cassidy,
19 the dual adjudication pieces, but then at the
20 tactical level, how do we create thrust that way?
21 So by educating folks about where they are, where
22 they need to be, here are your appointments,

1 here's where you are in the process Sergeant
2 Williams, we think that will create thrust and
3 then we'll figure out the bigger, high-end,
4 perhaps congressional pieces that need to happen
5 to get this process moving. Dan will do a great
6 job this afternoon of laying that out for you and
7 kind of talk about it but they don't know, they
8 don't know where they are in this process. I hear
9 it over and over. I've been to seven, eight
10 locations and they don't know where they are on
11 this process and they just kind of wait and don't
12 know, sir, you know. I'm day six of 11 days of
13 this 227 day process, so.
DOCTOR GLINER: In that anonymous question I think what
14 you're asking is no we never -- we only present
15 you know rolled up results. We would never say
16 well Joe over there doesn't know a thing so, no,
17 never like that. It's always you know rolled up
18 results and so soldiers are never identified.
19 GENERAL GREEN: Is there a reason -- I mean you're
20 showing us kind of point-in-time data based on the
21 most recent surveys which you've aggregated, I'm
22 assuming, across all the different time groups but

1 I'm wondering, this has been gone since '07, I
2 know there's been multiple different satisfaction
3 surveys. Is there a reason you're not showing us
4 this over time?
5 DOCTOR GLINER: Well, the MEB and the pain
6 management are relatively new but these are
7 certainly over time so that the regular WTU survey
8 that we've been doing since '07 so yeah, it's just
9 that the MEB, we started it and we had to revise
10 it so we'll show those over time you know next
11 time you see them all when you go out to the
12 facilities so that was the reason why. Good
13 question. Okay, if there are no other -- go
14 ahead.
15 MS. DAILEY: I know we've got some lag here
16 but we have a buffet set up in the other room. I
17 thought we'd go into our working lunch, sir.
18 Who's the next briefer and what are you briefing?
19 DOCTOR GLINER: On nonclinical aspects of
20 the Warrior Care and Transition program.
21 MS. DAILEY: Are these the rest of your slides?
22 MALE SPEAKER: Yes.

1 MS. DAILEY: Is this the correct order? This is where
it's at, okay. So the operation is I need my members and
2 I'd like to invite General Williams and Colonial Gadsden
to have lunch with us. However, it's a working lunch so
3 I'd like my members -- there's a buffet set up in the
room here. Go through the buffet line, please bring your
4 lunches back and make yourself comfortable and our next
briefer will start on their presentation. This will be a
5 15 minute so by a quarter till, let's be back in

6 our places and our plates and, again, working

7 lunch. There will be briefing and you'll be

8 eating.MS. DAILEY: We are going to start our next

9 set of briefings. Please continue eating. Enjoy

10 your meal with one part of your brain, and then we

11 have another part we would like you to turn

12 towards are two briefers who I will let introduce

13 themselves if they would please. Thank you.

14 COLONEL MOZDEN: Good afternoon, everybody.

15 We are going to go ahead and get started back.

16 The next section we are going to discuss is on our

17 non-clinical aspects of the Warrior Transition

18 Program. We're going to talk to you a little bit

19 about our Organizational Inspection Program, some

20 best practices, some training that we do within

21 the command. And Kernel -- Lieutenant Kernel --

22 promotable, Scott and I are going to kind of tag-

1 team this as it were -- just kind of keep things
2 moving and take you through this discussion. So,
3 without further ado, I'm going to turn it over to
4 Lieutenant Colonel Scott.
5 LT. COLONEL SCOTT: Well, good morning
6 again, and by way of introduction I'm Lieutenant
7 Colonel Suzie Scott and I'm the Warrior Transition
8 Command Chief Nurse and Consultant to the Surgeon
9 General for Nursing Case Management. The reason
10 that I am here with Colonel Mozden briefing the
11 non-clinical case management portion
12 of this is because the two are very inextricably linked
in our program, and it is only logical that we present
13 you with an integrated picture of what we're doing so
that you can see how we operate in our Warrior Transition
14 Units and community-based Warrior Transition Units. So,
the success of our Warrior Care and Transition program is
15 directly attributable to the caliber of the cadre that
are assigned to our Warrior Transition Units, and the
16 quality training that they receive in order to
17 develop a core warrior care skills set. All of
18 our Warrior Transition Unit Cadre members complete
19 28 modules of online training. Then our company
20 commanders, first sergeants, squad leaders,
21 platoon sergeants, and case managers all attend a
22 ten day resident cadre orientation course that

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1 provides seven days of core training and three
2 days of specialty training. Updates to the
3 requirements that are articulated using a number
4 of venues as General Williams mentioned earlier
5 today. He conducts monthly video-tele conferences
6 with his commanders; we have the websites that he
7 mentioned as well. We have our annual training
8 conference and then the command also published
9 annual training guidance that directs mandatory
10 training for our cadre, to keep them up to speed
11 on what's happening with Warrior Care. In analysis
12 of our organization, program visits, Warrior
13 satisfaction surveys, interviews with cadre
14 members and warriors, indicated that we really
15 needed to undergo a significant change to our
16 cadre training program, as General Williams
17 mentioned. As a result we are currently
18 undergoing a complete redesign of the cadre
19 training course and transitioning from an
20 orientation program to a certification course.
21 Additionally, we are expanding the course to
22 include a specific course for that Primary Care

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1 Manager and expanding the core content in Case

2 Management, Behavioral Health, PTSD, TBI, Substance Abuse, and Suicide Prevention.

3 COLONEL MOZDEN: The annual Warrior Transition Command Training Conference that had been mentioned earlier, this

4 year is going to be in April. The focus of our conference this year is going to be on standardization of

5 that comprehensive transition plan that we've been talking about.

6 What we do is take the information that we're

7 getting back on our OIP's and we use that to

8 develop some of the tracks that are provided

9 within that annual training. You will see and have

10 heard that some of the human resource components,

11 the orders, transfers, that sort of thing -- has

12 been a consistent area of concern for our soldiers

13 and their families. For that reason we have a

14 specified track within our annual training to

15 provide an enhanced skill sets to our folks that

16 are doing HR in our units. In addition, there is

17 also an S1 weekly tele-con where they are sharing

18 information, providing updates, and our HR SME's

19 that go with us -- our Subject Matter Experts --

20 that go out from HR Medcom on our OIP's -- when

21 they have new information or they identify

22 potential best practices, they hang that on their

1 HR specific website for our folks to be able to
2 access. In addition, we've been gradually
3 expanding over the last couple of years at our
4 Warrior Transition annual meeting, tracks for our
5 clinical folks. So this year and last year we had
6 our PCM's and Nurse Case Managers. This year we
7 will also be continuing to add our OT's and now
8 our PT's which are working with us within the
9 program and additionally tracks for our SFAC
10 personnel and our Behavioral Health -- licensed
11 clinical social workers. AW2 Advocate training,
12 they have their own set of
13 training. They have their initial two-week training which will tie in and address some of the recovery
14 coordination training -- Dr. Guice that you were mentioning earlier. In addition the AW2 has a regular
15 yearly for all of their staff -- a training conference -- and as you see here, a list of additional monthly ongoing
16 kinds of training. The advocates we really see as our non-clinical realm experts in providing support for
17 soldiers and families.
18 LT. COLONEL SCOTT: Okay, in your request
19 for information in establishing our agenda, one of
20 your questions was "Do you have a standardized
21 methodology for identifying and promulgating best
22 practices?" The U.S. Army Medical Command has a

1 standardized 8-step process for identifying and
2 promulgating best practices. So, if you will bear
3 with me over the course of the next set of slides,
4 I'm going to walk you through that 8-step process
5 -- certainly not all with this slide -- and talk
6 to you about how the Warrior Transition Command
7 best practice process is embedded within that. So,
8 the first step of the Medcom process begins with
9 actually the recognition of good ideas and
10 improvements at all levels across the Medical
11 Command and within the industry. The second step
12 in the process consists of capturing and
13 communicating these successes and innovative
14 ideas. The medical command has several mechanisms
15 for completing these steps: One mechanism that we
16 at Warrior Transition Command use is to capture
17 potential best practices through our Organization
18 Inspection Program. The Organization Inspection
19 Program is designed to validate the compliance
20 with program standards and facilitate operational
21 improvements. It is also a mechanism of
22 identifying those innovations and sharing best

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1 practices between our Warrior Transition

2 units. So, during the course of the OIP as Colonel Mozden mentioned -- we have subject matter experts

3 formally soliciting and reviewing identified areas where they are achieving a high level of performance.

4 Now, the third step in the Medcom best practice transfer process is to validate those best practices. The medical

5 command has stated that the process owner which for us is Warrior Transition Command has the responsibility for

6 ensuring that it really is a best practice. We

7 are required to have data demonstrated results for

8 this. So with that, over the course of the last

9 two years we have completed 17 Organization

10 Inspection Program or staff assistant visits. We

11 are going to detail some of that information for

12 you over the course of the next couple of slides.

13 So our organization program concentrates on ten

14 focus areas and those are listed on this slide and

15 then we have one added focus area for our staff

16 assistant's visits and that is on Organization

17 Safety. Each of these focus areas again is

18 represented by Subject Matter Experts and

19 inspections are conducted using a standardized

20 check list that is grounded in our DoD and Army

21 policy as well. So the next four slides are a

22 review of the results of --

1 GENERAL GREEN: Can I ask you a question?

2 LT. COLONEL SCOTT: Yes, sir.

3 GENERAL GREEN: Just so that we understand

4 as you go through this. So in essence, when they

5 set up the Warrior Transition Command, they

6 segregated out -- I heard the number earlier --

7 4200 cadre? Is that roughly the staff of the

8 Warrior Transition Units? 4200?

9 LT. COLONEL SCOTT: Yes, it is.

10 GENERAL GREEN: And so those 4200 are now a

11 separate command that you are basically walking us

12 through how you basically oversee and do self-

13 inspection and work through

14 this. How is that all funded now? Is that -- were the
4200 positions basically put into programmatics? Is
15 something that is now POMd and now out into the -- for
the next five years, for the next ten years -- can you
16 give us an idea? I mean, clearly you are building
something here that sounds like it is long-term. I am
17 just trying to understand how will it expand and contract
based on what is going on?
18 GENERAL WILLIAMS: Sir, the program is

19 enduring just recently -- so the whole program is

20 enduring a combination of resources. Now, we

21 shift to 13 [Inaudible 0:10:02.2].

22 GENERAL GREEN: And prior 13 is being funded

1 by Army?
2 GENERAL WILLIAMS: Yes, sir. Yes, OCO and
3 DHP in some conversations.
4 GENERAL GREEN: Okay.
5 LT. COLONEL SCOTT: Okay, sir the next four slides
6 outline some of the results in 8 of the 10 focus
7 areas for your review. So this first one is on
8 command control, compliance rate, and our clinical
9 compliance rates overall. What this does is takes
10 an overall picture of all of the standards that
11 were analyzed for that section to come up with a
12 compliance rate and Colonel Mozden is going to go
13 into a little bit more detail after the end of
14 these to show you how that is calculated. So, as
15 you can see from this slide, one of our areas that
16 needs the greatest improvement across the
17 organization as we've already mentioned is that
18 area of Human Resources. We have talked to you
19 about some of the initiatives that we have got in
20 place to be able to address this and that is one
21 of the key pieces of the Organization Inspection
22 Program is that we are able to target in and hone

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1 in on where we need to make improvements and make

2 those

3 targeted immediate program improvements to the system as we go through.

4 GENERAL MOZDEN: I'll cover this slide on transfers and MODS. Remember the earlier discussion about one of the

5 areas of concern for soldiers was transferring -- getting the orders to transfer. With FRAGO 4, this is really

6 targeted primarily toward those reserve component soldiers that are in our program. There is a requirement

7 when their in the WTU that they actually be

8 counciled on the existence of the CBW2, that this

9 program is available to you -- you know, so that

10 they have a knowledge base as they are going into

11 it that there are some other choices.

12 If the CBW2 is not enough option because of their

13 medical needs, is there a W2 that is closer to

14 home for them? Because one of our principals is

15 to allow that soldier to heal as close to home as

16 is feasible. So, we actually have this as an

17 inspectible item on our OIP checklist. When our

18 team goes out they look to see, and they talk to

19 the soldiers and the reserve component soldiers

20 and "Are you aware of this?", "Have you been

21 counciled about this program?", "Are you going to

22 be able to be moving on to this program, if not,

1 do you know why?" The MODS compliance rate --
2 MODS is our large data system -- we have a Warrior
3 Transitional Module within that. We use that data
4 to track -- it is an administrative database. It
5 doesn't have -- it's not a clinical process, but
6 it answers the questions really of kind of who all
7 is there, where are they, why are they there, what
8 is happening with their progress in either moving
9 to a REFRAD, return to duty, or through their
10 board process.
11 MR. REHBEIN: Colonel? One of the questions
12 I would have -- it would certainly help me at
13 least if I knew what the definition of compliance
14 for each one of these areas was
15 so -- I don't know what the compliance rate means if I don't know what constitutes compliance.
16 LT. COLONEL SCOTT: And we have a slide -- a summary slide -- that actually talks through that coming up here
17 in about three slides.
COLONEL MOZDEN: Next slide, we have -- you recalled that
18 we have now incorporated AW2 Advocates within our WTU structure. That was a new addition 18 months ago or so
19 -- and one of the great things about that is the
20 AW2 Advocate, because they are a specialist in all
21 of those non-clinical areas, when they are within
22 that WTU they are able to provide their expertise

1 to the entire team that is working with soldiers.
2 Even if the soldier may not specifically meet the
3 criteria for AW2, the knowledge base -- the
4 expertise that that Advocate has is spread all
5 across the triad. We are working with soldiers
6 both who are AW2 recipients and those who are
7 moving through the program without AW2 support.
8 And then the FRSA of compliance -- this gets to
9 our family issues that we have been talking about
10 -- and we have a requirement -- again it is looked
11 at when we go out on these OIP's -- "Does the unit
12 have a FRSA identified, are they having group
13 meetings, what is the activity level, what is the
14 involvement of the families as a result of that
15 activity?" --
16 LT. COLONEL SCOTT: If I could -- FRSA is Family
17 Readiness Support Assistance --
18 COLONEL MOZDEN: Sorry.
19 LT. COLONEL SCOTT: This person, Ma'am, was
20 directly put into our Warrior Transition Units to
21 be able to help answer that exact question you had
22 earlier. Our FRSA is our mandated to engage a

1 family. They have to have support meetings for
2 the families, provide newsletters, bring the
3 families in to sit down and ask them without
4 their soldiers with them, "What's going on, what can we do for you to be able to help your soldier"? Direct them
5 to the resources that they need to be able to help them get their questions answered while going through this
6 process.
COLONEL MOZDEN: This is our summary look at these areas
7 that we have just been talking about. This gets to how do we decide what is compliant and what isn't compliant.
8 There is a scoring process that is attached to
9 that. The team that goes out has subject matter
10 experts that represent all of these areas. So for
11 example, in HR we have our MEDCOM HR staff out on
12 these visits to sit down with the HR staff in the
13 WTU, and although it is an inspection program,
14 much of what we do while we are out there is of a
15 training nature as well. It is a technical
16 assistance visit. If we identify a particular
17 problem area, they will put their inspection
18 process on hold and really dive into more of a
19 training mode, if you will -- to fix while they
20 are on the ground -- issues that have been
21 identified while they are there.
22 DR. TURNER: Could you go through what some of the

1 criteria are for HR for example? Like, what is 75
2 percent for HR?
3 LT. COLONEL SCOTT: I've actually got -- I'm
4 sorry.
5 COLONEL MOZDEN: No, go ahead.
6 LT. COLONEL SCOTT: I've actually -- in the
7 clinical presentation that we are going to give
8 you after the SFAC, I've got a sample from the
9 clinical OIP checklist that will show you the
10 standard, the reference that we use to develop
11 that standard, and that they are measured against,
12 and then it shows you the scoring blocks on that,
13 if that will help. And we can provide you the OIP
14 checklist themselves for HR and all of the other
15 sections as well.
16 COLONEL MOZDEN: The items that are on the checklist are all based on the guidance and the requirements that were
17 put to the field as they implement the program. The FRAGO's, the [Inaudible 0:17:21.4], and that sort of
18 thing. To answer your question about HR, the kinds of things they look at are orders; they look at promotions,
19 eligibility for promotions. They look at transfer orders; they look at MODS to see if that MODS database is
20 accurate. So, they really look at the entire
21 realm of HR support that should be being provided
22 to that soldier.

1 MS. DAILEY: Other big ticket areas in your
2 HR include timeliness of TDY payments, their
3 financial -- are they still -- if they have just
4 come off the battle field, are they still getting
5 their battlefield pays? There are a number of
6 areas in the HR that are the hot button issues for
7 service members.
8 DR. TURNER: SGLI?
9 COLONEL MOZDEN: Yes.
10 MS. DAILEY: Another good one -- SGLI
11 payments, the catastrophic SGLI payments.
12 COLONEL MOZDEN: Really if you think in
13 terms of this is an Army unit, so that HR person
14 in that Army unit is responsible to make sure all
15 of the appropriate Army HR functions are being met
16 and then with the addition of some of the
17 specialty things that are unique to the WT.
18 DR. TURNER: In the WTU, how many people
19 work in HR?
20 COLONEL MOZDEN: In the WTU?
21 DR. TURNER: Yes.
22 COLONEL MOZDEN: We have -- that has a ratio

1 -- just as our squad leaders and our case managers
2 have, and it is a 1 to 50 ratio, currently. And
3 we can't tell that HR is a very -- that is an
4 intensive part of the work that is done within a
5 WTU.
6 DR. TURNER: Do you have manning fill
7 problems in HR?
8 COLONEL MOZDEN: Yes. Well, manning fill is also
continuity. You know, folks move in and move out, right?
9 They come in and we get them trained up and they say "Oh
this is really great!" and then they are gone, so then
10 you are doing that train up mode again. We have moved to
civilian hoping to enhance that continuity piece.
11 Doesn't always work, because you know if there are other
opportunities on the installation -- people take those.
12 So that was -- as with other positions -- it is a
13 challenge, certainly.
14 DR. TURNER: In your command, you've
15 mentioned 4200 people. Is that the total you
16 require or is that how many you have? If that is
17 just how many you have, what percentage is that of
18 what you require? Are you like 90 percent manned
19 or 80 percent manned --?
20 COLONEL MOZDEN: I can't answer that, if
21 someone here can -- I can answer for nurses. I
22 know we are in great shape there. I think we are

1 good in terms of personnel, or fill. But I don't
2 want to speak to that because I don't know the
3 exact answer for you but we will get it for you,
4 certainly. No problem. MS. CROCKETT-JONES: I
5 have a question about the FSRA performance rates.
6 Is that assessment basically done by interviewing
7 the personnel who are responsible for providing
8 the FRSA programs or support? or is that done by
9 assessing family response or something like that?
10 How is that performance rated? By population of
11 families that take part, or by --
12 LT. COLONEL SCOTT: We actually conduct that
13 assessment using multiple modalities. We have a
14 standardized checklist where we are looking for
15 specific standards to be met, but we also bring in
16 as part of our OIP's -- we call the unit in
17 advance and tell them -- direct them to ask family
18 members, a representative of family members to
19 come in -- and we talk directly with the family members
and ask them about the support that they are receiving,
20 and ask them whether or not their needs are being met and
also ask them what else needs to be done to be able to
21 make improvements to the family support.
But then we also inspect to make sure, "Are they
22 publishing a newsletter as they were directed to do, are
they reaching out to families, are families being

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1 included in scrimmages, have families been invited
2 to participate in warrior activities with them?"
3 So we are looking at it from both directions on
4 that one.
5 COLONEL MOZDEN: This is just another way of
6 looking at that summary slide. Using that bar
7 graph again, you can see our areas of challenge.
8 LT. COLONEL SCOTT: This is the same information
9 presented in a little bit of a different format by
10 compliance -- overall compliance rate by Warrior
11 Transition Unit. So, we are using this slide to
12 bring you back to the MEDCOM best practice
13 process. So the fifth step in the MEDCOM process
14 is to decide and resource those best practices.
15 So, Warrior Transition Command is a business
16 process owner, briefs medical command leaders, and
17 the MEDCOM leaderships decide on that resourcing.
18 As you can see from the overall performance rates
19 that are listed on this slide, there are
20 opportunities for identification of best practices
21 at several of our Warrior Transition Units who
22 have performed exceptionally well in specific

1 areas and then through the overall program as
2 well. So, we are looking at it from both
3 perspectives as we look at that in that process.
4 Then the sixth through the eighth steps in the
5 best practice transfer process are establishing a
6 transfer plan, publishing that action plan and
7 then executing the
8 initiative, and then finally, monitoring the best practice transfer. As potential best practices are
9 identified, we communicate those to the leadership team for analysis, and then we communicate those to our
10 Warrior Transition Units through General Williams' monthly commander video teleconferences, the knowledge
11 management websites that our STRATCOM and G6 personnel have established. We have a monthly dispatch
12 communication system to be able to articulate any
13 new changes to our Warrior Transition Unit's
14 there, and then we have our routine training
15 conferences as well, as examples of that knowledge
16 transfer process. I'd like to illustrate this with
17 a great example of this process in action. This
18 also goes back to our concerns over pain and over
19 management of multiple medications with our
20 warriors in transition. One of our best practices
21 is putting a dedicated pharmacist with each of our
22 Warrior Transition Unit activities. This practice

1 was actually identified during an initial review
2 of commendable practices during an Organization
3 Inspection Program. We then communicated that
4 information to that other Warrior Transition Units
5 and said hey this is a potential best practice and
6 definitely a commendable idea. Indeed, our other
7 Warrior Transition Units validated that this was
8 indeed a best practice. The date was also
9 validated by our pain taskforce in their review of
10 practices that improved care in Warrior Transition
11 Unit's around the country. The pain task force
12 looked at measurable data to look at the impact of
13 putting a dedicated pharmacist with our Warrior
14 Transition Units.
15 DR. GUICE: Excuse me, could you just
16 articulate what those data points were?
17 LT. COLONEL SCOTT: Ma'am I would have to
18 get back to you with that information from COLONEL
19 GALLOWAY and the pain
20 task force.
DR. GUICE: Okay. Thank you.
21 DR. TURNER: What does dedicated pharmacist mean?
LT. COLONEL SCOTT: There is one pharmacist that is
22 solely responsible for managing the needs of that Warrior
Transition Unit population. As an example, the

1 Walter-Reid Warrior Transition Unit has hired a specific pharmacist that is embedded in the staff and works only
2 with Warriors in Transition.

3 DR. TURNER: It is a manning add?

4 LT. COLONEL SCOTT: It is a manning add.

5 COLONEL MOZDEN: Now that is somewhat

6 dependent on the size of the location. So for

7 example, we were just out at Ft. Huachuca. We

8 have a very small WT population so financially it

9 wouldn't make sense to hire a pharmacist for that

10 small population. But this is an asset of the

11 MTF, and so the MTF dedicates one of their

12 pharmacists to be the specific pharmacy consultant

13 person for the WT's. So that when we are in

14 transition process, and we are going through all

15 of the people that first three days of assessment

16 -- which we were discussing earlier -- one of the

17 people he actually sits down with is a pharmacist.

18 "Let's take a look at your meds -- they do some

19 education right there, and then they establish

20 that link with the soldier. On a regular basis

21 they are doing medication reconciliation for that

22 soldier.

1 DR. TURNER: So the manning add is for the
2 facility and not for the medical treatment
3 facility?
4 COLONEL MOZDEN: If we go back to the
5 initial slides that Colonel Mozden briefed, our
6 Warrior Transition Units -- our part of that
7 medical treatment facility, and part of that
8 larger TDA for that medical treatment facility.
9 DR. PHILLIPS: Are they available after
10 hours and on weekends?
11 COLONEL MOZDEN: The pharmacists?
DR. PHILLIPS: Yes.
12 COLONEL MOZDEN: I don't know the answer to that. I
would think through the offices of the hospital because
13 that -- we still have that connection with the MTF 24/7
-- that they would be able to do that.
14 DR. GUICE: Yes, sir?
MASTER SEARGENT MACKENZIE: I'm sorry I -- this is just
15 overall -- on these best practices that you
16 referred to, is there a follow-up evaluation on
17 compliance with taking on these best practices? I
18 mean, is it just "Hey, this is a great idea", or
19 is it "Hey, this is what you are going to do now"?
20 LT. COLONEL SCOTT: To get back to where I
21 was going with that -- and I'm very glad I had a
22 script of notes here to be able to take you back

1 to that -- the MEDCOM pain campaign task-force --
2 one of the specified tasks in the op-order for the
3 pain campaign task-force is the dedicated
4 pharmacist for our Warrior Transition Unit
5 population. So, to be able to take that back --
6 so that is now a task that each of our MTF
7 Commanders has to analyze and resource and is one
8 of the pieces that we will look for for compliance
9 with that op-order as we go through that for pain
10 campaign. Question? MS. CROCKETT-JONES: The
11 slide you had with the FY10WT Performance Rates --
12 this shows 17 units out of the 29. Is that
13 correct? And is this review done across the
14 board, all 29 plus 9?
15 COLONEL MOZDEN: Yes, we do visit all of the
16 units but we try to get to everybody at least
17 every two years -- MS. CROCKETT-JONES: Okay.
18 COLONEL MOZDEN: -- because we've got that
19 one team that is going out every other week --
20 that's what they are doing. They are on the road
21 visiting the units, and they
22 are either doing a SAV -- that's Staff Assistance Visit,
or they are doing and OIP depending on where their unit

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1 is within their command time. But we do see all of the units in the CPWTU's.
2 DR. GUICE: I had one more question. I'm looking at the -- your best practice where you have got Ft. Bliss and
3 the pharmacist -- and I certainly understand that you will give us the information, but I am cross-walking that
4 back to a previous slide which is the Warrior
5 Transition Unit Survey on Pain Management, and I
6 don't see Bliss listed on that. Is that because
7 the survey wasn't done at Bliss or it just didn't
8 get put on here? Because one would predict that
9 if that was a best practice then that would have
10 reflected somehow on this nice slide, and I just
11 don't see Bliss as a single note.
12 COLONEL MOZDEN: We will take that back to
13 Dr. Gliner. I'm not sure. And we have at this
14 point -- have pharmacists in all of our W2
15 locations, not just at that particular location.
16 DR. GUICE: Because if it really does -- and
17 you say you are data-driven to identify best
18 practices, one would presume that having that
19 resource there that has been there probably the
20 longest, that that would have some sort of impact
21 on the data that you are collecting regarding pain
22 management --

1 COLONEL MOZDEN: We'll look at it.

2 DR. GUICE: -- either neutral or whatever.

3 COLONEL MOZDEN: Right.

4 DR. COAKLEY: I have a question. Are the

5 pharmacists given standardized training? For

6 instance, you have the add of manning at the one

7 facility and then the pharmacist at Ft. Huachuca.

8 Is that like a clad of duty or do they actually go

9 through some formal training for that to be a

10 dedicated asset?

11 COLONEL MOZDEN: The pharmacy consultants for OTES-G,
Colonel Labadie, works with the pharmacists that are
12 involved with the WTU's and actually remember we were
talking about our annual conference? They are adding a
13 dedicated pharmacy track for WTU pharmacists at our
meeting this year. So, we hope to keep that asset
14 because I will tell you it has been a wonderful addition
to the group.
15 This is a bit of a laundry list if you will.

16 These are items that have been identified by the

17 OIP teams when they have been out visiting. Some

18 of these items are just the team felt that "Okay,

19 it is a requirement but you know they are doing it

20 really well here", and some others are areas where

21 we will consider this as a potential best practice

22 but it needs to be vetted through the process that

1 Colonel Scott has been talking about and will
2 continue to discuss here with you. But this just
3 gives you an idea of some of the kinds of things
4 that we have found. For example, some of the
5 things we try to act on right away -- 1) Ft.
6 Campbell, that HR Accountability database. That's
7 where are MEDCOM HR staff will get right on that.
8 They say "this is a best practice, we need to get
9 that out to our HR staff across the enterprise in
10 the WTU's", and they will put that on their
11 website and they will talk about that on their
12 teleconferences. The -- Yes, sir?
13 GENERAL WILLIAMS: Going to the Master
14 Sergeant's point and your point earlier -- so what
15 do you do with all of this stuff? You are going
16 on -- you are finding a lot of stuff, so what?
17 This is part of the synchronization drill. And
18 the reason why we have got artillery members
19 besides the fact that we don't hear very well, we
20 are also anal. So, it is a synchronization of a
21 bunch of different data tools -- this is one of
22 them. This is --

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1 what this represents Sir Ma'am is WTC looking at
themselves. We've done a pretty good job of that. I
2 asked the question months ago, "So what"? What do we do
with all of this? And as Cathy just talked about, on the
3 low end it is a -- Williams sends out to all of the
commanders in a monthly VTC. They high end is a DAX
4 order, as was talked about. "This is what you will do"
with the Army leadership and although I work for the
5 Surgeon General, I have a bee line to the Vice.

6 So, when the Vice is sitting next to you and

7 talking to all of the Senior Mission Commanders in

8 the field and saying "You know, Williams has been

9 out here looking at this stuff and I think it is

10 pretty important too" so he kind of raises his

11 fist and this happened. So yes, the full

12 continuum of action. What I bring to the

13 organization is action. What are we going to do

14 with this stuff? So we have got people

15 identifying best practices, we have got people

16 probing us and poking us, okay. Those are all

17 good. So let's take all of the diagrams and

18 superimpose them on it, and look at the three or

19 four things -- and my early read tells me is what

20 I told you earlier -- cadre training, education,

21 and jobs. And so as we continue to move on on

22 this, I think we will continue to see ourselves

1 better and this will be a -- so this is a very,
2 very powerful tool that I don't think we have
3 really -- I just told you the whole continuum of
4 how we get after the action piece of that. So my
5 organization now will have -- when they come back
6 and talk to me, they are going to show me best
7 practices, and then they are going to show me the
8 action plan with a sync matrix associated with it
9 -- how we get after it.
10 GENERAL GREEN: The point we are struggling
11 with a little bit is that the very first best
12 practice you show us was at Ft. Bliss. Ft. Bliss
13 is not on any of your slides in
14 terms of their compliance rates. Are we missing
something? I mean, we went back through all of your
15 slides and Ft. Bliss is not listed anywhere, so how do I
know that that is a best practice if there is nothing in
16 any of the data that says that they were --
LT. COLONEL SCOTT: What we gave you is a representative
17 sample of the last quarter's OIP visits and that is why
you only see six facilities represented there. The best
18 practice -- identified best practices that are
19 listed on the next couple of slides have actually
20 been from fiscal year 10 and 11 visits. So, we
21 just gave you a snapshot of -- and did not give
22 you the entire picture. We can certainly provide

1 you that added data.

2 GENERAL GREEN: I think that what we are

3 looking for is for you to tell us how you identify

4 it as a best practice, so we would expect to see

5 data showing that something that you were

6 measuring was better at that facility. If you

7 could help us with that, okay?

8 LT. COLONEL SCOTT: Right. Okay.

9 GENERAL GREEN: Okay.

10 COLONEL MOZDEN: Best practices within the

11 AW2 program? They are working to -- Colonel

12 Gadson, did you want to speak to any of that or do

13 you want me to just cover that?

14 COLONEL GADSON: You can do it, just make

15 sure you cover the highlights.

16 COLONEL MOZDEN: Sure. Okay. So, a few

17 things just to highlight with AW2 -- they are

18 working on performance measures -- full assessing,

19 monitoring, and implementing their program

20 improvement techniques. They have a new hire

21 orientation, and one of the things that I think is

22 really great because I like to see this in any

1 kind of training is when you are using actual case

2 examples when you are training people -- the real

3 life experiences of

4 those Advocates to share with the new folks that are coming on board. Then their monthly development, their

5 AW2 newsletter, and so-forth -- to really continue -- because remember the Advocates are not all sitting in one

6 place, one location where they can have training. Our Advocates are across the country. Many of them are

7 working on their own in remote locations, and so they have developed some creative ways to keep in touch with

8 them, keep their training up, and making sure that

9 they are getting the updates that the need to keep

10 abreast of all of the new resources that are out

11 there for soldiers.

12 COLONEL GADSON: Cathy, I would just add

13 that our C2 or Commander Consultant is -- I can

14 say it is a little bit more of a challenge but we

15 try to -- through our regional supervisors and our

16 Southeast division supervisors that work for my

17 branch here, so parts of [Inaudible 36.58.6]. We

18 are organizing the full regions currently. We are

19 looking at in the future, potentially adding two

20 additional regions just because the density of the

21 Advocates to the regional supervisors is

22 continuing to grow and I think we might look at

1 some expansion in the Southeast division, as you
2 might imagine. Our largest population is in the
3 Southeast reflective to the service population and
4 the Southeast and Southwest where most of our
5 service members come into the service. We
6 communicate through the regional supervisors,
7 continuing to share best practices. As Cathy
8 said, we use case examples and so I think it is a
9 two way street in terms of how we are able to
10 share information. Now, what I think we can do
11 better -- what I would like us to be able to do
12 better is to have more contact with our Advocates
13 from our supervisors. I think we are -- it's
14 tough. I mean, out West -- my West regional
15 commander is in Denver and he has got folks in
California, Alaska, Hawaii, Montana, all over the
16 country. And so he wouldn't be able to do his job if he
had to travel to see all of those. So, some of our
17 Advocates get very little contact with our leadership,
and so that is -- I don't want to say it is a weakness
18 but it is certainly a challenge. We are looking at ways
to do better there.
19 GENERAL WILLIAMS: And ma'am, I just want to
20 make sure I don't walk away from your point
21 earlier about the best practices. What you saw
22 presented was an example. It wasn't all of the

1 best practices, it was a snapshot. What we will do
2 is we will walk back so that you have -- we have a
3 parallax issue here. We are looking at data and
4 it doesn't show -- we don't see the audit trail.
5 We can go back and show you that audit trail from
6 that best practice. I want to make sure I don't
7 walk away from you on that. Ma'am?
8 DR. GUICE: I was just going to ask Colonel
9 Gadson to kind of tell us how the AW2's relate
10 back to the WTU's and how that is kind of
11 coordinated, because your people are not just in
12 WTU's but you are spread across in other
13 facilities as well. Then, how does that
14 information get transmitted from the WTU people
15 where you do have some AW2's but not a hundred
16 percent, and then promulgated throughout the field
17 so that the pitchers and catchers know what is
18 going on?
19 DR. GADSON: Right. Out of our -- these are rough
20 numbers but we have about 170 Advocates, 168 I
21 think. About 46 of them or so reside in WTU's, and
22 so the soldiers that are in the WTU's that meet

1 the AW2 criteria, that is essentially what they

2 are there for is to assist that population and

3 they do continue to assist other populations as an

4 exception because they are

5 valuable assets, but we focus on the AW2 population. When they are able to learn, or there is some point of

6 emphasis that we share our lessons in our monthly supervisor or conference calls -- those issues can come

7 up. So, when the regional supervisor identifies something, he or she can bring that up to the Advocates

8 supervisor and we then as a leadership can make the decision to disseminate that lesson. And again, through

9 our web, through our Advocate newsletter, and

10 ultimately if we think it is something that we

11 need institutionalize, we can infuse it into our

12 new hire Advocate training as well as our annual

13 training that we do. [GENERAL WILLIAMS whispers to

14 DR. GADSON] Right, our makeup of Advocates -- over

15 100 of them actually are contractors either

16 through primarily the Circle contract, but we also

17 have some provided to us through the Man contract.

18 The remaining numbers of those Advocates are also

19 our general government workers.

20 DR. TURNER: This is more just a request for

21 information unless you know this off the top of

22 your head. Of your 4200 people, if you could

1 maybe give me the -- what is your percent manning?
2 What is your requirement versus what you are
3 manned at? And of that, based on what you just
4 said -- could you give me the breakdown of GS
5 contract and active duty folks, and of those
6 active duty, what percentage of those are
7 deployable? And like I said if you could just
8 give me a snapshot --
9 DR. GADSON: Okay. We are supporting a
10 population of roughly 8200.
11 DR. TURNER: Yes, sir.
12 DR. GADSON: The Advocates are about 100 or 102
13 contractors and the remaining are general
14 supporters -- or government workers. None of them
15 are active-duty. I
16 don't have any uniform Advocates.
DR. TURNER: No active-duty. Okay.
17 GENERAL WILLIAMS: And sir, you were talking about the
greater end 4200 of cadre. We can get that for you.
18 DR. GADSON: Right. And the second part of your question
-- I don't have any --
19 COLONEL MOZDEN: And just to add to that on Dr. Guice's
question about the follow on information and how
20 information gets transferred -- when that soldier
21 is leaving, he is going to be retiring and moving
22 on to a new Advocate, they work within their WWAS

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1 system for that information transfer. So,
2 regardless of location for that soldier or at this
3 point veteran, they would be able to carry that
4 information forward.
5 DR. GUICE: So the population of WTU
6 participants that are also in AW2 would be?
7 DR. GADSON: Roughly 1000.
8 DR. GUICE: Roughly 1000. So out of 10,000,
9 1000 are AW2's?
10 DR. GADSON: Yes, ma'am.
11 DR. GUICE: Thank you.
12 LT. COLONEL SCOTT: Okay. An additional
13 request for information from you was to discuss
14 our information resources, both from a cadre
15 perspective and from a wounded warrior
16 perspective. The Warrior Transition Program
17 guidance and policy is outlined in the Department
18 of Army orders -- the Deputy Chief of Staff for
19 personnel has developed Warrior Transition Unit
20 consolidated guidance and both MEDCOM and Warrior
21 Transition Unit policies and procedures cover
22 guidance for our Warrior Transition Unit's. This

1 slide again, as well as with our best practices

2 slide and the data there, from our OIP visits --

3 this slide is only a representative sample of this

4 list. It

5 is not all inclusive. Our Warrior Transition program has
these assets available to them electronically with all of
6 the MEDCOM policies and procedures and orders through
AKO. This is just to give you some sense of what is
7 there.
So, in accordance with the Department of the Army
8 Execution Order 118-07, Healing Warriors, that General
Williams mentioned this morning -- each Warrior
9 Transition Unit is responsible for creating their

10 own installation specific handbook for warriors

11 and families.

12 We did not bring you a copy of each of those

13 Warrior

14 Transition handbooks today; however, you should be

15 able to expect to receive a copy of that handbook

16 when you visit each of our Warrior Transition

17 Units and community-based Warrior Transition Units

18 when you go out to conduct your visits.

19 Additionally, every warrior and family member

20 receives an orientation briefing on available

21 resources when they arrive to each -- to the

22 Warrior Transition Unit or community-based Warrior

1 Transition Unit. This briefing includes access to
2 websites, the wounded soldier and family hotline
3 number, and additional resources that are
4 available to them through their community, through
5 the MTF, through the installation where they are
6 residing to be able to ensure that they have
7 tailored resources for their specific community
8 and their specific needs. Hotlines are manned 24/7
9 to be able to respond to warrior and family needs.
10 Cadre members are also oriented to the resources
11 available to warriors and family members and they
12 receive a specific block of instruction at the
13 cadre orientation course on the National Resource
14 Directory and on Military One source during that
15 course. Additionally, as we mentioned previously,
16 any updates to resources that are available are
17 provided to our cadre members through
18 multiple venues as we continue to talk to you about throughout the day.
19 We additional have an Ombudsman Program. Our 61 ombudsman serve as intermediaries to address our soldiers
20 and family member's needs. What they do is they cultivate and sustain those positive relationships with
21 the military treatment facility leadership, the installation, the Warrior Transition Unit staff -- all in
22 order to be able to affect resolution to soldier

1 problems. There is a Department of Labor Liaison
2 assigned to our Warrior Transition Command and he
3 works directly with our staff to be able to
4 identify ways to inform warriors and families of
5 employment opportunities.
6 Then in a few moments, Mr. Watson is going to
7 talk to
8 you about the successes of our Soldier/Family
9 Assistance Center and the details of that program
10 as well.
11 COLONEL MOZDEN: And this again a partial
12 listing, but these are some of the AW2 resources
13 that are available to their advocates to use as
14 they are working with their soldiers and family
15 members. As you will see, they have a great
16 expertise in all of those non-clinical areas of
17 supporting the family and the soldier. And this
18 is where, again, if we wanted to add to this list
19 -- this partial list -- this would be where our
20 discussion earlier about the CAP program, again,
21 certainly something that the Advocates and the
22 WTU's are aware of and access. In particular, one

1 of the areas where the Advocates have been very
2 helpful is in working with the soldiers and
3 families on adaptive housing and also in the
4 vehicle lieu, with the Vehicle Assistance Program.
5 But you will see here that it is a very extensive
6 list of the resources that they work with and
7 bring to bear for their soldiers.
8 This is just our summary slide. We are wrapping up. I hope that you have a pretty good understanding now of our
9 program -- kind of across the board -- the things that we are trying to accomplish. Clearly, we are not done. We
10 are still developing. We are working continuously to improve our processes, improve our programs, bring the
11 information back that we get from the field or from our inspection visits and better our program as we move on.
12 Pending any additional questions -- Ma'am, Sir?
13 DR. GUICE: Did you get the answer to your
14 question about compliance, Mr. Rehbein?
15 MR. REHBEIN: I think so. I think I got as
16 much answer as you can give me today without
17 getting into a long detail of list.
18 DR. GUICE: Okay, great. Well then we are
19 going to -- sorry, go ahead?
20 MASTER SERGEANT MACKENZIE: One of the
21 questions I had is as the soldiers travel from
22 medical facility to medical facility -- you know

1 we talk about these best practices -- is there a
2 resource for family members in the service to go
3 "Hey, they are doing this over here, why aren't we
4 doing this here?" -- You know, is there some kind
5 of -- where they identify? It's not just you as
6 the staff or the staff at the WTU's but sometimes
7 it is the family members and the service members
8 that come up with these best practice ideas. Is
9 there -- I didn't see anywhere -- maybe I just
10 missed it. Is there a resource for them to import
11 into this system, or is it only on your visits
12 that you identify this stuff?
13 COLONEL MOZDEN: We certainly hear about it
14 but I am not aware of a formal mechanism for doing
15 that.
16 LT. COLONEL SCOTT: If I understand your question
17 correctly, you are asking is there a mechanism --
18 GENERAL WILLIAMS: Feedback.
19 MASTER SERGEANT MACKENZIE: It is that feedback, because
you know some of these guys are -- they are alert and in
20 tune, and they may be treated at Launch Tube and then
they are going to Walter Reid, and then they are going to
21 Ft. Bragg -- then they are going out to CBWTU, and they
are going to touch with all of these different things.
22 Is there a way for them to feed back into the system to
help you accelerate that process of getting these best

1 practices out there?

2 LT. COLONEL SCOTT: Absolutely, we have

3 multiple venues and mechanisms for family members

4 and soldiers to be able to input into the system

5 through our Integrated Customer Response System,

6 ICE, which they can access electronically. Each

7 of our medical treatment facilities also has

8 customer feedback surveys, manually, to be able to

9 provide that feedback. We also have routine town

10 halls and forums for our soldiers and family

11 members to talk directly with commanders on that

12 installation, to be able to talk face to face so

13 that there is no one specific mechanism, but a

14 multiple of venues where that feedback is input

15 and then fed up to the MTF, to the region, to

16 Warrior Transition Command to be able to make

17 those improvements and communicate those across

18 the system. Yes, sir?

19 DR. PHILLIPS: I have some cadre questions,

20 if I may. How is the orientation course for the

21 cadre's put together? Who puts that together and

22 how often is that reviewed?

1 LT. COLONEL SCOTT: Our AMID Center and School has
2 responsibility for developing and executing our
3 Cadre training program. They develop that program
4 through direct feedback and input from Warrior
5 Transition Command as to what needs to be executed
6 and how that training needs to be run. Our
7 Warrior Transition Command G3
8 receives guidance from General Williams who then provides that to the course. It is -- as we find areas that need
9 to be added and improved to the program -- those are immediately added to the program.
10 GENERAL WILLIAMS: Yes, so credential by Major General Rubenstein, on behalf of the Surgeon General, that's who
11 credentials the course. So -- go ahead sir, and then I'll follow.
12 DR. PHILLIPS: I was just going to ask are
13 they cadre evaluated, I mean, can they fail the
14 course? Is that --
15 GENERAL WILLIAMS: Yes. Yes, they can sir,
16 and that is the kind of rigor talked about earlier
17 -- I'm trying to put into the course and make it
18 more of a credentialing course. I am the third
19 Warrior Transition Bubba. Major General Tucker
20 was the first one. Gary Cheek was the second. I
21 am the third. So, Mike Tucker, Major General
22 Tucker started the process and said "we need to

1 have a formal process where we can credential the
2 cadre members". And so it began, and many of the
3 folks standing up there helped do that -- put that
4 together. It is pretty good. But, I am a trainer
5 too and as I looked at we needed to raise the bar
6 a little bit. So, I just met with General
7 Rubenstein -- that was one of my first visits. I
8 said "Sir, I am coming to you with a bunch of
9 stuff here that I think needs to be in the sauce".
10 It is a pretty good product but we need to
11 continue to adapt back to your point earlier,
12 ma'am, "how do you get the latest and greatest",
13 the senior base sort of stuff. You know, I said
14 to one of the courses "This is just PowerPoint".
15 It has got to be something interactive, it has got
16 to be scenario based. If you look at some of the
17 CD's that they are using now, it is real soldier
18 -- using real soldier language. I was blown away
19 actually by some of the things we have done in
20 such
21 a short time I have been here. So, we are going the right way on that.
22 DR. PHILLIPS: Do you think this will ever lead to say a secondary MOS for a cadre?

1 GENERAL WILLIAMS: Yes, that is kind of getting back to
what General Horst was saying. Do you do a special,
2 additional skill identifier associated with them? -- and
they do get that, but the incentivization and the
3 recognition of these cadres -- we can do a better
4 job of that. I was talking to my Major earlier
5 and I misspoke earlier -- actually the
6 instructions to the board have already been done,
7 what General Horst was talking about earlier. We
8 are already moving along that way to make a big
9 deal out of it. So the real "so what" of that sir
10 -- you know, to a two-star who sits on this board
11 with these other Sergeants in the room and the
12 other Colonels, recognize that and make it so it
13 is just a thing. It is just a PowerPoint. They
14 have to actively take this and say "Okay, I am
15 going on this board, I understand what a Drill
16 Sergeant does, and I understand that is an
17 important job -- but here is another important job
18 and it is on the same level of exertion and
19 strength having knowing little about the training
20 base done in our various training centers -- it is
21 on par with that level of effort. And oh by the
22 way, these Sergeants are sometimes younger than a

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1 Staff Sergeant, Sergeant 1st class, who is doing
2 this. This is an E5 who was a year ago shooting
3 tank rounds down range and now is asked to be this
4 buddy/wing man/shipmate of someone going through
5 this process. So, I am taking that extremely,
6 extremely important -- of high importance for the
7 program.
8 DR. PHILLIPS: Thank you.
9 GENERAL WILLIAMS: Sure.
10 GENERAL STONE: Could you spend some time
11 reviewing with
12 us the unique challenges of community-based health care
delivery? And when I say that -- your community-based
13 WTU's are mainly using the Tri-Care delivery network.
Most of those providers are not in the information
14 technology systems that are unique to our MTF's and our
VA system. How do you assure data capture? How do you
15 assure that your pharmacy reviewer is able to capture the
data on medication usage to provide an equal standard of
16 care across the delivery system?
17 COLONEL MOZDEN: The cadres that work with
18 the CBW2's have some very unique challenges.
19 Clearly the nurse case management is intensive.
20 Not only are they looking in the community,
21 identifying a provider, finding a provider that
22 will work with Tri-care and so on, and then they

1 have to also get the records back to make sure
2 that we have got that information and the clinical
3 information back for our folks to review to be
4 able to move forward. They physician has those
5 same responsibilities that the PCM has on the
6 installation, working with soldiers where they can
7 just go right across the street and have that
8 consult at the MTF instead of having to do that
9 through the community. So, it certainly is more
10 challenge in different kinds of ways for those
11 soldiers that are being seen by Tri-care
12 providers. We do have a certain percentage of
13 soldiers based on where they live who will be
14 enrolled prime to a sister service facility. For
15 example, soldiers who are living near the Navy
16 facilities down in Norfolk and so on, and a lot of
17 work has gone into developing those relationships
18 with those providers at the sister services to
19 make sure that we are getting a good flow of
20 information and working with them just as we are
21 with the network providers out in the community.
22 The soldier that is on a sole provider, say for

1 example,

2 that pharmacy review. We are concerned about him out in the community -- we are able to do that because of the
3 electronic capabilities that we now have utilizing PMART and some of the other tools where we can reach out and
4 find out if he is using his Tri-care benefit. It doesn't matter where he is using it, we are able to identify that
5 pharmacy and work with the soldier. They all get counciled -- "this is how it works while you are in the
6 program, here's where you need to get your

7 medications, and so on".

8 DR. TURNER: Just to follow-up on that,

9 first of all I want to commend you guys on this

10 briefing and trying to dance around an immense

11 amount of information in a very short period of

12 time. I know it was very difficult, and I

13 appreciate your effort on that. Just maybe this

14 will help me understand who is responsible for

15 what. If I were to go to say Ft. Stewart, so I go

16 to Ft. Stewart and I go to the WTU there. What is

17 the manning of what kind of people are at the --

18 how many are cadre, how many are nurses, how many

19 are Human Relations? What is the typical manning

20 -- and again, I am just picking this out of the

21 air -- if I go to Ft. Stewart, I walk into the

22 WTU, who is going to -- what smiling faces am I

1 going to see?

2 COLONEL MOZDEN: All smiling, sir, all smiling.

3 [Laughter]

4 DR. TURNER: I am sure they are. I am sure

5 they are. So if you would just kind of give me a

6 break down of what are the people I am going to

7 meet -- are they GS civilian cadre? And what do

8 they do?

9 COLONEL MOZDEN: So typical WTU, knowing

10 there is no typical, is based on a company

11 structure so they would be supporting about 200

12 WT's. So when that soldier comes in to the WTU,

13 he is in processing. His first stop,

14 hopefully, is always with the HR folks.
DR. TURNER: Those are GS?
15 COLONEL MOZDEN: Those are normally GS civilian
personnel, correct. Now, he will also be meeting with
16 his squad --
DR. TURNER: With a 1 to 50 ratio?
17 COLONEL MOZDEN: Yes. He will now also be meeting with
his C2 folks, his commander, his 1st sergeant, his squad
18 leader, who is going to be his wingman/best buddy.

19 And in turn there is a platoon sergeant working

20 -- and they are green suit folks.

21 DR. TURNER: Right. They are cadre.

22 COLONEL MOZDEN: And that cadre, by the way,

1 is a mix. We have a mix of active component
2 soldiers. We also have a good number of reserve
3 component, mobilized, guard reserve folks that are
4 working as cadre within our units and in our
5 command slots. So, we have a mix. This is a --
6 you know, when you look at our population about
7 half of our soldiers are reserve component.
8 DR. TURNER: So I walk in, I have got all my
9 friends here from my unit with me, and then who
10 else do I see?
11 COLONEL MOZDEN: Okay, so you are going to
12 see those folks. You are also going to see your
13 Nurse Case Manager. DR. TURNER: GS?
14 COLONEL MOZDEN: A mix. We have both green
15 suit and civilian Nurse Case Managers. Within the
16 green suit we have some that are active component
17 nurses and we have some that are mobilized
18 reserve.
19 DR. TURNER: No civilians?
20 COLONEL MOZDEN: Yes. About half of them
21 are civilians and the other half are what we would
22 call "green suit" and a mixed combo.

1 GENERAL WILLIAMS: Sir, we can give you that.

2 DR. TURNER: That is fine. That is fine.
COLONEL MOZDEN: Then they would also see of course,
3 Behavioral Health is a very important part of our
program, and so we do have dedicated licensed social
4 workers who work with that soldier immediately -- and we
can provide you all kinds of detail -- but they are doing
5 a risk assessment right off the bat of you know working
with the soldier and his family. So it is a mix of
6 military folks and civilians that are working with

7 that soldier both on his admin issues and then

8 also on his clinical issues.

9 DR. TURNER: So nurse, behavioral health,

10 and admin people?

11 COLONEL MOZDEN: Social worker and also, of

12 course, the physician - PCM. And our PCM's for

13 the most part are civilian. They might be retired

14 military, but they are civilian providers.

15 DR. TURNER: If you need someone in Bavaria, I am

16 available. [Laughter]

17 COLONEL MOZDEN: Okay, we will make not of that.

18 DR. GADSON: Thank you. In a WTU, they have AW2

19 Advocates too so if he doesn't -- if he was

20 transferring from a major medical facility such as

21 [1:02:46.5], we would have someone do a battery on

22 him so if he was going from one advocate to

1 another, if he was someone who wasn't in the
2 program but may have had a recent medical
3 adjudication that would make him eligible for the
4 program then it would be screened and we would
5 pick him up in the program.
6 DR. TURNER: Screened by who?
7 DR. GADSON: The advocate, the chain of
8 command in the advocate.
9 DR. TURNER: Thank you very much.
10 DR. GADSON: You bet.
DR. GUICE: Any other question? I have -- go ahead. I
11 have one last one before we break.
MASTER SERGEANT MACKENZIE: One thing I wanted to ask
12 maybe for you, General, or your staff. I mean, we are
all working in a joint environment so I would be remiss
13 if I didn't ask this question. With this training
program that you all are coming up with and are currently
14 revamping and making even better and better and
15 better, are there opportunities for other
16 personnel to attend this training in order to
17 facilitate better care of their individuals who
18 may not be in the Warrior Transition Unit based on
19 the nature of their job?
20 COLONEL MOZDEN: Well currently we run this
21 course every six weeks, and with the requirements
22 that we have for maintaining our new cadre coming

1 in, our slots are pretty routinely filled.
2 However, we have had -- I believe we have had or
3 have we just talked about some of the Nurse Case
4 Managers?
5 LT. COLONEL SCOTT: We did.
6 COLONEL MOZDEN: Yes. Particularly those that are
7 working, for example, at BAMC where we have got
8 multiple level service members. We have had those
9 folks that have come through, but at this time we
10 have not opened it to anybody else in the other
11 services. But it certainly is a model. Now, and
12 the other is that we have the online pieces, of
13 course, are the same across all services. So, for
14 example, with MHS Learn community for our Nurse
15 Case Managers, it doesn't matter if they are Air
16 Force, Navy, or Army, they would be taking those
17 same courses.
18 MASTER SERGEANT MACKENZIE: I guess that is
19 what I was getting at. Is there an application
20 process or somebody to contact to say "Hey, I need
21 to get my folks authorized on some of this level
22 training"? Because MHS Learn is

1 all about -- which if you are authorized to access
certain modules, can you get that training? Is there a
2 means to do that?
GENERAL WILLIAMS: Yes, I would say -- thanks Cathy. So
3 currently two weeks -- I am talking about the two weeks I
am trying to add on to it -- clearly, those last two
4 weeks when I was in my last job. That is exactly the
model I was going to. I said "If I was Admiral Mullin, I
5 would want this comprehensive soldier fitness
6 resilience piece, because it is generalizable and
7 super ordinate to any color of cloth. And so, the
8 first two weeks I am still learning a lot about --
9 that is kind of the block and tackling of being an
10 Army Sergeant in a WTU. But the model that I am
11 going to go to, clearly those last two weeks would
12 be something that would be very appealing I think
13 to any service member. So, I don't know about the
14 first two weeks. We would have to take a look at
15 it. And I will lastly say as a commander, it
16 makes sense to me. Why wouldn't we have a
17 generalized model that would be a -- cut across
18 all services? Let me do some more thinking on it.
19 That is a great question though Master, great
20 question.
21 MR. REHBEIN: The ombudsman. A couple of
22 questions -- active duty, civilians, GS? Who do

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1 they report to? But more importantly we talk
2 about identifying best practices. Quite often it
3 is that ombudsman that can help you identify worst
4 practices.
5 LT. COLONEL SCOTT: They do.
6 MR. REHBEIN: How is what they know fed back
7 into the system?
8 LT. COLONEL SCOTT: Our ombudsman are generally a
9 combination of GS and contractors, and they are
10 reporting -- the report to that installation
11 commander for that feedback and have a direct
12 liaison and direct
13 relationship with that MTF commander as well, within that.
14 COLONEL MOZDEN: They were actually established right at the really early phases of AMAC, when the MEDCOM Chief of
15 Staff said "I want to know what is going on out there right now", and so they started that ombudsman program
16 very early in the process with borrowed military manpower, and then over time it has been now converted.
17 They have got -- and often times they are retired
18 military, but they are GS civilian or contract.
19 They are not really in that chain of command of
20 the WTU. They are an MTF asset and work more with
21 the patient advocates, for example, in the
22 hospital.

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1 MR. REHBEIN: Does what they know end with the MTF
2 Commander or does it move -- LT. COLONEL SCOTT:
3 No.
4 MR. REHBEIN: -- on up to the top level.
5 COLONEL MOZDEN: Yes. They report up to the
6 MAG, the Medical Assistance Group at the MEDCOM
7 level.
8 GENERAL WILLIAMS: Yes, sir. They are very
9 helpful when I go visit and I am in the room.
10 They support the installation at large, but they
11 are very much tailored and obtain to the WTC
12 population. Every time I visit they are always in
13 the room and I go and talk to them. You said it in
14 plain English earlier sir, and your vignette is
15 exactly how I think. You know, talk me through
16 literally how all the different pieces affect the
17 life. My colonels did a great job of letting it
18 out, but just to kind of -- Sir, when you come in
19 and you check in to a WTU, what we say is that you
20 are going to be in HHC.
21 So we have a receiving company, where it receives
22 you,

1 does an assessment, makes sure you are not going
2 to do something bad to yourself, and then the CTP
3 -- you've gotten fragments of all of that -- and I
4 am willing, we
5 can lay out longitudinally how kind of the life all the way to when you retire and you become part of Greg's
6 population. That is actually the first thing I asked for when I came in. "Walk me through the entire process,
7 longitudinally". So we have that, and we can give you that also. Yes, sir.
8 So the HHC, and then you go to one of the line companies where you are actually going to be managed, and then we
9 talked about the remote care company a little bit
10 -- a platoon at the company. So the companies
11 that I have out there right now -- there will be a
12 remote platoon managing the folks who have wounds
13 or injuries or illnesses that require not a whole
14 lot of intense care. So you kind of have a
15 continuum within a battalion or a company -- high
16 end when you come in for those first thirty days,
17 get a CTP, "what are your expectations, Williams?
18 What do you want to do, what do you think?" "Well,
19 I don't know I haven't quite healed right, thank
20 you for asking me". So that is continued to be
21 evaluated over time. They go to one of the line
22 companies and potentially you would be remotely

1 cared for, so that is kind of the continuum as the
2 current stance of our TDA and we will give you all
3 of that. And actually one last point to that -- I
4 am trying to go away from a one-size-fits-all TDA
5 in the G3. I hope there are no G3's here in the
6 Army, but you know the bean counters, they just
7 want "here is the one thing, and it fits all" so I
8 am trying to go to more of acuity based as was
9 mentioned earlier by General Horst. His
10 population is primarily PTSD and mental health
11 things, so do we really need the right handed
12 screw driver at this particular organization if we
13 don't have a need for that?
14 So, as we manage patient flow to these various
15 camps,
16 posts, and stations, we ought to get a sense of
17 what the
18 requirements are there and build that around that model.
That is what I am trying to go to right now, more of an
19 acuity based model.
DR. TURNER: Requirements.
20 GENERAL WILLIAMS: Requirements based. Exactly right.
What is your need here? So that is what we are going
21 towards. And also, triggers. I didn't talk about this,
but how do we know what is coming next? You know as a
22 rat kind of winds down, Afghanistan is still kind

1 of cooking -- what is coming and what nature of
2 the population is coming into the various camp
3 posts and stations. So all of that is what we do.
4 DR. TURNER: It would certainly make that
5 2012 POM easier if you knew the requirements.
6 GENERAL WILLIAMS: Bingo. Yes, sir?
7 DR. GUICE: General before you sit down, one last
8 question and then we will take probably a much
9 needed break. What problems were the WTU's
10 designed to solve, and have you solved them?
11 GENERAL WILLIAMS: Good question. I think
12 the WTU's were brought about to provide command
13 and control, intuancy too, so command and control
14 and medical oversight at one-stop location. That
15 is really the elevator speed to it, for both
16 active guard and reserve. So, all of the
17 population -- wounded, ill, and injured. Currently
18 10,000 we have kind of rough numbers. It is 5, 3,
19 and 2. 5000 active, 3000 guard, 2000 reserve,
20 8000 in the WT, and 2000 in the CBWTU. So that is
21 kind of the stance of it. Have we solved it? No.
22 I think that we are doing pretty good. I think

1 that we are U3, U4 of this thing, so I welcome all
2 of this as I mentioned to you earlier Doc. I
3 think with the onset of the DIAG report, your
4 continuing efforts here, because I know this is
5 going to be something that continues for a while
6 --
7 this only makes us better. The Army is a learning
organization. We are transparent. I told all of my
8 guys, "You have thick skins and let's go after this".
I was pretty impressed a couple of weeks ago when we got
9 the results from the DIAG report and the 29 observations
and the fifty-six recommendations -- everything from
10 Williams. All those resources you talked about and all
of those numbers we have been throwing at you. You don't
11 have them all in one document. How come? That is
12 a big deal for me. That is one of my priorities
13 -- so that sergeant down there can pull off of his
14 shelf, one consolidated guidance to help his buddy
15 out. We don't have that right now. So, no we
16 have got a long way to go. That was the one
17 thing. The other thing that was very concerning
18 for me in the report was this notion that a
19 quarter of our soldiers are addicted to some sort
20 of pain medication. That is problematic. So, the
21 way I have been answering in the press and on the
22 hill is "I don't know". I have got to go after

1 that. Now, they came back with "Now, Williams,
2 those were nurses that were reporting on that if
3 you look at the report". I said, "Right, but
4 anecdotally". What is the science part of that?
5 We have got to go after that. We are a science
6 efficacy based organization. We have got to go
7 after that. That was the second thing. And then
8 the third thing is -- I was hardened by it -- is
9 that 91 percent of the WT's in the program, the
10 wounded warriors said this was the place to heal.
11 So, I thought -- and I think that was 756 as I
12 recall. Multiply that by .91. I thought that was
13 good news, you know, that after all things beings
14 said -- after microphones being stuck in people's
15 faces and when you go out to these four places,
16 understand you are going to Hunter first, and you
17 are going to see people who are the other end
18 saying "you
19 know what, this is half-full or half-empty", but you are
going to hear hopefully, 90 percent that are going to say
20 "hey, you have got it about right with these sorts of
suggestions". The part that -- what I will take away
21 from it -- and I know we have other briefers here, but
the piece -- all of you all are very, very helpful and I
22 have got lots of notes. I am a big note taker. But one
of the things that is very important to me is the Army

1 family. And Master Sergeant I heard you kept
2 hitting on that and I know that was by no
3 accident. We formally believe that it takes a
4 whole family to heal this process, whether you be
5 active, guard, or reserve; whether you be wounded,
6 ill, or injured. And so, we have got a lot of
7 observations and we have asked a lot of questions
8 but we have got a lot of observations and we have
9 asked a lot of questions, so now it is time to go
10 after this in a very deliberate way to ask Ms.
11 Williams how you help Sergeant Williams heal. And
12 like I always say, I tell my guys is that -- I've
13 got a son who is a freshman at Virginia Tech. He
14 is going to be an Army Lieutenant one day. I am
15 doing this for Zach Williams. I am doing it for
16 him and so that -- pray that hopefully it doesn't
17 happen -- but if he is a wounded, ill, or injured
18 soldier, him and -- Zach Williams and his wife to
19 be -- he better not get married now, he is only
20 19. But hopefully he and his wife have a way
21 forward that I made it a little bit better on my
22 watch. So, that is what we are all about.

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1 Transparency, action, moving ahead, cadre,
2 education, jobs -- that's what we are all about
3 right now, and we will continue to get better as
4 we sharpen ourselves with this process. So I look
5 forward to working with you all. The way ahead,
6 as I told you earlier, Doc, this is the beginning
7 from my perspective sir. We are not closed. We
8 are transparent. If we were
9 not able to answer some of the things here, I will gladly give them to you. I know General Horst from a past life,
10 so anything you need of course I work very closely with General Stone. Not only am I the Warrior Transition
11 Commander, I am the Surgeon General also, so some of the conversations you will hear that are coming forward now,
12 with the installation and also when Sheila and Dan get up here, I have tangential knowledge and I am a part of
13 those task forces, purposely so by the Surgeon
14 General, because I am the one that -- it affects
15 my population. So, if nothing else you will see
16 these warriors and their families are spun by a
17 lot of other different pieces and influenced, so I
18 am concerned about what General Lynch is doing, I
19 am concerned about what General Bostic is doing,
20 the G1, and the other pieces as they influence my
21 population. So, thank you.
22 GENERAL GREEN: I have one corollary and --

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1 GENERAL WILLIAMS: Yes, sir. Absolutely.
2 GENERAL GREEN: -- give us a quick answer,
3 because I realize it is an opinion question. But,
4 when the war's end, do you believe this is
5 sustainable if you are only dealing with ill and
6 injured?
7 GENERAL WILLIAMS: Sir, I think it is
8 sustainable. I think this is the price of doing
9 Army work, I really do. You mentioned earlier, and
10 I caught what you said, the whole collapsibility
11 aspect of it -- that perhaps in some future -- and
12 this is what I challenge my staff. It is a
13 different stance, but there has got to be some
14 mechanism in place to take care of ill and
15 injured. I think we will always have wounded. Do
16 I think the wars will end? Since the last ten
17 years tell me otherwise? Just look at the news
18 the last few days, but hypothetically, sir, I
19 think this is -- the Warrior ill and injured task
20 force, the Warrior Transition Command, is
21 something that is. And I think it endures perhaps
22 a -- perhaps, in a scaled down version of its

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1 current model, and perhaps much more joint in its

2 way -- back to your point.

3 DR. GUICE: We'll take a 15 minute break.

4 GENERAL WILLIAMS: Yes, ma'am. Thank you.MS. DAILEY: I ask that we reassemble. We are going to cue up our nex

5 briefing here please. I'd just like to thank all

6 of the

7 briefers for being so patient. This is an all Army day, and I think the task force appreciates the opportunity to

8 march through these in a pace that allows them to ask questions and to really absorb this information. So,

9 we're going to bring on Soldier and Family Assistance Centers briefers and the Facilities and Organizations

10 that provide support to family, and our briefer is MR. WATSON: Okay, good afternoon. My name is Christopher

11 Watson. I'm with FMWRC, SFAC program. Basically, I'm with the wounded following division. You have the SOS and

12 the SFAC program, which is a division that falls

13 under direct and family programs which falls under

14 the FMWRC. That's the layout. Discussion points

15 discussion points, how does the SFC interface with

16 the WTU? How does the Army define successful

17 services to family caregivers? How does the Army

18 benchmark SFAC performance against comparable

19 services to family caregivers? How effective is

20 the SFAC providing meaningful information? How

21 well or how quickly does the SFAC meet customer

22 needs, provide any surveying customer feedback

1 data. Okay, I want to begin, the core SFAC
2 services, SFAC director, SFAC director establishes
3 committee meetings with the WTB command and the
4 triad. At that point, they discuss the major
5 issues and concerns within the SFAC, and concern
6 the family members and the WTs. That's how the
7 information is relayed between the WTB and the
8 SFAC. That is a GS12 position. Information
9 referral information referral is the one that
10 conducts the DA Form 5897, when the family member
11 and soldier initially enters the SFAC. At that
12 point, they take that client tracking down, put it
13 into the CTS system. At that point, as the WT and
14 family member visit each one of those core SFAC
15 services, the data is already
16 in the system. Instead of the family having to repeat it two and three times, it goes in once.
17 HR Military Benefits basically, we have a CAT card and an ID card machine in each of the SFACs. The ones that
18 aren't currently located in the SFAC have been chosen by Garrison ACS Director SFAC Director in a joint effort
19 that we better suited place like the in-processing center because of some of the SFACs are located within an
20 in-processing center. So, some of those decisions were made within the Garrison. It still serves the same
21 purpose, but being that the SFAC is located right in the in-processing center, walked down the hall three doors,
22 you'll get an ID card. Those HR are GS. If we have

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1 two of them in there, there's normally a GS-11 and
2 a GS-9 within that SFAC, and that's how we
3 interlock with the WTB and the WTU transferring
4 information like who's coming in on the gains
5 roster and vice versa. So, when we come to the
6 newcomers' orientation, we know who we're going to
7 be meeting and who we're going to be addressing at
8 the newcomer's orientation. Education councilor,
9 DS education councilor goes into besides the
10 counciling goes into the Go Army Ed, teach them
11 how to do the TA assistance. Basically once they
12 go through the priority list to be sure they have
13 a computer prior and they have access to the
14 internet, and they can okay. Then, you've got to
15 teach them how to use the system, so you do a
16 hands-on in our computer lab that's in our SFAC.
17 We have between two and some SFACs have fifteen
18 computers within our SFAC footprint. So, we do a
19 hands-on with the soldier and the family member.
20 We don't assume that everyone knows how to utilize
21 the computer system to go in and go through the Go
22 Army portal and such and such. So, we walk them

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1 through it. Financial councilor GS as well,

2 financial councilor

3 establishes training in reference to financial management
and developing a spending plan to have the family members
4 in the WTs. They can bring in consolidated bills. They go
over with the family member and with the WT to insure
5 their stay there don't go into an indebtedness because
when they show up, a lot of families show up already with
6 a lot of bills. Now, they just left their home that they
were paying a mortgage on, and now they're showing up at
7 your SFAC and your WTU, your WTB. You've got two sets of
bills.
8 So, we catch them at the get-go, do an IM brief and go
through their finances with them.
9 Social service assistant, GS as well social

10 service assistant crisis intervention, outreach

11 services surrounding community tie in with all the

12 related partners within the community, and GS as

13 well. Transition support, ACAP ACAP is a

14 contracted physician. The ACAP again works within

15 the SFAC. Several of the SFACs will have a

16 computer lab set up where they can do the TAP and

17 DTAP within the SFAc. The ACAP also works one on

18 one with the family members and the WTs doing

19 their resumes. Some of them it can take weeks to

20 do a resume besides just going through a DTAP or

21 TAP and think you're going to get the training.

22 No, it takes a lot more than that when you have

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1 PTSD and TBI. So, SFACs are designed to bring the
2 family members and the soldier back in one on one,
3 work through the resume, go online, USA Job
4 Search, go on CPOL, and teach them how to utilize
5 the system to search for those jobs. It's a lot
6 more in depth and it's a lot more time than the
7 average. Child, youth and school services again
8 GS, UIS within an SFAC. Again, our computer room,
9 we utilize that for the training. Family members
10 can come in throughout the day as well to utilize
11 the computers to go into the USA Jobs job search
12 internet because just because they have a computer
13 in their room, it doesn't mean they want to sit
14 in their room and utilize it there. There's a social network as well within the SFAC. So, when the family
15 members come in, we encourage them to utilize that computer lab.
16 Partner services to the far right there we had the defense finance accounting services. Again, someone had
17 mentioned TDY travel vouchers, and we had DFAS in several of our SFACs. If need, we can also call the DFAS forward,
18 or we can make a priority appointment for the soldier because family members, they'll come in not understanding
19 that the solider got all this pay while he was in combat. He came back. He was an inpatient. Now, he's outpatient.
20 Oops, my pay so at that time it has to be
21 explained about the DFAS. TSGLI we have between
22 E8 and Sergeant Majors within the majority of our

1 SFACs that have the severely injured soldiers that
2 do the TSGLI. They'll go to the soldier with the
3 paperwork, and go with the family member as well
4 because several of the soldiers have PTSD PBI.
5 Just because you explain to the soldier what needs
6 to be done, you prefer to have the family member
7 with them to go through a non-medical tenant so
8 they fully understand what else is needed.
9 Veterans Administration self-explanatory. Social
10 Security Administration we bring them in, hot
11 desk. Soldiers can come in one on one and sit with
12 the SSA and discuss social security. Staff Judge
13 Advocate, we hot desk right at the SFAC. We also
14 can make a priority appointment for the family
15 member, solider over at legal. Non-governmental
16 organizations self-explanatory. State Veterans
17 organizations, chaplain service, OPM, DOL DOL,
18 we've got them in about eleven of our SFACs, DOL,
19 department of labor. They place a real life lines
20 within our SFAC which works with the soldiers with
21 employment. Prior to the WT leaving our WTB or WTU
22 location, we've already locked them in with the VA

1 employment at their

2 home of record or wherever they're going. They're already locked in and already starting to work as far as
3 employment. So, we took it a little step further. The Army One Source, self explanatory, local volunteer
4 veterans' groups. We have several of them that come into our SFACs and seated as well that works with the soldiers
5 like Texas Vets and such and such that come in and work with the WTs, and again, these are a lot of the partner
6 services. The National Guard and Reserve warriors support and
7 services National Guard Reserve normally they have a liaison that's on the installation with like the MTF or
8 located on the installation. A lot of time we'll

9 call them to the SFAC to talk with the reserve

10 National Guard component. Take for instance,

11 Walter Reed is basically connected to the hospital

12 fourth floor, but they have the capability to

13 bring the reserve and the National Guard down

14 within the SFAC and talk to the WTs to discuss

15 those matters that the reserve has about even down

16 to, "Can I take a leave? Can I not take a leave?"

17 Those kinds of situations that they have so many

18 questions about. Currently, Walter Reed has the

19 National Guard component seated in their SFAC.

20 They have one that's physically sitting there, so

21 they took it a step further and just started hot-

22 desk them. I just wanted to point that one out.

1 Next one, MCOM assumed the SFAC mission 15 June,
2 '07 self explanatory. SFAC will provide services
3 care to support the warrior transition unit. If a
4 warrior transition unit or warrior transition
5 battalion has a recommendation, they'll link them
6 to SFAC as well. We have to adjust staff. SFAC
7 directors along with the ACS can adjust the staff
8 within it. Take for instance if you have one HR.
9 Once you do your evaluations, you realize you have
10 an ID card machine, but
11 also the HR within SFAC is doing an SGLI, doing DD-93s, a lot of soldiers are coming in with take for instance a
12 spouse brings in a brief case of records and stack of paper and wants you to go through with them. SFAC needs
13 to sit there with that family member and WT, and go through it one by one. Just say, "Oops, guess what? You
14 had an order in here, but you just didn't have an award. So, you didn't add this point back at such and such an
15 award, and you missed the cutoff. You can dig back through there." They have to go back through the system
16 and back date and such and such. So, it involves a lot of sitting, going through more in depth with each WT and
17 family member. It's not just, "What do you have?"
18 Provides a safe haven to promote healing and
19 provide services dedicated to the needs of
20 warriors and their family members. The SFACs are
21 set up. We have cooking classes. We go out. We do
22 apple picking. We do different events to bring the

1 families in there. We have kitchens in the
2 majority of our SFACs. They do baking, you name it
3 to get the families involved because if you don't
4 get the families involved, they're not really
5 going to open up to you. So, you've got to come up
6 with the different events to say we care and get
7 them into you. SFAC three-way deliver model full
8 time SFAC staff member on site, like I was
9 mentioning HR is actually setting SFACs. Staff
10 brought forward to SFAC when required such as the
11 SJA. That'd be a hot desk. Most legals are going
12 to stay over in their office, and you're going to
13 call to make a priority appointment. If need be,
14 they'll come to your location and hot desk within
15 your SFAC. Priority appointment at alternate
16 location that is convenient to WTs. WT, if you
17 have some I met WTs that couldn't wear the
18 uniform anymore because of being around the other
19 person in the uniforms sent him into fear. "I
20 can't get a haircut because of this, the vibration
21 of the
22 clippers." So, there's different situations that you and along with the SSA and staff has to make to say, "Let's

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1 make this priority appointment because it best fits the soldier's needs." It's not a personal need of you. No
2 saying, "Nope, you've got to do it here." You've got to make the priority appointment to get them where they need
3 to be.
Currently, we have a total of 208 total GS staff, and
4 again that's what we authorize 208. Staff will support WTU population with two to thirteen staff with each
5 location. If the population is below a hundred, the minimum we can have is two staff. If it's above the
6 hundred, what we're going off is the one to fifty
7 ratio, when we started the staffing. So, if you
8 had a population of 150 and above, yes you had
9 your three, and you could adjust going higher.
10 Each 50 WTs, you could just buy one more staff,
11 but the current staffing again, if they're below a
12 hundred population like you have Fort Irwin, you
13 have Balboa, you have several locations that could
14 have under 50 WTs. If you looked at that, and you
15 place thirteen personnel that have 37 WTs, okay,
16 it's not going to balance out because the size of
17 the installation, soldiers that are deploying. You
18 can set priority appointments at several locations
19 which wouldn't interfere with the current
20 population on the installation. So, it's a lot of
21 factors that go into that. If you make a priority,
22 will it really be a priority appointment? Again,

1 the WTs have priority on the installation. SFAC
2 director, supervised by the ACS Director. MILLCON
3 billing projects, I'm going to show you at the
4 end, five opened with thirteen planned and under
5 construction. August 2007, SFAC concept plan, ACS
6 on steroids, that was the concept. 2009, self-
7 explanatory, 2010-2011 developed and implement
8 SFAC founder support plan to encourage and support
9 family members. That's currently we'll be
10 working with the WTC now. They're developing a CTP,
family support plan is going to interlock with that CTP,
11 and it's going to all be digital when it's said and done.
Most utilized SFAC services, information referral again,
12 the information referral has to know all the services
within the SFAC and the installation. The family member
13 comes in with questions referenced to recreation, the
information referral needs to know exactly where that
14 location is. They have to pick up the phone and say, "I
have WT, a family member coming in to your location
15 because they want to participate in such and such an
event." It isn't just, "Here, the building is such and
16 such." It doesn't work that way. It's a lot of
17 involvement. HR resources, education counciling,
18 transition employment, and again, it goes in
19 sequence. Current warrior population with the CBWT
20 users 10,000 total, again, I'll show you a little
21 bit more. SFAC survey conducted during October
22 through November 2009 total responses from

1 October the first through the thirtieth of
2 November was 944. Again, this went out to the
3 family members. The main categories of responses
4 percentage of total, enlisted E-1 through E-7, 90
5 percent of responses. This is the primary deployed
6 group of soldiers. It's just a fact. Officers
7 choose their responses as well. This is from the
8 survey. Most utilized SFAC service, education
9 services used 47% of the time. Financial
10 counciling, EER used 35% of the time, HR 26%, ACAP
11 23%, TAP DTAP used 10% of the time. That ACAP is a
12 must. If it's a way to get the ACAP kicked off
13 soon as the WTs get there, it is a must because
14 you never know when that "I'm returning to duty,"
15 could turn into, "You may be transitioning." So,
16 if you wait too long, I highly encourage that ACAP
17 at the beginning. Computer room, there's always
18 soldiers and family members
19 in that computer room constantly. It's always open throughout the duty day, and they can get in an access
20 it. It's good hands-on tools. Again, our staff works with them to teach them those trades. A lot of soldiers would
21 be surprised how many just getting the computer fired up is an issue.
22 Partner service varied, employment assistance, veteran benefits, information referral, recreation, youth

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1 services, TSGIL, and a lot of those services, again
depend on the population that was at installation where
2 they did the surveys, the family members that respond,
and it can go on and on because TSGIL at certain
3 installations, yes, this is going to get utilized
4 a lot. At others, you don't have the severely
5 injured or you don't have the ones that have the
6 required hospital stay and such and such for the
7 entitlements. Family support and child care, yep
8 that's not as you can tell that's not that high.
9 One would assume that families are coming in.
10 They're going to really utilize that child care a
11 lot. When the family members get there, the family
12 members are of keeping that family member with
13 them. They always want to check their children
14 with them. Even though you're coming into an SFAC,
15 you've got this room, and children can play. The
16 priority is the family member just feels like,
17 "Nope, I've got to have them with me." So, just so
18 you can get a clear picture of that family support
19 piece there. Chaplain and transportation, normally
20 again within the installation, there's the
21 chaplain. Satisfaction question, written comments
22 reflected of a nine to ten point scale. Statements

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1 included lifesaver and a Godsend. When a lot of
2 family members again, when they show up, they
3 won't tell you until you're sitting down and
4 talking to them, that their car broke down two
5 states over. Now, you've got to work with them.
6 Just say, "How do I get
7 that car out of the impound yard, and get it to our location?" Each one of my SFACs has a certain amount of
8 donations within their GPC card that they have access to, and ultimate like yellow ribbon and different YMCAs.
9 They've got money earmarked just for the wounded warriors, for flights, for just for those emergencies
10 involving the POB and different things that they need. Different organizations, it's already earmarked money for
11 them. That's when a lot of that comes into effect, when you're saying, "Here's an emergency. Let's fix it." We've
12 got to tap into it.
What additional services needed at the SFAC?
13 Eighty-seven percent response rate of "no other
14 services needed." Basically once you bring them
15 in, and you call up the partner services for a
16 soldier or family member says they need
17 assistance, you're contacting that other agency.
18 You're either bringing it forward, or you're
19 sending the family member to them. They're
20 completely satisfied, and then they'll come back
21 to you. A lot of them want to hug you, bring you
22 flowers and all that good stuff. I get all that

1 from the field. Different family members come in,
2 and they're thanking. So, it really is an
3 outstanding program that works. What more could
4 have been done during the first days? Seventy
5 percent indicated nothing more could have been
6 done. Again, by the CTP, the family members along
7 with the WT in process within the first seven
8 days. So, all the family members come through, and
9 you're addressing with each one of your staff
10 members all their issues, and they also do an
11 assessment that you're walking through with them.
12 You're not just saying, "Do an assessment and hand
13 it to me." You're going through it. So, you're
14 addressing each issue. Would you like us to
15 contact you for further support? Seventy-one
16 percent saying, "No further contact." However 29
17 percent who would like contact provided a valid
18 email
19 and telephone number. They took the time and effort to
put down the accurate information, which meant they
20 really appreciated the services, and we kept that open
contact with them.
21 Several WTs even after they transitioned, we still have
to reach out to and assist. I had individuals that had
22 already exited the military transition. They wanted me to
work with them and get their records from Indianapolis

1 and such and such. So, you just don't say no.
GENERAL GREEN: Can I ask are you only surveying people
2 who came through your doors?
MR. WATSON: They come through our door, and we go down
3 at the in brief?

4 GENERAL GREEN: What's your outreach to get

5 the 87 percent response rate of no other services

6 needed? Are you surveying people who only came

7 through your doors?

8 MR. WATSON: That's how we set the survey up,

9 sir, when we did this, sir.

10 GENERAL GREEN: Are you surprised they got

11 what they wanted?

12 MR. WATSON: No, sir.

13 GENERAL GREEN: Okay.

14 MR. WATSON: But, again, this was a survey

15 that we did for that two months, and that was our

16 initial survey because of the SFAC program. At the

17 time we kicked off, it's new.

18 That was a survey that we sent out.

19 LT COLONEL SCOTT: Sir, if I could clarify,

20 one of our requirements for all of our warriors in

21 transition is that they in-process through the

22 Soldier Family Assistance Center. So, all of our

1 they have the contact information, and all of our
2 soldiers must go through there as part of that
3 initial in brief, whether they continue to use
4 those services are not. Some are mandatory. Others
5 are there and available if they need them. If that
6 helps clarify where that 87 percent, I think
7 that's a good valid number because we require them
8 all to go through there.
DR. PHILLIPS: Do you have any information on what the
9 other 13 percent or the other 30 percent said?
MR. WATSON: No, sir.
10 GENERAL GREEN: Just one more clarification, so you're
fortunately your active duty who go to the WTUs to go
11 through this. Are the families also going through with
them at the time?
12 MR. WATSON: Family is coming through with them, sir.
GENERAL GREEN: A hundred percent?
13 MR. WATSON: I wouldn't say a hundred percent, sir because
sometimes the family members don't have a choice, and
14 sometimes they don't come until later after the
15 WTs there for a while.
16 MASTER SERGEANT MCKENZIE: Just a little
17 clarification, General. Actually, I watched this
18 in action at Walter Reed working there from 2007
19 when this was set up and literally watched my job
20 as a liaison get more and more taken away by these
21 it came from me trying to find all these
22 resources to hey, I ran this place called the SFAC

1 to put all this stuff together to I just started
2 sending people to it because it was like it was
3 all right there. Then, as a liaison dealing in the
4 joint environment, I was still able to get even
5 further assistance working with other services as
6 well. So, this model, I mean, I'm not just in the
7 soldiers that I've worked with personally, I'm not
8 surprised by these numbers at all because those
9 folks at Walter Reed, it's just been that whole
10 watch them from a little tiny office to three
11 construction projects as they expanded and watched
12 a lot of really, really positive results come out
13 of that. That's just first hand knowledge as a
14 liaison.
15 MR. WATSON: Okay, IMCOM Garrison used the customer
16 management services to evaluate all customer
17 support activities via their interactive customer
18 evaluation
19 ICE, and I believe everybody's familiar with the ICE process. Someone had mentioned earlier about how do we
20 get the input from the family members, and within 72 hours, we have to respond. Basically, within
21 immediately, ISFAC addresses the issue. I'm just going to let you read that.
22 As you get down, you see SFAC directors had this customer service and positive CMS activities written into the

1 performance standards. Example, Fort Stewart's SFAC supports the third infantry division, has along history
2 of excellence supported by an annual positive customer service response rate in 98 percent, 209 ICE comments
3 received. SFACs also participate in all garrison
4 activities, town all meetings, Army family action
5 plans, conferences and activities, garrison focus
6 groups and activities. Every SFAC has strong
7 liaisons with the local WTU and attends all WT
8 town all meetings providing an immediate open
9 forum of issue presentation and discussion. So, it
10 allows that feedback.
11 GENERAL WILLIAMS: I want you to see
12 everything if you look at the DIG report or when
13 you go out and start looking at these, there's a
14 continuum. You'll hear things like some of them
15 are underutilized. We're not really using
16 resources to full transparency to the other end of
17 the continuum where commanders actually go and
18 hold the morning formation at the SFAC. We've got
19 the whole continuum there, and so they're a great,
20 great resource. Then, we have at Walter Reed in
21 San Antonio, we have other it's really super
22 sized in terms of the resources we can bring to

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1 bear. So, what we had is the Army community
2 service, the things that normally were in the ACS
3 consolidated in one location, and they are
4 fantastic. I've been to five or six them, and they
5 keep a very accurate, I think you talked about
6 this, assessment of how they're being used. They
7 actually
8 there are people there who check the counter and go, "Oh, this month I had this amount. Do you guys actually
9 do this?" You talked about this already. So, you've got that piece, kind of a bean counter aspect
10 of it. I think it's value-added. I think it's good. What you'll see when you go out there, varying responses about
11 this to be totally transparent with you in terms of, "Ah, we could use that other thirteen percent," that you just
12 asked over here, sir, and we can get that. We can find out, to the other extent, "It's okay."
13 So, I haven't quite made my mind up. General Lynch is a friend of mine, and we've talked a lot about this. I have
14 not been to every single one of these, but I just
15 gave you kind of the ground truth of where this
16 is, where this kind of lays. It lays everywhere
17 from it's a very good investment to a very good
18 investment that someone underutilized and perhaps
19 we big Army, we ought to look at ways to open up
20 these resources to other folks on the CANCE post
21 or station. That's what's being talked about in
22 some places.

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1 GENERAL GREEN: And their families?

2 GENERAL WILLIAMS: Yes, sir. WTs and their

3 families.

4 DR. PHILLIPS: So, a quick cursory look, it

5 appears all the WTs have an SFAC. It appears also

6 that none of the community based transition units

7 have an SFAC. So, what's our mitigation strategy

8 for the gap between WTUs and community based WTUs?

9 GENERAL WILLIAMS: Yes, sir, great question.

10 In the compo three, two and three, the guard and

11 reserve, most of their resources are virtual.

12 They're virtual SFAC. I think I got the acronym

13 right. Do you have that in the brief? So, the

14 mitigation strategy sir to answer your question is

15 that most of this are and I've looked at this

16 websites. They're pretty dog-gone good. I was just

17 looking at them last week. Someone asked me. Is

18 there a perception perhaps, and there are some in

19 the

20 guard and reserve who actually have physical brick and mortar, these I don't know how many, but we can get that

21 for you. There are some physical brick and mortar SFACs in the guard and reserve in the communities, but the

22 preponderance, the guard and reserve solution is virtual. It's very, very good, very, very expansive, good, very,

1 very good. I'm kind of double transparency, I really like they are top notch.
2 You'll see this top notch structures out there. The first one I went to was in Carson, and there's two sets.
3 They're kind of a large set and a small we have two variance.
4 MR. WATSON: We have a large and a small.
5 GENERAL WILLIAMS: We have a large and a
6 small variant, and all the resources that he
7 talked about from family day care to getting your
8 ID Card, you can go in and spend a day as a spouse
9 of a wounded warrior, and your needs will be taken
10 care of. Now, do you always have that need? Is it
11 that high where you have to hit on all those
12 things all the time? I'm not so sure. Depending on
13 you'll see that when you go out there and start
14 looking at this. Sir, you have a question?
15 MR. REHBEIN: I think we have to be careful
16 and keep track of the guardsmen or the reservist
17 that's up there struggling with TBI, trying to
18 deal with a virtual SFAC through a website. I can
19 see that that would be a sore not only very
20 difficult, but a source of large frustration for
21 those folks.
22 MR. WATSON: Yes, sir.

1 MR. REHBEIN: If we could somehow extend
2 that, make it less virtual and more personal.
3 GENERAL WILLIAMS: I'm only at a kind of a
4 one star level. I've talked to just last week the
5 guard and reserve. I'm brain dead right now. I'll
6 get it later. In terms of, that's exactly what I
7 said. I said, "Do you need more
8 here?" So, I have not got this in front of my army leadership about that. It clearly is the question was is
9 there a potential for a have/have not sort of scenario here, and some of the things you're talking about. I
10 said, "Well, maybe." Let me tell you what it is right now.
11 What it is is predominately virtual in the guard and reserve, and a brick and mortar project at all my
12 twenty-nine. That's what it is is right now. If we need to close that gap to be careful for the guard and
13 reserve, okay, let's go after that. I don't disagree with that necessarily, but that's kind of where it is right
14 now. Go ahead, please. You can help me.
15 MS. TUDDENHAM: My name is Colleen Tuddenham.
16 I'm in Axiom right now, and I used to work SFAC,
17 but sir, I'm thinking that as you go into your
18 incorporating your remote care into the WTUs on
19 the installation, and as those soldiers who are
20 assigned to a CBWTU, they're going to be in
21 processing there, then, as people like SFACs are
22 going to be doing some needs assessment and be

1 pushing out more services that haven't been
2 available yet, that's one answer. Second answer is
3 one thing you can't do virtually is child care,
4 but we have had. I hear generally that Knox is
5 largely a guard population. So, that many of their
6 family members are not there. Their family members
7 are all over the place, but that SFAC at Fort Knox
8 has been instrumental in helping them find child
9 care remotely through the CYS NACRA program.
10 Please don't ask me right now what NACRA means,
11 but I can find out for you. So, I think we will be
12 improving.
13 GENERAL WILLIAMS: We'll do course of action
14 in front of you. Kadabe and General Purcer,
15 that's what their names are.
16 DR. GUICE: One question since this resource
17 is really designed for the WTUs and the wounded
18 warriors, what
19 other resources are available on these bases for other families, just sort of the, you know, non-wounded
20 population, and are we providing double so that we've got overlap of-
21 GENERAL WILLIAMS: The short answer is that's what I was mumbling about a second ago. The Army community services,
22 the ACS and so and I'll turn the brief back over to you. Go ahead if you want to talk about it.

1 MR. WATSON: You have the ACS that all the family members that aren't WTs. They go to the ACS center and HR.
2 GENERAL WILLIAMS: So, the question about double tap, that's not her words.
3 MR. WATSON: The SFAC being central located
4 close to a location that make it convenient to the
5 warriors. Some of those would overlap, would be
6 the same service.
7 DR. GUICE: Then, another question, you have
8 a lot it looks like you have a lot of process
9 measure. You count a lot. You count a lot of this
10 and a lot of that. MR. WATSON: CTS.
11 DR. GUICE: It seems like a better measure
12 since you've already headed there is the "So
13 what?" When they leave the military, do they have
14 jobs? Do they take advantage of educational
15 opportunities? Do you do a follow-up survey? It's
16 kind of when you're there and people are telling
17 you stuff, you say, "Yes, I know. I got all of
18 it," but two years out, what would they did they
19 really get what they needed as once they leave
20 that safe environment, then you're really going to
21 know if you got what you needed, right?
22 GENERAL WILLIAMS: Roger, roger.

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1 MR. WATSON: I'll take that one back.

2 GENERAL WILLIAMS: Ask the right question, go

3 measure it and do a longitudinal assessment of did

4 it work. You had this enhanced access to these

5 benefits. How many soldiers that came through Fort

6 Carson got a job? Where is their job? How many of

7 their family members got a job? That's

8 what this conference that Greg and I are doing the next
couple of days is all about. So, you're spot on. We have
9 much more to do on that, in terms of measuring. They're
all out there. So, you kind of have this my sense of
10 this over the past few years, we've got a lot of stuff
going. We started a lot of fires, so we really haven't
11 asked a lot of questions about, "Okay, did this work? Is
it working? Is it the right thing for the buck?" Sir?
12 GENERAL GREEN: I was just going to ask. Is this SFAC
completely new manning on top of the ACS, and will the
13 MILCON obviously the MILCON's being done for the SFACs.
Is that something that's going to be of use as well to
14 the ACS?

15 GENERAL WILLIAMS: Is it new manning first?

16 MR. WATSON: New manning, roger, it is new

17 manning. That 208 roger in addition to the ACS.

18 MS. TUDDENHAM: Except the ACAP is contract.

19 ACAP is contract and the child and youth are NAF.

20 GENERAL HORST: There's also another tidbit of

21 information, and this has been one of the bane of

22 my existence as senior commander and Darrell knows

1 this one well. If you have look at the chart
2 that's going to come up where you see no MILCON or
3 no construction money, those are all SFACs that
4 are not being resourced by the Army MILCON program
5 because the Army has said, "These are not enduring
6 WTUs." So, in the example of Fort Meade where
7 there is no MILCON, the only reason there's an
8 SFAC there is just because there was a private
9 consortium of business folks that came together
10 and put that SFAC together. So, there are some
11 gaps in the coverage and services of SFACs across
12 the constellation of WTs, and that's an Army issue
13 to deal with and Darrell and I are dealing with
14 it, but truth in lending is it is not uniform
15 across the constellation of WTs.
16 MR. WATSON: Roger.
17 GENERAL HORST: And, Rick, if you would not
18 tell the
19 Surgeon General I said that, because I don't need any more hate mail.
20 MR. WATSON: Okay, driving on. Warrior and their family members have questions about their financial situation
21 and money issues, considered an initial assessment issue. One of the family's concerns is when the financial
22 council is going down through each one of these questions with them, and you get down to consider TSGLI, the ones

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1 that do get the TSGLI, you need to go through and explain
that's a large you get 25-50-75-100 thousand to a young
2 soldier at one time, and you set up investment classes,
and do the utilization of those funds instead of just
3 saying, "Here you go." Other family consideration
4 that needed a look, and as I explained earlier
5 that the family members coming in. The family
6 member still has a mortgage, but now the wife is
7 here with you. Who's going to assist with ensuring
8 that the mortgage is getting paid? Who's going to
9 assist with making sure that POV doesn't getting
10 repossessed while they're currently at the WTB,
11 and all those factors come into play. It's their
12 willingness to address financial management. It's
13 the family option, but you need to really convince
14 them that it's a best needs to sit down and go
15 through this with you. Some people try to keep the
16 stuff as personal as possible, but that wouldn't
17 be one of them. So, it's your job in the SFAC to
18 convince them. They need to open up. You need to
19 go through their financials with them.
20 COLONEL GADSON: Just kind of a general I
21 won't call it an observation, but this base has
22 been kind of bolden today so, we're creating a

1 larger picture of how the army's taking care of

2 our wounded and injured.

3 Have said that, going back nearly four years

4 ago for me, my observation I think is still pretty

5 from going through four years ago to now, kind of

6 bringing back my memories is that there's a lot

7 folks out here trying to

8 help these warriors, and we're almost I think we could see almost stepping on each other, and so, I think our

9 challenge, and I'll just speak for myself is, is as we think about this, we've got to remember about this

10 warrior.

I have eighteen years in the service, and a wife

11 that was way smarter than me that could navigate this stuff. We weren't the typical warrior in terms of our

12 experience. We're talking about much younger families, some that have parents that have no idea what the

13 military is about, and we've got I call it this conglomeration of folks trying to help, and we end up not

14 helping anybody, or we don't get those assets.

15 They need (inaudible) to them because they're just

16 overwhelmed.

17 That's really I think really a larger

18 challenge.

19 Some of these some of these systems, and some of

20 these organizations we have have been reactionary,

21 and I don't know if we've really gone back and

22 said, "Okay, what is it that we can peel away?" We

still seem like we're looking to add, add, add and not necessarily thinking about what we need to retract. Give these times of challenging resources, this may be one of the things that we really should look at, but those kinds of things are hard and painful.

All these things are well intended, but they are

I'm telling you my memories still are preserved that it was too much.

MR. WATSON: Okay, next thing. Basically, the financial councilor, the Association of Financial Counseling and Planning Education is a non-profit professional organization created to promote the education and training of professional and financial management. This is where we send our financial councilors through to ensure that they're certified. If you're going to work in there, you just can't unless you're certified.

This one right here when we get down to the locations, like when you go to the bottom little triangle, no construction. Basically those SFACs are in preexisting buildings, with no construction plans for those location. Seven thousand square foot MILCON project, self explanatory. MILCON open, the inside square was written

1 in yellow. It tells you the one that is currently open, and then MILCON planner in the red.
2 The three that are overseas in Baumholder, K-town and up in Honesfield and Graf. There's three of them over there.
3 They also have like six geographically dispersed locations that has WTs. Some have five. Some could have
4 to up to twelve WTs located over in Europe like
5 Vicenza, Wiesbaden, a couple of locations. Okay,
6 and that's our POC information. One is (inaudible)
7 is Mr. James Larsen. SFAC program manager is Mr.
8 Charles O'Leary, and then myself. If you email,
9 you'll get a quick response because we go through
10 emails constantly. There's no delay because we get
11 all kinds of financial issues and personal one on
12 one issues with clients in the field that's got to
13 be resolved.
14 MASTER SERGEANT MACKENZIE: Yes, sir. First
15 of all, like I said I watched you guys in action,
16 and I was very impressed right down to folks
17 coming back out of different locations. That's
18 like, "Do you need any help?" "No, I called the
19 SFAC, and they've got hooked up with whatever I
20 need to get back in." So, kudos to you guys from
21 making this work at least in the Walter Reed area
22 that I'm familiar with. With that being said

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1 though, as things start combine and they start to

2 go into a more joint environment, there are so

3 many services that you guys are capitalizing on.

4 Are you integrating with other DS branches, or are

5 you looking to retract back just into the WTU?

6 MR. WATSON: We're currently at like we work at the

7 Bethesda one, and we're coming together with the

8 Navy

9 with the Fleet and Family Readiness, and they're going to be placing like four there of family advocate staff

10 within the SFAC as well. The footprint, they're also going to have different Navy liaisons, Air Force

11 liaisons, also located in the same area like on the joint.

12 Balboa, down there, we've got four employees working at Balboa. Even though they're on the Naval base, there's

13 four Army employees working along with the education for the Navy along with the ACAP, similar services with the

14 Navy to the joint effort.
Fort Dix, that's fallen under basically Air Force.

15 They're working with the Air Force up there as

16 well. So, we have been a lot with the other

17 services, and I believe some of those other

18 services are evaluating in the near future any

19 duplicated services that are out there,

20 duplications. Like, they have the Air Force that's

21 so similar. We have the Army that's similar in

22 some of these locations. It's all we're actually

1 designed to kind of bring some of that down to
2 size. So, yeah.
3 GENERAL WILLIAMS: So, as part of the DAIG
4 report review, this is one of the big buckets, and
5 so as we trot this out and look at efficiencies
6 that I talked about earlier, are we getting the
7 bang for the buck? How we're doing at the
8 different camps posting stations. We're working
9 that way ahead. It's a big part of the due back to
10 the Army and about SFACs. Like I said, you have a
11 full continuum. You have a low end, but the Army
12 has resourced these sir, ma'am, is what I'd tell
13 you. It's something that's in traction. You heard
14 General Horst talked about there are some gaps.
15 Everyone is not a part of the way ahead in terms
16 of who has SFACs and how they'll be. Well, they
17 all have them, but are they all being sourced by
18 the Army. So, it's something that we're going to
19 continue to look at, and continue to evaluate
20 because I know General Lynch
21 well. Like, day two, he came up to say, "Can we talk about this SFAC thing?" I said, "Okay, sure." And, I
22 said, "Let me go out and look around a little bit." So, I've been to a few places, gave him my feedback, and it's

1 how I just told you. Low end, it's this. High end, it's
that. The folks who are measuring as the Master Sergeant
2 said it works. It's value added. They're separated away
from the bigger populations at the post. The other
3 populations go to the ACS, Army Community Services, and
so it's one stop shop for these services that he talked
4 about. That's what this is, the long and short of it, and
that's where we are.
5 GENERAL GREEN: Please don't take my comments
6 the wrong way.
7 GENERAL WILLIAMS: Yes, sir.
8 GENERAL GREEN: I'm impressed with the level
9 of effort going into this. I mean, we were doing
10 the math up here. It brings you about 4,400
11 people. You almost have one person hired for every
12 two deployed casualties. So, I mean, it starts
13 getting to where my question on sustainability
14 becomes a little tough. Now, when you bring in the
15 ill and injured, and I'm not discounting the ill
16 and injured, but remember the ill and injured were
17 handled by a system prior to the war, and so it
18 really is a question of is there a different group
19 of ill and injured than what we had prior to the
20 war, and there may be.
21 GENERAL WILLIAMS: I understand what you're saying.
22 GENERAL GREEN: All the resources that are

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1 going into this.

2 GENERAL WILLIAMS: Yes, sir, I understand.

3 It's fair. It's just are you all done? What's

4 next? Is it Dan or Sheila? I'll get you offline.

5 I'll keep this moving. Go ahead Suzanne.

6 LT COLONEL SCOTT: Good afternoon. Over the

7 course of the next hour, or hopefully less, I'd

8 like to address the

9 measures of effectiveness and systems of accountability for the clinical aspects of the warrior care and
10 transition program. I'm going to review the status of the implementation of the interim guidance for clerical case
11 management for the wounded ill and injured service member. It's outlined in DTMA-33, and detailed
12 information on training, performance measures and clinical sensitive outcome measures.
13 Throughout the course of the morning and early afternoon, you've heard from General Williams and a number of
14 representatives from Warrior Transition Command and IMCOM. On the definitions of success and best practice,
15 given that the medical case management aspects of

16 the Army's Warrior Transition Program are nested

17 in the overarching program, I'm not going to

18 readdress the material that we already covered

19 this morning, which is why I'm standing twice up

20 here with you this morning. I'm going to focus now

21 this afternoon on some of the clinical performance

22 measures and providing some clinical focused

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1 details to the information that we already
2 provided. Now, with that said.
3 GENERAL STONE: Suzanne, I wonder if you
4 could pause just a minute.
5 LT COLONEL SCOTT: Yes, sir.
6 GENERAL STONE: We've visited this a couple
7 of times, and I'm come back to Dr. Guice's
8 question before the break. We stood up a Warrior
9 Transition Command for what reason, and have we
10 accomplished what we're trying to accomplish? We
11 heard the answer to that, and I don't want to sort
12 of where I'm sort of chewing on this to surprise
13 this. So, as you begin your presentation, I want
14 you to think about we have a group of disease
15 processes that we are managing in soldiers through
16 the Warrior Transition Command. All of us in
17 clinical practice recognize the fact that we live
18 in certain guidelines of diagnostic related
19 groups. We have certain time lines in which we
20 maximize care. We
21 all know that the DAIG report has criticized Army management of transition points. I want you to think
22 about as you do this presentation whether we have maximized the transition points for a soldier, let me

1 take an easy one, with a BK amputation. If we reach nine
months, do we have the sophistication after these years
2 of working to say that at nine months that soldiers
should have maximized recovery and we are at a transition
3 point or we're not?
We know that these are incredibly complex battle injuries
4 with an average of 4.2, I believe injuries per soldier,
and it may not be as simplistic as I'm trying to make it,
5 but I think that Dr. Guice asked a really very
6 important question, and General Green has really
7 approached that of we're making a very
8 extraordinary investment in this population, and
9 are we really delivering the level of
10 sophistication that we need to not just
11 administratively, which is extraordinary, and I
12 think you've demonstrated that, but have we really
13 moved beyond where we were three years ago in the
14 management of these casualties and these ill and
15 injured to provide set guidelines by which we
16 should be living, and then when we don't meet
17 benchmark, why not, and how are we managing? So,
18 with that said, I'm not asking you for an answer
19 at this moment, but as you do this next hour or
20 so, maybe less and maybe not, our we delivering
21 what we think we could. I don't know if I've
22 approached what you were asking.

1 LT COLONEL SCOTT: To give you the bottom
2 line up front, sir, I I think that we have some
3 mechanisms in place that we've identified to be
4 able to answer that question. Do I have the answer
5 for you today on that? No, and I'll talk you
6 through that as we walk through the slides, and
7 talk to you about where we've talked to General
8 Williams about where we need to go from here to be
9 able to answer your questions, pinpoint by WTU
10 site to
11 be able to look at that, and looking at it by diagnostic group too as well.
12 DTM8-33 directs the services to establish clinical case management policies and processes to care for our
13 wounded, ill and injured service members. Our Army specific case management policies and processes are
14 embedded in the core policies of our program, and a key component of our mission as we successfully transition
15 our warriors and their families is a provision of that medical care. We execute this task through our
16 comprehensive transition plan policy, and as noted previously, in the CTP policy, the focus of the
17 comprehensive transition plan is that soldier's
18 future. It's the triad of care which includes the
19 case manager and the primary care manager are
20 tasked with providing support and counciling to
21 assist each warrior in setting and achieving their
22 personal goals and transition plan. So, that's

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1 really the foundation in a nutshell of everything
2 we do from a medical management perspective. We
3 couch it and maintain it within that CTP. So,
4 within the Warrior Care Transition program
5 guidance and policy, I want to highlight the
6 relevance to case management in several of these
7 resources. Again, this is not an exhaustive list,
8 and there's relevance to case management and most
9 of the references that we sited this morning, and
10 certainly case management and the primary care
11 managers are actively engaged as we consolidate
12 these resources into one regulation and policy.
13 The regulations that I'm going to cover address
14 specific tasks that are outlined in DTM8-33. The
15 operations order 7-55 which is the MEDCOM
16 implementation of the Army Medical Action Plan
17 established the Army's programs for delivering an
18 integrative and comprehensive continuum of care
19 and services for warriors and families. Annex B
20 established the WTU standards and established case
21 management and primary care management ratios. You
22 asked that question earlier, where did these come from?
It was our Army manpower management analysis personnel

1 that analyzed the work that we were doing in terms of medical care, case management and primary care, and they
2 said our ratios will be one to 200 for our primary care managers, and then our case managers were initially
3 established at one to eighteen in our medical centers, and one to 36 in our smaller facilities.
4 A second manpower workload analysis study was completed in 2008, and those case management ratios were further
5 refined to a baseline maximum of 20 warriors per case manager in all of our facilities. This is a higher
6 standard than is established in the DTM, which
7 established a maximum case load of 30 per case
8 manager. Annex K established our Warrior in
9 Transition Program standards, and this specifies
10 the time frames for conducting initial and follow
11 on assessments, specifically both our primary care
12 manager and our case manager as well as our
13 behavior health social workers have a requirement
14 to do an initial assessment and medication review
15 and risk assessment within 24 hours of that
16 soldier's arrival at a warrior transition unit or
17 CBWTU. Then, our case managers are required to
18 conduct a reassessment and update to their care
19 plan on a weekly basis. Annex K also established
20 the access to care standards for our warriors in
21 transition. So, our warriors in transition have
22 access to a care standard of 24 hours for urgent

1 care, three working days for routine primary care,
2 and three working days for initial specialty care,
3 and that's coincident to the conditions that
4 brought them to that warrior transition unit or
5 that are required for them to go through the
6 medical evaluation board process for those
7 specific conditions. Now, we talked earlier this
8 morning about FRAGO 3 and FRAGO 4. These meet the
9 tasks that are specified in
10 DTM8-33 by establishing processes to identify wounded, ill and injured service members for assignment to case
11 management, and by establishing process to facilitate the transition process.
12 So, I'd like to bring back the example that you all asked us about this morning with, sir you had a family who's
13 called you because their son was admitted to a psychiatric hospital, and you wanted you asked the
14 question about how do we know that they get access to the appropriate case management services and into a warrior
15 transition unit as necessary.
The Surgeon General established a policy that all of our
16 behavior health patients that are seen on the
17 network will be case managed. That does not
18 necessarily mean that they will be placed into a
19 warrior transition unit, but we identify those
20 patients as Colonel Masden mentioned through the
21 absent sick process, and that are medical
22 management team at each of our military treatment

1 facilities evaluates that soldier, and analyzes
2 their need for case management services, and is
3 also communicating with the warrior transition
4 unit and that soldier's command to ensure that if
5 needed that would get put into a warrior
6 transition unit. So, they've got that feedback
7 loop closed to ensure that we get them connected
8 into the system.
9 DR. TURNER: How many case managers do you
10 have at each facility?
11 LT COLONEL SCOTT: It depends on the size of
12 the facility and the services that are being
13 provided. Right now, within our warrior transition
14 units, it's ratio based, and then for our non-WT,
15 for our traditional case managers, it varies from
16 facility based on the needs of that facility. We
17 can get you those numbers as well when we provide
18 you the TDA piece. Now, in terms of full
19 transparency as General Williams had mentioned
20 earlier today, I do need to tell you that
21 we do this well at some facilities, and we have areas of improvement. So, we have pockets of excellence and worked
22 out better in some places than others, in terms of the communication process and the assessment process.

1 Now, FRAGO 3 also provided guidance and clarity on the optimal identification screening, referral and management
2 of our wounded, ill and injured soldiers, and established clear entry and exit criteria to allow our warrior
3 transition units to enable the delivery of comprehensive medical case management. Colonel Masden outlined that
4 this morning for you as well.
FRAGO 4 made the transfer process between our warrior
5 transition units and our community based warrior
6 transition units more efficient. The intent of
7 this FRAGO was to ensure that all of our warriors
8 received an evaluation, care and transition
9 services at a location that was commensurate with
10 their needs and closest to their support network.
11 So, in a nutshell, from a case management
12 perspective, this FRAGO requires our case managers
13 to assess the needs of the soldier, to determine
14 if that soldier's clinical needs can be met in
15 their home community, and then to affect the
16 transition of that soldier to a CBWTU if that
17 indeed can be accomplished. If it can't, if the
18 clinical care isn't available in their home
19 community, or if they don't meet other transfer
20 criteria such as they're a high risk soldier and
21 really need to be in a warrior transition unit to
22 be able to have that close-knit base without the

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1 remote care piece, then there's also a mechanism
2 in FRAGO 4 that requires us to council those
3 soldiers and tell them why they're not going to go
4 home to their home community as well.
5 DR. GUICE: Can I ask you a question about the
6 coordination between your MTF based case
7 management and the WTU case management system?
8 They're both doing
9 assessments.
LT COLONEL SCOTT: Yes, ma'am.
10 DR. GUICE: They're both in the MTF, they're developing a
treatment plan. In the WTU, you've got the comprehensive
11 transition plan.
LT COLONEL SCOTT: Yes, ma'am.
12 DR. GUICE: So, who went? You know, what we have is we're
assessing these people a lot. So, who trumped? Who's got
13 the trump card, and then how does your treatment plan
interact or interdigitate with your CTP and oh by the
14 way, then you've got to loop in all of your case managers
that are on the outpatient side of it, all your specialty
15 case managers.
16 LT COLONEL SCOTT: Yes, ma'am.
17 DR. GUICE: So, how does all of that actually
18 work in practical? It's nice to go through the how
19 it's supposed to work, but I'm sure it's probably
20 not so neat in practicality.
21 LT COLONEL SCOTT: Ma'am, when you're dealing with
22 patients with complex needs, and the reason that

1 they're in a WTU and have a case manager is
2 because they've got complex needs, is there are
3 generally many care coordinators and case mangers
4 interacting with that patient on a daily basis.
5 I'm sure Colonel Gadsen can tell you I had twenty
6 people coming up to tell me, "Hey, I'm your case
7 manager. I'll take care of all of your needs." We
8 are working to standardize all case management
9 services across the continuum both for our
10 traditional and warrior transition units. One of
11 the things that I'm working with General Williams
12 is revamped the Cadbury course (SP?). The case
13 management component of that course, all case
14 manager will go through that training whether
15 they're in a WTU or not. We worked that through
16 the AMED Center and School to make sure that
17 happens. So, everybody has the same baseline
18 understanding of care of
19 complex patients.
Now, we have also said that the primary case manager for
20 all of our wounded, ill and injured soldiers in a WTU is
that WTU case manager, and they will coordinate with the
21 specialty case managers that are working with those
disease specific or illness injury specific components of
22 that.
DR. GUICE: Unless the warrior is still an inpatient.

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1 Then, I'm assuming the inpatient one trumps?
LT COLONEL SCOTT: Actually, what we have done is we
2 assign a WTU case manager the moment that they arrive at
that MTF, and that WTU case manager is working hand in
3 hand with that inpatient team and the discharge
4 planner on a daily basis so that there is an
5 overlap, and no gap in that services as we make
6 that hand off. So, yes, ma'am. While they're an
7 inpatient, that inpatient team to include the
8 discharge planner and the case managers that are
9 working that inpatient side have the rose, but
10 we're right there working with them to make that
11 hand off happen, and they got that assignment as
12 soon as they walked in the door.
13 DR. GUICE: The treatment plan that they
14 leave or are discharged from the facility hospital
15 with gets somehow incorporated into the CTP. So,
16 the rehabilitation piece of that is acknowledged
17 and has a trajectory within that.
18 LT COLONEL SCOTT: Yes, ma'am, and I'm going
19 to show you our AHLTA note. We have recently
20 developed a standardized aim form for using AHLTA
21 that incorporates the clinical care plan, and CTP
22 so you can see both of those components, so that

1 every member of the care team has that same level
2 of information and can track on that.
3 DR. GUICE: Could you provide the task force
4 with an example or a sample of the CTP, just a
5 paper one so that we can kind of see that and have
6 an understanding of how that looks when we go out
7 and ask people about that?
8 LT COLONEL SCOTT: With an example of the
9 Comprehensive
10 Transition Plan
DR. GUICE: Yes.
11 LT COLONEL SCOTT: Or the AHLTA note that our case
manager.
12 DR. GUICE: A CTP, yep. That'd be very helpful. Thank you.
LT COLONEL SCOTT: And, I'm going to show you I'm going
13 to show you some sample slides from CTP as well from the
automated version of that as we go through as well.
14 Sample CTP, okay.
To continue with this, I'd like to also point out that
15 our risk assessment and mitigation policy also mandates
the develop development of medication review process.
16 So, our primary care managers and nurse case
17 managers have to initiate that risk assessment
18 within twenty-four hours of arrival and complete
19 that weekly thereafter. Then, to facilitate the
20 communication as I mentioned, our risk levels are
21 documented in AHLTA in our case management note as
22 well as the automated comprehensive transition

1 plan as well. So, we've got it in both places. I
2 talk with my hands, so I have to put the pointer
3 down, or I can't brief you. Before moving to
4 discussion of case management training and
5 education, I'd like to draw your attention to the
6 last bullet on this slide that identifies the fact
7 that a core competency of case management is the
8 appropriate termination of case management
9 services. This really ties back to the previous
10 discussion that we had on policies and processes
11 established for our wounded, ill and injured
12 service members. Annex K to Op Order 7-5, and our
13 CTP guidance established clear standards for case
14 managers to follow in the appropriate termination
15 of case management services. So before closing a
16 case, case managers within our Warrior Transition
17 Units, our case managers must establish follow on
18 care for that warrior in transition. So, we are
19 always having a warm hand-off to ensure that our
20 warrior is connected with the resources that they
21 need once they leave our warrior transition unit,
22 whether that's with a VHA representative or

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1 directly with care providers in the community, or
2 if they're returning to the force, connecting them
3 with the resources that they needed for that
4 follow on care. One of the issues that Colonel
5 Gadsen and General Williams addressed earlier this
6 morning was that appropriate hand-off and
7 transition, and in the course of our COAD COAR
8 conversation, we noticed that that was that the
9 hand-off in that particular population, there was
10 a gap. So, we are working what we discovered
11 through the course of the analysis is our soldiers
12 were being returned to duty, and may have complex
13 care needs that weren't necessarily getting
14 communicated to the team that was receiving them
15 at the gaming locating where that soldier was
16 PCSing to. Now, there are traditional case
17 managers available in each of our MTFs. So, we
18 were doing great with our hand-off with the VA,
19 not so great with our hand-off back to our own
20 folks in our MTF. So, we'll be continuing to case
21 manage these folks. So, we're working with human
22 resources command to be able to make that link.

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1 When we've got a soldier PCSing, a COAD, COAR
2 soldier that's PCSing, our case managers will be
3 able to make that direct link with that new
4 location to be able to ensure that they're being
5 engaged, and meeting the needs of that COAD, COAR
6 population.
7 GENERAL WILLIAMS: Suzanne, I would add as of 1 February, HRC is actually still at since a special management
8 branch inside the folks that manage the EF&P program and such for our COAD soldiers. So, now our COAD soldiers get
9 instructions. The same kind of checklist, making sure the location that they're going to has the adequate medical
10 has the appropriate medical expertise, the facilities (inaudible) soldier is single and is used to be in
11 barracks, or a combinations. Is there a plan that can meet accommodation needs, and so we're continuing to
12 develop that process, but that was really an
13 immediate need that we kind of identified over the
14 last couple of months and got it implemented at
15 Fort Knox Wednesday. LT.
16 COLONEL SCOTT: Thank you. Now, the purpose
17 of this slide was to transition into a discussion
18 about training and education. DTMA-33 outlines
19 the provision of effective clinical case
20 management processes and says that we need to have
21 the appropriate trained personnel to be able to
22 care for them throughout the continuum of care.

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1 It also says that case management training needs
2 to use a patient-centered approach to case
3 management and explicitly directs the completion
4 of MHS-learned training modules to be able to
5 educate you. As an organization, warrior
6 transition command has conducted an in-depth
7 analysis of case management training needs and the
8 basis of this analysis was the identification of
9 core competencies for case managers. Now, the
10 medical management guide that's published by DoD
11 TRICARE Management Activity provides basic
12 principles, concepts, processes for the
13 implementation of case management services and it
14 uses the definition and standards of practice for
15 case management that are employed by the Case
16 Management Society of America but broadens that to
17 focus on the care of our unique military
18 population. So bring this all back together, the
19 core competencies that
20 you see listed on this slide are directly linked to the standards of practice for case management that are
21 established by the Case Management Society of America. So we've got it all tied back together so that we provide
22 exactly the same standard of care regardless of your practice setting to be able to care for that unique

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1 military population and also address the unique needs of
the wounded, ill and injured service members that will be
2 in our warrior transition units. Now, the analysis of
the 10-core competencies that were listed on the previous
3 slide coupled with the critical tasks that are
4 mandated by DoD and Army Regulations and Policies
5 resulted in 32 key tasks that you see identified
6 on that slide and it's the mastery of these tasks
7 that's necessary to achieve competency in case
8 management. The DTM also states that case
9 managers have to have -- it must be either
10 licensed registered nurses or degreed social
11 workers. All medical or clinical case managers
12 that are assigned to our warrior transition units
13 and community-based warrior transition units are
14 registered nurses and while
15 DOCTOR TURNER: That's 400 registered nurses.
16 LT. COLONEL SCOTT: 536 I think was my --
17 please don't quote me on that number. We will
18 provide you the exact number but it's a little
19 over 500 assigned or WTUs and CBWTUs, yes, sir?
20 DOCTOR TURNER: Congratulations on finding that.
21 LT. COLONEL SCOTT: It's an ongoing
22 challenge, yes, sir. Yes, sir. Now, while

1 certification and case management is not required,
2 it is highly recommended and encouraged and we're
3 moving to standardized job descriptions in our
4 civilian hire nurse case managers and as we update
5 those job descriptions, we're ensuring that the
6 skills qualification statement in those job
7 descriptions includes language stating that
8 certification is highly encouraged and our most
9 recent standardized job
10 description was for a GS-13 regional senior nurse case manager at each of our regions and this job description
11 specifically states that certification will be required within one year of employment. Now, that job description
12 is currently still out for classification, so we'll see. I'm hoping and assuming that it will come back with that
13 language still in it as we work that through because that is such an important part of our requirements as we move
14 through that. So you asked, sir, earlier about what incentives we have for our cadre [ph] members as they
15 work this. Our military nurse case managers are
16 eligible to apply for incentive specialty pay if
17 they're certified case managers. That is one of
18 the requirements for that certification pay and
19 specialty pay and that encourages that
20 certification and ongoing professional development
21 for this body of [inaudible]. We've also
22 established a comprehensive training plan to

1 ensure that case managers possess the foundational
2 skills to effectively assist warriors and their
3 families regain health or improved functional
4 capability. As part of the current warrior
5 transition unit cadre orientation course, case
6 managers have to complete all of the MHS learn
7 modules that are listed in the DTM as a
8 prerequisite for attending the resident cadre
9 course and then once the case managers graduate
10 from the cadre course, they also complete a unit-
11 level, competency-based orientation program and
12 those completed competency-based orientation
13 checklists are an organization inspection program
14 inspectable item as are the certificates of
15 completion and all the MHS learn modules so as you
16 go out and visit with our WTUs and CBWTUs, you
17 will be able to go into each of those and look at
18 the competency of our nurses and the validation of
19 that in their folders as you walk through.
20 Additionally, we've also talked about initiatives
21 through the AMED Center and School and the AMED
22 Center and

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1 School, in collaboration with us, developed an 80-hour nursing case management distance education program and
2 this course consists of two phases, basic and intermediate, and at the completion of this course, case
3 managers are prepared with the core competencies that are necessary to pas a case management certification exam.
4 So it provides them initial training and education. And, again, we are also in the process of developing a primary
5 care manager course because right now our primary care managers are not required to attend that cadre
6 orientation course. And, again, as many of you
7 are healthcare providers sitting around the table
8 today, you know that continuing education is a
9 critical component to our ongoing professional
10 development and this is very true for our case
11 managers and primary care managers and we have
12 several mechanisms in place to facilitate this
13 education process. We conduct a monthly video
14 teleconference with the regional senior nurse case
15 managers who then conduct teleconferences with the
16 warrior transition units and CBWTUs within their
17 regions to share knowledge and expertise. We also
18 collaborate with the medical command medical
19 management team to conduct a monthly audio call
20 that's enhanced with defense connect online
21 technology for viewing slides for all case
22 managers. That's both the traditional and WTU

1 case managers. Then our command surgeon conducts
2 a monthly audio call with our primary care
3 managers, battalion surgeons and brigade surgeons
4 as well. Then the content of the primary care
5 manager and case management tracks at the warrior
6 transition command annual training conference is
7 based on our careful analysis of the clinical
8 training gaps related to the comprehensive
9 transition plan process so we're trying to tie
10 that all back together as we bring folks together
11 in-house to be able to enhance their education and
12 training process. And in addition to the
13 warrior transition command hosted websites, through the Army Nurse Corps Leader Academy we also have a
14 professional forum for case managers so that they can exchange questions and information that are relevant to
15 case managers across the Army as we work through that. The DTM8-33 requires us to have a mechanism for tracking
16 completion of required training and we do this in the Army through the Army Training and Requirements and
17 Resources System and then, additionally, the TRICARE management activity conducts a routine data poll from
18 [inaudible] where we can track module completion.
19 We get a data poll on a monthly basis by nurse
20 case manager name, by courses that they've
21 completed and MHS learned when we're working
22 through that. And then in addition to the data

1 that we've captured through case management
2 encounters in ALTA, the warrior transition command
3 has the ability to track the number of patients
4 receiving case management services through our
5 medical operational data system or MODS as
6 Colonial Madsen mentioned earlier this morning.
7 In our warrior transition command, G1 has
8 developed a weekly report that is validated by
9 each warrior transition unit to ensure that case
10 management and squad leader ratios are maintained.
11 Additionally, each region conducts an evaluation
12 of length of stay and reports of status on
13 warriors in the program that have been in the
14 system for more than 530 to the warrior transition
15 command on an ongoing basis. And then we also
16 conduct a target review of select performance
17 matrix during our organizational inspection
18 program visits as well. So to give that to you in
19 a pictorial format and I apologize, this is a very
20 busy slide, but I didn't want to give you just one
21 or two in this particular slide. I wanted to give
22 you a snapshot of the number of warriors in

1 transition at each of our WTUs and the correlating

2 case management ratios at a given point in time

3 and this

4 particular data poll is done on Valentine's Day this year. As you can see, none of our warrior transition

5 units exceeds the DoD cap of 30 warriors that I've got marked on here. On this particular day, though, there

6 were four warrior transition units where the case management ratio was above the 1 to 20 and you can see

7 here, it's very busy, but where that blue bar exceeds that 20 mark, we've got four that are above that. Now,

8 what we have done with that is we have worked directly with our G1 to coordinate with each region and with

9 MEDCOM to effect some corrective action with each

10 of those warrior transition units and that's

11 either adding additional case managers to be able

12 to assist with that or move forward. Yes, ma'am?

13 DOCTOR GUICE: So if I'm reading the slide

14 right, while you had four of the blue that are

15 above the line, you've got lots more red that are

16 above the -- where you've got case management

17 available. Does that mean there are slots in

18 there...

19 LT. COLONEL SCOTT: The red lines that you see are

20 numbers of warriors in the -- I'm sorry, the

21 number of case managers. So yes, ma'am, we have a

22 number of warrior transition units where we've got

1 additional available resources.

2 DOCTOR GUICE: So you had excess capacity?

3 What the red means is you have excess capacity

4 there and it's one, two, three, four, five, six,

5 seven, eight, nine, ten, eleven -- 10 or 12, I

6 can't --

7 LT. COLONEL SCOTT: Yes, ma'am.

8 DOCTOR GUICE: So what's the plan? I mean

9 it seems like you've over resources some

10 facilities and under resourced a few others?

11 LT. COLONEL SCOTT: We are currently

12 engaging through our G1 and with the MEDCOM team

13 to look at right sizing of our warrior transition

14 units to make sure that we have

15 the right number of cadre members at each of our facilities. Now, that said, as General Williams

16 mentioned earlier today, we are taking a look at this endeavor not just based on ratios of 1 to 20 or 1 to 10,

17 we are looking at it in terms of the intensity of services required and the acuity of those soldiers within

18 each of those warrior transition units because a ratio of 1 to 20 may not be right for the Walter Reed's and

19 Bamsey's of the world and it may also not be right for small facility with very few warriors with not as complex

20 needs so we're trying to balance that and look at

21 that across the continuum. Yes, ma'am, absolutely

22 see that.

1 DOCTOR PHILLIPS: Is there a way to predict
2 when they will be on the front end when there
3 might be a surge needed and entrance into the
4 units? For example, when a division is deployed?
5 LT. COLONEL SCOTT: Absolutely and our G1
6 and MEDCOM personnel are in directly communication
7 to be able to anticipate that and we've actually
8 moved cadre in anticipation to support that. Yes,
9 sir, you had a point?
10 GENERAL WILLIAMS: Sir, to your point. It's
11 what I was mentioning earlier. We're trying to
12 establish triggers where we can anticipate and get
13 ahead of this so you don't have -- what we do is
14 we do a lot of rearranging of the chairs of the
15 Titanic here and so you want to do it as early as
16 you can so that you don't have red above the line
17 there. So that's exactly what we're doing.
18 Working with G35 7 and [inaudible], figure out the
19 triggers associated when we need six, seven
20 months. Right now what's happening is, I just had
21 a VTC with a couple of my battalions a week ago.
22 They're saying sir, we're finding out too late.

1 We need to know six months in advance so we can
2 anticipate what this looks like. So sir, you're
3 spot on. It's what we're doing. We just put this
4 together for the Chief of Staff at MEDCOM. Once a
5 unit
6 achieves 85 percent capacity, 95 percent capacity and triggers associated with that so you can anticipate that
7 and get ahead of that curve.
LT. COLONEL SCOTT: I mentioned earlier that I was going
8 to show you a snapshot picture of one of our OIP checklists to put this into context a little bit. This
9 is just one page of the clinical OIP inspection checklist and we will provide you with -- we can provide you with
10 that entire checklist for each of the functional areas and that will give you some frame of reference. But what
11 you'll see on this is our standards are based on
12 our policies and orders and that each of those
13 then has a reference back. So you had asked how
14 these are scored so as we look at each one of the
15 standards, the subject matter expert will either
16 give it a met, partially met or not met or we
17 didn't assess it and that is given a score and
18 then the entire checklist is then tallied and
19 given a percentage based on the number of
20 standards that are assessed within each of those
21 functional areas. Did that provide a little bit
22 of clarity with what we were talking about earlier

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1 this morning on that or did I muddy the waters
2 even more? Okay.
3 MS. DAILEY: [Inaudible], this was one of
4 your areas of questions and visibility of these
5 organizational checklists so here's an example of
6 one and there are like ten functional areas that
7 these will outline for the WTUs. This is just one
8 page.
9 DOCTOR GUICE: I would assume, though, that
10 your red, yellow and green indicators that there's
11 some -- for instance, for the first one -- the
12 first one's pretty straightforward so there should
13 be a little bit more fidelity with actually what
14 gets your red, what gets your green?
15 LT. COLONEL SCOTT: Honestly, it's either --
16 they either met the 24-hour mark or they didn't
17 met the 24-hour mark
18 as we go through that, yes, ma'am.
DOCTOR GUICE: And if it's 50 percent, it's partially?
19 LT. COLONEL SCOTT: Well, yes, ma'am. Twenty-four
and-a-half hours, yes, ma'am. For some of these it's
20 clearly a met or not met. There are other, and this
probably isn't -- the clinical checklist probably isn't a
21 good one to use an example of where you would get a
partially met in here. One of the examples may be on the
22 [inaudible] sheet. You know they have plans to publish a
newsletter, they've got the first one drafted but it has

1 not been disseminated to the families so that
2 would potentially be a partially met as opposed to
3 hey, we're just not even doing this standard; if
4 that makes sense.
5 DOCTOR TURNER: Ma'am, when you reported
6 these before they were given in percentages, so
7 these are all equally weighted?
8 LT. COLONEL SCOTT: Yes. These are
9 currently all equally weighted.
10 DOCTOR TURNER: Thank you.
11 LT. COLONEL SCOTT: So for the total number
12 of tasks divided by the overall weight to be able
13 to get that.
14 GENERAL GREEN: I guess my question would be
15 so your standards, okay, which came out in the
16 regulations. So 72 hours for this, 14 days for
17 that, okay, etc., etc., all based on what's
18 published in your guidance, correct?
19 LT. COLONEL SCOTT: Yes, sir.
20 GENERAL GREEN: Okay. So has there been --
21 I mean so if you're getting -- if you've got
22 excess nurses and you can do them in 12 hours,

1 you're still measured based on a 24-hour, right?

2 LT. COLONEL SCOTT: Yes.

3 GENERAL GREEN: And if you've got all the

4 occupational therapy you ever need, you can see

5 them in three days instead of 14 days, but as long

6 as you met the 14 days, you met the [inaudible]

7 that was published in the guide?

8 LT. COLONEL SCOTT: Yes, sir.

9 GENERAL GREEN: Okay. And so my question is a little different. What are you doing to look at in terms of optimal time for these things actually to occur? So for

10 instance, I'll use the 14-day occupational therapy. So if you've done enough of these cases now that you kind of

11 know when a patient is out of his immediate harm and basically now to a point that he can get started on this,

12 is there an optimal time to start occupational therapy?

13 LT. COLONEL SCOTT: And sir, we've certainly incorporated that into our comprehensive transition plan

14 guidance and while 14 days may seem arbitrary, our

15 occupational therapy specialists have looked at

16 the program requirements and the needs of our

17 soldiers as they get introduced to our units and

18 worked into the program. So that has -- our OTs

19 have said this is the ideal time for getting that

20 initial assessment done. We don't want to do our

21 initial OT assessment on day one. We need to get

22 those critical things to be able to get the

1 baseline set and then we'll come in and assess at
2 around 14 days.
3 GENERAL GREEN: And I accept that it's just
4 that my question is what's the basis for the
5 initial 14 days and the reason I'm asking is I
6 don't really care about the occupational therapy
7 but I'm very interested in are you looking at data
8 that tells us when the optimal time is to get
9 people into the next stage of their recovery and
10 for those who you have enough documentation now to
11 say that, I'll use MEBs, it's unlikely that
12 someone with this level of injury is going to
13 return to duty, that you start the processes in
14 parallel to get the MEB going at the same time
15 while they're recovering and you folks have the
16 data now to tell us that these are kind of the set
17 points where we should be going ahead and getting
18 things started but I haven't seen any of that
19 data.
20 LT. COLONEL SCOTT: And I don't have that
21 information
22 with me today. We'll take that back and --
GENERAL GREEN: But you do have some of that? You are

1 collecting that? Almost like a clinical practice guideline, what would be expected at this point in time
2 and if they're ahead of that, things you might be able to accelerate or if they're behind that, things you might be
3 able to do to help get them back on track?
LT. COLONEL SCOTT: Yes, sir. Yes, sir. I'm looking at
4 my boss, too. Yes, yes, sir. One of the --
Male Speaker: We'll get back to you on that. It's what
5 General Stone was asking.

6 LT. COLONEL SCOTT: Yes, sir. I've got that

7 -- that's my last slide. I'm saving the best one

8 for last.

9 GENERAL WILLIAMS: Do you have a slide on

10 orthopedics?

11 LT. COLONEL SCOTT: Yes. It's my last slide.

12 GENERAL WILLIAMS: So the short answer is we

13 don't have a whole lot of those matrix associated

14 with that? Why don't we go there. That's what

15 General Stone was asking about.

16 LT. COLONEL SCOTT: Not yet.

17 GENERAL WILLIAMS: We have a pilot that we

18 just started looking at -- won't you go to that

19 slide [inaudible].

20 LT. COLONEL SCOTT: Where is -- am I going

21 the right way?

22 No. I've got the whole pointer upside down. No

1 wonder

2 my -- this is where General Williams was asking me

3 to take you in, and General Stone, where you were

4 asking to go with this and we're not there yet.

5 We are just making the initial steps and we have

6 just completed a proof of concept to show that we

7 can take an ICD-9 code or a group of ICD-9 codes

8 and analyze -- bring in clinical practice

9 guidelines and civilian benchmarks to be able to

10 analyze that for length of stay, for direct and

11 purchased-care visits and return to the force as a

12 start for some initial baseline measures of

13 effectiveness to look at that. So what we did,

14 initially, to establish a baseline

15 was we have a DoD VA clinical practice guideline for low back pain.

16 GENERAL WILLIAMS: Sir, what I would say is embryonic at best right now, but this is what the Surgeon

17 General challenged me to do when I came in from the very beginning. Find out, are you par, are you shooting bogie

18 golf, are you on the plus side, where are you on this thing given a certain modality, whether it be orthopedic,

19 whether it be PTSD, establish the benchmarks or the decisive point if you want, if you will, to decide where

20 you are, and then that will help provide trust in

21 the organization. Because you know a particular

22 camp poster station that has a high proliferation

1 of mental health or PTSD folks, your population,
2 you're managing it about right there Williams.
3 This one over here, your kind of, you're a
4 littleyou're playing bogie math over here, bogie
5 golf. So that'swe've just started doing this sir,
6 this is what the Surgeon General has challenged me
7 to do. Come up with matrix to figure out to see
8 how you are doing. That's what I talked about
9 earlier.
10 DR. GUICE: Down at the very bottom you have
11 average length of stay 724, is that stay in
12 LT. COLONEL SCOTT: Oh, that's for 724.2
13 which is the ICD9 code for Lumbago, which is
14 DR. GUICE: So that's the code it
15 should be in parenthesis with the code.
16 LT. COLONEL SCOTT: Yes ma'am.
17 DR. GUICE: It's a bit confusing
18 because none of your number even got close to
19 that.
20 LT. COLONEL SCOTT: No. No ma'am. In fact,
21 when we look at the clinical practice guideline if
22 youfor low back pain if you take all of the

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1 assessments and referrals and therapies into

2 consideration you are looking at a length of stay

3 of about 180 days, so we use that as the benchmark

4 with this one to be able to go, and what you

5 can see on here is we have got some pockets of excellence that are definitely below the 180 days and we

6 have some that higher that we need to work on as we are working through that.

7 DR. GUICE: And when you refer to length of stay are you referring to a hospital length of stay or a WTU

8 LT. COLONEL SCOTT: No ma'am in our WTU in our WTU yes ma'am.

9 DR. GUICE: Thank you.

GENERAL WILLIAMS: So organizationally ma'am what

10 you are seeing is about 6 months or so. I have

11 raised a up to the level of one of my other

12 division chiefs, for lack of a better word, a SIG,

13 a Senior Initiative Group person how will do

14 nothing but manage Lean 6 Sigma projects like this

15 and get after matrix to help determine where we

16 are. The hard science of what we are doing.

17 GENERAL GREEN: I'd just encourage

18 you a little bit on this effort. I think that

19 some of the things that drive the longer stays in

20 WTU in terms of delays in making decisions on when

21 to start the medical board

22 GENERAL WILLIAMS: Yes Sir.

1 GENERAL GREEN: --can be ironed out
2 by the data that you have. Because you will have
3 good data on who is going to be able to be
4 retained on duty and who is less likely to be
5 retained on active duty, which allows you to do
6 your primary mission, which is transition, but
7 beyond your primary mission, which is transition
8 to help these folks get on with life and hopefully
9 recover and get them back to quality of life, is
10 it made guide all the Services in terms of how we
11 deal with these things across the boards.
12 GENERAL WILLIAMS: Yes Sir.
13 GENERAL GREEN: Whether we have them
14 in WTU's or not. Because right now there is a
15 huge gap in terms of when we start a medical board
16 if left up to a physicians
17 discretion as to when they feel they have got "Maximum Medical Benefit" as so I'm not trying to take away from
18 "Maximum Medical Benefit", but if we have good data on when that is physicians react to that and we can get some
19 of these cases moved
GENERAL WILLIAMS: You're exactly right, yes sir.
20 COLONEL GADSON: Sir in my case, my point, I argue the same thing with the system. I lost my leg so I was;
21 I knew what the audit of MEB was going to be, even though I had surgeries up to 15 months after I was initially
22 wounded. That process could have-I could have

1 been on the next process by the time my surgeries,
2 but it was in the sequential mindset of a
3 concurrent mindset when it is obvious, you know,
4 may have save us some time. Now I continue to
5 serve, but where it really hurts a soldier or
6 service member is when they are trying to get on
7 with their life, when they are trying to
8 transition and it's costing them money. It's
9 costing them financially. It's costing them
10 getting into schools if they can't make the
11 transition in an efficient manner, so there is a
12 lot of room for how we deal with these things.
13 GENERAL GREEN: Yeah, and
14 unfortunately it may also be very demoralizing
15 both to them and their family not to press on and
16 return to quality of life.
17 COLONEL GADSON: Right, and as we
18 have talked about allowing us to continue to go up
19 in the WTU it is completely opposite, so we know
20 where we going, we start having problems and stuff
21 that is well documented.
22 LT. COLONEL SCOTT: Okay. I'm going to

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1 take you back toone of the case management best
2 practices that we identified during a very early
3 organization and inspection program visit was the
4 use of a template for nurse case manager note
5 using an AIM form in AHLTA. And recognizing for
6 this the potential for this AIM form to allow for
7 a standardized methodology for capturing case
8 management information and improved documentation across the enterprise the Army Nurse Corp. established a working
9 group of representatives from within each region to develop one standardized case management AIM form. We
10 conducted and developed and staffed an approved note for use in AHLTA and then conducted training for all case
11 managers for using defense connect online technology in October and then directed its use by all case managers
12 starting on 1 November of last year. Now the standardized note provides a communication link for, as I
13 mentioned, for that comprehensive transition plan
14 and the clinical team members. And additionally,
15 it provides explicit directions on capturing
16 workload and acuity in accordance with the DTM.
17 So, I'm going to walk you through a couple of
18 screen shots of that AIM form as we work through
19 this.
20 MASTER SERGEANT MACKENZIE: Can I
21 ask you a question?
22 LT. COLONEL SCOTT: Yes. Sir.

1 MASTER SERGEANT MACKENZIE: This is
2 something I've seen along the way and I'm just
3 curious with this initiation of this form starting
4 in 1 November, was also included in that program
5 to go and capture the old information on this
6 already in the program to make sure that that
7 information does not get put into a different file
8 that they can't seem to locate?
9 LT. COLONEL SCOTT: This is still within your
10 electronic health record in AHLTA. What this AIM
11 form does is standardize the methodology for
12 capturing that information for our case managers
13 and ensure that all the data points are captured
14 with every visit. So, the data was there, it is
15 now going to be there on a more consistent basis
16 and in a standardized format so when that AIM form
17 gets opened or the AHLTA gets opened up by a
18 member of the health care team they know the same
19 place
20 to go for the information every visit, as it is SOAPED
out in the AHLTA note, if that makes sense.
21 MASTER SERGEANT MACKENZIE: It does. And the
reason for my concern is being a Wounded Warrior for 7
22 years there are pieces of my information that have not
been located yet because of these transitions through

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1 electronic systems. There was no policy or procedure for
bringing that old information forward into the new
2 technology, and I just want to make sure that as
important as case management is and what you all are
3 doing that that information is being brought along
4 with it.
5 LT. COLONEL SCOTT: It doesn't change
6 anything. This is just a tool within AHLTA within
7 that electronic health record, so it does not
8 change any of that. Yes ma'am.
9 DR. GUICE: Was there not development
10 of a standard sort of a purple case management
11 tool by health affairs that came out of LOA3, I'm
12 remembering this one tool and it sounds like you
13 all have elected to just do that data capture
14 within the AHLTA note instead of going to the
15 purple tool?
16 LT. COLONEL SCOTT: You're talking about
17 the clinical case management documentation tool,
18 that is still in development and we are just now
19 at the initial test phase, the concept has been
20 developed and we are just at the initial test
21 phase at our sites in selecting those sites where
22 that is going to get tested.

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1 DR. GUICE: So, how does that work
2 with the-how do you see that working with the new
3 page in AHLTA?
4 LT. COLONEL SCOTT: We will have to see
5 where that goes and where that takes us. We have
6 an immediate need right now. We've got to be able
7 to communicate now and can't wait for that future
8 note to be able to document the data and then be
9 able to extract that information out of the system
10 and our electronic health records to be able to
11 move forward. As you are aware, with the DTM we
12 are required to capture, as an example, we are
13 required to capture case management and acuity and
14 the visits whether it is opened, continued or
15 closed and what we were finding honestly ma'am is
16 that we were not getting good consistent
17 information every time. The standardized AIM form
18 allows us that specific information to be captured
19 the same way because it prompts the nurse to say,
20 "Oh yeah, I gotta put in my E&M codes and I gotta
21 put in my G-code with every visit", so it
22 processes that and then back with our CPT if you

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1 got a radio button in front of you that prompts
2 you to do it you're going to put the information
3 there and our providers also know when they open
4 up that note if they want to see what the soldiers
5 when their last scrimmage was for the CPT they
6 know exactly where to go within that context of
7 that SOAPED note same place every time. And then
8 it also allows for data pull to when we are
9 analyzing records by IDC9 code. So, this is the
10 here-and-now fix. We will see where things go
11 with CCM. Yes ma'am.
12 So, this is an initial page. When a case manager opens
their standardized AIM form for case management
13 documentation this is the screen that they see, and as
you can see it immediately prompts them to complete
14 required tasks, so everything that's in blue on all these
forms is a required field for all of our WTU case
15 managers to complete. The active duty tab in our AIM
forms captures those WTU specific data points and is
16 designed to communicate the risk assessment comprehensive
transition plan to that clinical team. And then if you
17 note that the risk assessment in the upper left
18 hand corner will give us with every visit they are
19 going to give us their current assessment of that
20 soldier for their risk assessment and then if
21 there has been a change whether or not they have
22 talked to the PCM and coordinated with the

1 specialty care providers on that. And then we also
2 have in the center comprehensive transition plan
3 when it was updated and reviewed and then the
4 lastwhen that transition review board has been
5 scheduled and the results of that if it has been
6 conducted as we work through that. And then we
7 have also go a place for comprehensive transition
8 plan goals to be placed into this note as well to
9 be able to link the overall CPT with the clinical
10 plan when we are walking through this. And then
11 we have a component for the nursing care plan to
12 be included in the note and then we also have a
13 indicator and prompt to be able to remind the
14 nurse to print this out and ensure that soldier
15 agrees to this as well, because that is an
16 important component of
17 this. GENERAL WILLIAMS: Sir, what I
18 would say is embryonic at best right now, but this
19 is what the Surgeon General challenged me to do
20 when I came in from the very beginning. Find out,
21 are you par, are you shooting bogie golf, are you
22 on the plus side, where are you on this thing

1 given a certain modality, whether it be

2 orthopedic,

3 whether it be PTSD, establish the benchmarks or the
decisive point if you want, if you will, to decide where
4 you are, and then that will help provide trust in the
organization. Because you know a particular camp poster
5 station that has a high proliferation of mental health or
PTSD folks, your population, you're managing it about
6 right there Williams. This one over here, your kind of,
you're a littleyou're playing bogie math over here, bogie
7 golf. So that'swe've just started doing this sir, this
is what the Surgeon General has challenged me to do.
8 Come up with matrix to figure out to see how you

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12 LT. COLONEL SCOTT: No ma'am in our WTU
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15 you are seeing is about 6 months or so. I have raised a
up to the level of one of my other division chiefs, for
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17 projects like this and get after matrix to help determine
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18 GENERAL GREEN: I'd just encourage you a little
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19 drive the longer stays in WTU in terms of delays
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10 doing that that information is being brought along with it.

11 LT. COLONEL SCOTT: It doesn't change anything. This is just a tool within AHLTA within that electronic health

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15 nurse to print this out and ensure that soldier
16 agrees to this as well, because that is an
17 important component of
18 this. LT. COLONEL SCOTT: Thank you. Now,
19 the purpose of this slide was to transition into a
20 discussion about training and education. DTMA-33
21 outlines the provision of effective clinical case
22 management processes and says that we need to have

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1 the appropriate trained personnel to be able to
2 care for them throughout the continuum of
3 care. It also says that case management training needs to use a patient-centered approach to case management and
4 explicitly directs the completion of MHS-learned training modules to be able to educate you. As an organization,
5 warrior transition command has conducted an in-depth analysis of case management training needs and the basis
6 of this analysis was the identification of core competencies for case managers. Now, the medical
7 management guide that's published by DoD TRICARE Management Activity provides basic principles, concepts,
8 processes for the implementation of case
9 management services and it uses the definition and
10 standards of practice for case management that are
11 employed by the Case Management Society of America
12 but broadens that to focus on the care of our
13 unique military population. So bring this all
14 back together, the core competencies that you see
15 listed on this slide are directly linked to the
16 standards of practice for case management that are
17 established by the Case Management Society of
18 America. So we've got it all tied back together so
19 that we provide exactly the same standard of care
20 regardless of your practice setting to be able to
21 care for that unique military population and also
22 address the unique needs of the wounded, ill and

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1 injured service members that will be in our
2 warrior transition units. Now, the analysis of
3 the 10-core competencies that were listed on the
4 previous slide coupled with the critical tasks
5 that are mandated by DoD and Army Regulations and
6 Policies resulted in 32 key tasks that you see
7 identified on that slide and it's the mastery of
8 these tasks that's necessary to achieve competency
9 in case management. The DTM also states that case
10 managers have to have -- it must be either
11 licensed registered nurses or degreed social
12 workers. All medical or clinical case managers
13 that are assigned to our warrior transition units
14 and community-based warrior
15 transition units are registered nurses and while
DOCTOR TURNER: That's 400 registered nurses.
16 LT. COLONEL SCOTT: 536 I think was my -- please don't
quote me on that number. We will provide you the exact
17 number but it's a little over 500 assigned or WTUs and
CBWTUs, yes, sir?
18 DOCTOR TURNER: Congratulations on finding that.
LT. COLONEL SCOTT: It's an ongoing challenge, yes, sir.
19 Yes, sir. Now, while certification and case management
is not required, it is highly recommended and encouraged
20 and we're moving to standardized job descriptions
21 in our civilian hire nurse case managers and as we
22 update those job descriptions, we're ensuring that

1 the skills qualification statement in those job
2 descriptions includes language stating that
3 certification is highly encouraged and our most
4 recent standardized job description was for a GS-
5 13 regional senior nurse case manager at each of
6 our regions and this job description specifically
7 states that certification will be required within
8 one year of employment. Now, that job description
9 is currently still out for classification, so
10 we'll see. I'm hoping and assuming that it will
11 come back with that language still in it as we
12 work that through because that is such an
13 important part of our requirements as we move
14 through that. So you asked, sir, earlier about
15 what incentives we have for our cadre [ph] members
16 as they work this. Our military nurse case
17 managers are eligible to apply for incentive
18 specialty pay if they're certified case managers.
19 That is one of the requirements for that
20 certification pay and specialty pay and that
21 encourages that certification and ongoing
22 professional development for this body of

1 [inaudible]. We've also established a
2 comprehensive training plan to ensure that case
3 managers possess the foundational skills to
4 effectively assist warriors and their families
5 regain health or improved
6 functional capability. As part of the current warrior transition unit cadre orientation course, case managers
7 have to complete all of the MHS learn modules that are listed in the DTM as a prerequisite for attending the
8 resident cadre course and then once the case managers graduate from the cadre course, they also complete a
9 unit-level, competency-based orientation program and those completed competency-based orientation checklists
10 are an organization inspection program inspectable item as are the certificates of completion and all the MHS
11 learn modules so as you go out and visit with our
12 WTUs and CBWTUs, you will be able to go into each
13 of those and look at the competency of our nurses
14 and the validation of that in their folders as you
15 walk through. Additionally, we've also talked
16 about initiatives through the AMED Center and
17 School and the AMED Center and School, in
18 collaboration with us, developed an 80-hour
19 nursing case management distance education program
20 and this course consists of two phases, basic and
21 intermediate, and at the completion of this
22 course, case managers are prepared with the core

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1 competencies that are necessary to pas a case
2 management certification exam. So it provides them
3 initial training and education. And, again, we
4 are also in the process of developing a primary
5 care manager course because right now our primary
6 care managers are not required to attend that
7 cadre orientation course. And, again, as many of
8 you are healthcare providers sitting around the
9 table today, you know that continuing education is
10 a critical component to our ongoing professional
11 development and this is very true for our case
12 managers and primary care managers and we have
13 several mechanisms in place to facilitate this
14 education process. We conduct a monthly video
15 teleconference with the regional senior nurse case
16 managers who then conduct teleconferences with the
17 warrior transition units and CBWTUs within their regions
to share knowledge and expertise. We also collaborate
18 with the medical command medical management team to
conduct a monthly audio call that's enhanced with defense
19 connect online technology for viewing slides for all case
managers. That's both the traditional and WTU case
20 managers. Then our command surgeon conducts a monthly
audio call with our primary care managers, battalion
21 surgeons and brigade surgeons as well. Then the content
of the primary care manager and case management tracks at
22 the warrior transition command annual training

1 conference is based on our careful analysis of the
2 clinical training gaps related to the
3 comprehensive transition plan process so we're
4 trying to tie that all back together as we bring
5 folks together in-house to be able to enhance
6 their education and training process. And in
7 addition to the warrior transition command hosted
8 websites, through the Army Nurse Corps Leader
9 Academy we also have a professional forum for case
10 managers so that they can exchange questions and
11 information that are relevant to case managers
12 across the Army as we work through that. The DTM8-
13 33 requires us to have a mechanism for tracking
14 completion of required training and we do this in
15 the Army through the Army Training and
16 Requirements and Resources System and then,
17 additionally, the TRICARE management activity
18 conducts a routine data poll from [inaudible]
19 where we can track module completion. We get a
20 data poll on a monthly basis by nurse case manager
21 name, by courses that they've completed and MHS
22 learned when we're working through that. And then

1 in addition to the data that we've captured
2 through case management encounters in ALTA, the
3 warrior transition command has the ability to
4 track the number of patients receiving case
5 management services through our medical
6 operational data system or MODS as Colonial Masden
7 mentioned earlier
8 this morning. In our warrior transition command, G1 has developed a weekly report that is validated by each
9 warrior transition unit to ensure that case management and squad leader ratios are maintained. Additionally,
10 each region conducts an evaluation of length of stay and reports of status on warriors in the program that have
11 been in the system for more than 530 to the warrior transition command on an ongoing basis. And then we also
12 conduct a target review of select performance matrix during our organizational inspection program visits as
13 well. So to give that to you in a pictorial
14 format and I apologize, this is a very busy slide,
15 but I didn't want to give you just one or two in
16 this particular slide. I wanted to give you a
17 snapshot of the number of warriors in transition
18 at each of our WTUs and the correlating case
19 management ratios at a given point in time and
20 this particular data poll is done on Valentine's
21 Day this year. As you can see, none of our
22 warrior transition units exceeds the DoD cap of 30

1 warriors that I've got marked on here. On this
2 particular day, though, there were four warrior
3 transition units where the case management ratio
4 was above the 1 to 20 and you can see here, it's
5 very busy, but where that blue bar exceeds that 20
6 mark, we've got four that are above that. Now,
7 what we have done with that is we have worked
8 directly with our G1 to coordinate with each
9 region and with MEDCOM to effect some corrective
10 action with each of those warrior transition units
11 and that's either adding additional case managers
12 to be able to assist with that or move forward.
13 Yes, ma'am?
14 DOCTOR GUICE: So if I'm reading the slide
15 right, while you had four of the blue that are
16 above the line, you've got lots more red that are
17 above the -- where you've got case management
18 available. Does that mean there are slots in
19 there...
20 LT. COLONEL SCOTT: The red lines that you see are numbers of warriors in the -- I'm sorry, the number of
21 case managers. So yes, ma'am, we have a number of warrior transition units where we've got additional
22 available resources.
DOCTOR GUICE: So you had excess capacity? What the red

1 means is you have excess capacity there and it's one, two, three, four, five, six, seven, eight, nine, ten,
2 eleven -- 10 or 12, I can't --
LT. COLONEL SCOTT: Yes, ma'am.
3 DOCTOR GUICE: So what's the plan? I mean
4 it seems like you've over resources some
5 facilities and under resourced a few others?
6 LT. COLONEL SCOTT: We are currently
7 engaging through our G1 and with the MEDCOM team
8 to look at right sizing of our warrior transition
9 units to make sure that we have the right number
10 of cadre members at each of our facilities. Now,
11 that said, as General Williams mentioned earlier
12 today, we are taking a look at this endeavor not
13 just based on ratios of 1 to 20 or 1 to 10, we are
14 looking at it in terms of the intensity of
15 services required and the acuity of those soldiers
16 within each of those warrior transition units
17 because a ratio of 1 to 20 may not be right for
18 the Walter Reed's and Bamsey's of the world and it
19 may also not be right for small facility with very
20 few warriors with not as complex needs so we're
21 trying to balance that and look at that across the
22 continuum. Yes, ma'am, absolutely see that.

1 DOCTOR PHILLIPS: Is there a way to predict
2 when they will be on the front end when there
3 might be a surge needed and entrance into the
4 units? For example, when a division is deployed?
5 LT. COLONEL SCOTT: Absolutely and our G1
6 and MEDCOM personnel are in directly communication
7 to be able to anticipate that and we've actually
8 moved cadre in
9 anticipation to support that. Yes, sir, you had a point?
GENERAL WILLIAMS: Sir, to your point. It's what I was
10 mentioning earlier. We're trying to establish triggers
where we can anticipate and get ahead of this so you
11 don't have -- what we do is we do a lot of rearranging of
the chairs of the Titanic here and so you want to do it
12 as early as you can so that you don't have red above the
line there. So that's exactly what we're doing. Working
13 with G35 7 and [inaudible], figure out the triggers
associated when we need six, seven months. Right now
14 what's happening is, I just had a VTC with a
15 couple of my battalions a week ago. They're
16 saying sir, we're finding out too late. We need
17 to know six months in advance so we can anticipate
18 what this looks like. So sir, you're spot on.
19 It's what we're doing. We just put this together
20 for the Chief of Staff at MEDCOM. Once a unit
21 achieves 85 percent capacity, 95 percent capacity
22 and triggers associated with that so you can

1 anticipate that and get ahead of that curve.

2 LT. COLONEL SCOTT: I mentioned earlier that

3 I was going to show you a snapshot picture of one

4 of our OIP checklists to put this into context a

5 little bit. This is just one page of the clinical

6 OIP inspection checklist and we will provide you

7 with -- we can provide you with that entire

8 checklist for each of the functional areas and

9 that will give you some frame of reference. But

10 what you'll see on this is our standards are based

11 on our policies and orders and that each of those

12 then has a reference back. So you had asked how

13 these are scored so as we look at each one of the

14 standards, the subject matter expert will either

15 give it a met, partially met or not met or we

16 didn't assess it and that is given a score and

17 then the entire checklist is then tallied and

18 given a percentage based on the number of

19 standards that are assessed within each of those

20 functional areas. Did that

21 provide a little bit of clarity with what we were talking about earlier this morning on that or did I muddy the

22 waters even more? Okay.

MS. DAILEY: [Inaudible], this was one of your areas of

1 questions and visibility of these organizational checklists so here's an example of one and there are like
2 ten functional areas that these will outline for the WTUs. This is just one page.
3 DOCTOR GUICE: I would assume, though, that your red, yellow and green indicators that there's some -- for
4 instance, for the first one -- the first one's
5 pretty straightforward so there should be a little
6 bit more fidelity with actually what gets your
7 red, what gets your green?
8 LT. COLONEL SCOTT: Honestly, it's either --
9 they either met the 24-hour mark or they didn't
10 met the 24-hour mark as we go through that, yes,
11 ma'am.
12 DOCTOR GUICE: And if it's 50 percent, it's
13 partially?
14 LT. COLONEL SCOTT: Well, yes, ma'am. Twenty-four
15 and-a-half hours, yes, ma'am. For some of these
16 it's clearly a met or not met. There are other,
17 and this probably isn't -- the clinical checklist
18 probably isn't a good one to use an example of
19 where you would get a partially met in here. One
20 of the examples may be on the [inaudible] sheet.
21 You know they have plans to publish a newsletter,
22 they've got the first one drafted but it has not

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1 been disseminated to the families so that would
2 potentially be a partially met as opposed to hey,
3 we're just not even doing this standard; if that
4 makes sense.
5 DOCTOR TURNER: Ma'am, when you reported
6 these before they were given in percentages, so
7 these are all equally weighted?
8 LT. COLONEL SCOTT: Yes. These are
9 currently all equally weighted.
10 DOCTOR TURNER: Thank you.
11 LT. COLONEL SCOTT: So for the total number of tasks divided by the overall weight to be able to get that.
12 GENERAL GREEN: I guess my question would be so your standards, okay, which came out in the regulations. So
13 72 hours for this, 14 days for that, okay, etc., etc., all based on what's published in your guidance, correct?
14 LT. COLONEL SCOTT: Yes, sir.
GENERAL GREEN: Okay. So has there been -- I mean so if
15 you're getting -- if you've got excess nurses and you can do them in 12 hours, you're still measured based on a
16 24-hour, right?
17 LT. COLONEL SCOTT: Yes.
18 GENERAL GREEN: And if you've got all the
19 occupational therapy you ever need, you can see
20 them in three days instead of 14 days, but as long
21 as you met the 14 days, you met the [inaudible]
22 that was published in the guide?

1 LT. COLONEL SCOTT: Yes, sir.
2 GENERAL GREEN: Okay. And so my question is
3 a little different. What are you doing to look at
4 in terms of optimal time for these things actually
5 to occur? So for instance, I'll use the 14-day
6 occupational therapy. So if you've done enough of
7 these cases now that you kind of know when a
8 patient is out of his immediate harm and basically
9 now to a point that he can get started on this, is
10 there an optimal time to start occupational
11 therapy?
12 LT. COLONEL SCOTT: And sir, we've certainly
13 incorporated that into our comprehensive
14 transition plan guidance and while 14 days may
15 seem arbitrary, our occupational therapy
16 specialists have looked at the program
17 requirements and the needs of our soldiers as they
18 get introduced to our units and worked into the
19 program. So that has -- our OTs have said this is
20 the ideal time for getting that initial assessment
21 done. We don't want to do our initial OT
22 assessment on day one. We need to get those

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1 critical things to be able to get the baseline set
2 and then we'll come in and assess at around 14 days.
3 GENERAL GREEN: And I accept that it's just that my question is what's the basis for the initial 14 days and
4 the reason I'm asking is I don't really care about the occupational therapy but I'm very interested in are you
5 looking at data that tells us when the optimal time is to get people into the next stage of their recovery and for
6 those who you have enough documentation now to say that, I'll use MEBs, it's unlikely that someone with this level
7 of injury is going to return to duty, that you start the processes in parallel to get the MEB going at the
8 same time while they're recovering and you folks
9 have the data now to tell us that these are kind
10 of the set points where we should be going ahead
11 and getting things started but I haven't seen any
12 of that data.
13 LT. COLONEL SCOTT: And I don't have that
14 information with me today. We'll take that back
15 and --
16 GENERAL GREEN: But you do have some of
17 that? You are collecting that? Almost like a
18 clinical practice guideline, what would be
19 expected at this point in time and if they're
20 ahead of that, things you might be able to
21 accelerate or if they're behind that, things you
22 might be able to do to help get them back on

1 track?

2 LT. COLONEL SCOTT: Yes, sir. Yes, sir.

3 I'm looking at my boss, too. Yes, yes, sir. One

4 of the -- Male Speaker: We'll get back to you on

5 that. It's what General Stone was asking.

6 LT. COLONEL SCOTT: Yes, sir. I've got that

7 -- that's my last slide. I'm saving the best one

8 for last.

9 GENERAL WILLIAMS: Do you have a slide on

10 orthopedics?

11 LT. COLONEL SCOTT: Yes. It's my last slide.

12 GENERAL WILLIAMS: So the short answer is we

13 don't have a whole lot of those matrix associated

14 with that? Why don't we go there. That's what

15 General Stone was asking about.

16 LT. COLONEL SCOTT: Not yet.
GENERAL WILLIAMS: We have a pilot that we just started
17 looking at -- won't you go to that slide [inaudible].
LT. COLONEL SCOTT: Where is -- am I going the right way?
18 No. I've got the whole pointer upside down. No wonder
my -- this is where General Williams was asking me to
19 take you in, and General Stone, where you were asking to
go with this and we're not there yet. We are just making
20 the initial steps and we have just completed a proof of
concept to show that we can take an ICD-9 code or a group
21 of ICD-9 codes and analyze -- bring in clinical

22 practice guidelines and civilian benchmarks to be

1 able to analyze that for length of stay, for
2 direct and purchased-care visits and return to the
3 force as a start for some initial baseline
4 measures of effectiveness to look at that. So
5 what we did, initially, to establish a baseline
6 was we have a DoD VA clinical practice guideline
7 for low back pain.
8 GENERAL WILLIAMS: Sir, what I would say is
9 embryonic at best right now, but this is what the
10 Surgeon General challenged me to do when I came in
11 from the very beginning. Find out, are you par,
12 are you shooting bogie golf, are you on the plus
13 side, where are you on this thing given a certain
14 modality, whether it be orthopedic, whether it be
15 PTSD, establish the benchmarks or the decisive
16 point if you want, if you will, to decide where
17 you are, and then that will help provide trust in
18 the organization. Because you know a particular
19 camp poster station that has a high proliferation
20 of mental health or PTSD folks, your population,
21 you're managing it about right there Williams.
22 This one over here, your kind of, you're a

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1 littleyou're playing bogie math over here, bogie

2 golf. So that'swe've just started doing this sir,

3 this is what the Surgeon General has challenged me

4 to do. Come up with matrix to figure out to see

5 how you are

6 doing. That's what I talked about earlier.
DR. GUICE: Down at the very bottom you have
7 average length of stay 724, is that stay in
LT. COLONEL SCOTT: Oh, that's for 724.2 which is the
8 ICD9 code for Lumbago, which is
DR. GUICE: So that's the code it should be in
9 parenthesis with the code.
LT. COLONEL SCOTT: Yes ma'am.
10 DR. GUICE: It's a bit confusing because none of
your number even got close to that.
11 LT. COLONEL SCOTT: No. No ma'am. In fact,

12 when we look at the clinical practice guideline if

13 youfor low back pain if you take all of the

14 assessments and referrals and therapies into

15 consideration you are looking at a length of stay

16 of about 180 days, so we use that as the benchmark

17 with this one to be able to go, and what you can

18 see on here is we have got some pockets of

19 excellence that are definitely below the 180 days

20 and we have some that higher that we need to work

21 on as we are working through that.

22 DR. GUICE: And when you refer to

1 length of stay are you referring to a hospital
2 length of stay or a WTU
3 LT. COLONEL SCOTT: No ma'am in our WTU
4 in our WTU yes ma'am.
5 DR. GUICE: Thank you.
6 GENERAL WILLIAMS: So organizationally
7 ma'am what you are seeing is about 6 months or so.
8 I have raised a up to the level of one of my
9 other division chiefs, for lack of a better word,
10 a SIG, a Senior Initiative Group person how will
11 do nothing but manage Lean 6 Sigma projects like
12 this and get after matrix to help determine where
13 we are. The hard science of what we are doing.
14 GENERAL GREEN: I'd just encourage
15 you a little bit on this effort. I think that
16 some of the things that drive the longer stays in
17 WTU in terms of delays in
18 making decisions on when to start the medical board
GENERAL WILLIAMS: Yes, sir.
19 GENERAL GREEN: --can be ironed out by the data
that you have. Because you will have good data on who is
20 going to be able to be retained on duty and who is less
likely to be retained on active duty, which allows you to
21 do your primary mission, which is transition, but beyond
your primary mission, which is transition to help these
22 folks get on with life and hopefully recover and get them
back to quality of life, is it made guide all the

1 Services in terms of how we deal with these things
2 across the boards.
3 GENERAL WILLIAMS: Yes, sir.
4 GENERAL GREEN: Whether we have them
5 in WTU's or not. Because right now there is a
6 huge gap in terms of when we start a medical board
7 if left up to a physicians discretion as to when
8 they feel they have got "Maximum Medical Benefit"
9 as so I'm not trying to take away from "Maximum
10 Medical Benefit", but if we have good data on when
11 that is physicians react to that and we can get
12 some of these cases moved
13 GENERAL WILLIAMS: You're exactly
14 right, Yes, sir.
15 COLONEL GADSON: Sir in my case, my
16 point, I argue the same thing with the system. I
17 lost my leg so I was; I knew what the audit of MEB
18 was going to be, even though I had surgeries up to
19 15 months after I was initially wounded. That
20 process could have-I could have been on the next
21 process by the time my surgeries, but it was in
22 the sequential mindset of a concurrent mindset

1 when it is obvious, you know, may have save us
2 some time. Now I continue to serve, but where it
3 really hurts a soldier or service member is when
4 they are trying to get on with their life, when
5 they are trying to transition and it's costing
6 them money. It's costing them financially. It's
7 costing them getting into schools if they can't
8 make the
9 transition in an efficient manner, so there is a lot of room for how we deal with these things.
10 GENERAL GREEN: Yeah, and unfortunately it may also be very demoralizing both to them and their family
11 not to press on and return to quality of life.
COLONEL GADSON: Right, and as we have talked
12 about allowing us to continue to go up in the WTU it is completely opposite, so we know where we going, we start
13 having problems and stuff that is well documented.
LT. COLONEL SCOTT: Okay. I'm going to take you back
14 toone of the case management best practices that
15 we identified during a very early organization and
16 inspection program visit was the use of a template
17 for nurse case manager note using an AIM form in
18 AHLTA. And recognizing for this the potential for
19 this AIM form to allow for a standardized
20 methodology for capturing case management
21 information and improved documentation across the
22 enterprise the Army Nurse Corp. established a

1 working group of representatives from within each
2 region to develop one standardized case management
3 AIM form. We conducted and developed and staffed
4 an approved note for use in AHLTA and then
5 conducted training for all case managers for using
6 defense connect online technology in October and
7 then directed its use by all case managers
8 starting on 1 November of last year. Now the
9 standardized note provides a communication link
10 for, as I mentioned, for that comprehensive
11 transition plan and the clinical team members.
12 And additionally, it provides explicit directions
13 on capturing workload and acuity in accordance
14 with the DTM. So, I'm going to walk you through a
15 couple of screen shots of that AIM form as we work
16 through this.
17 MASTER SERGEANT MACKENZIE: Can I
18 ask you a question?
19 LT. COLONEL SCOTT: Yes. Sir.
20 MASTER SERGEANT MACKENZIE: This is something
I've seen along the way and I'm just curious with this
21 initiation of this form starting in 1 November, was also
included in that program to go and capture the old
22 information on this already in the program to make sure
that that information does not get put into a different

1 file that they can't seem to locate?
LT. COLONEL SCOTT: This is still within your
2 electronic health record in AHLTA. What this AIM form
does is standardize the methodology for capturing that
3 information for our case managers and ensure that
4 all the data points are captured with every visit.
5 So, the data was there, it is now going to be
6 there on a more consistent basis and in a
7 standardized format so when that AIM form gets
8 opened or the AHLTA gets opened up by a member of
9 the health care team they know the same place to
10 go for the information every visit, as it is
11 SOAPED out in the AHLTA note, if that makes sense.
12 MASTER SERGEANT MACKENZIE: It does.
13 And the reason for my concern is being a Wounded
14 Warrior for 7 years there are pieces of my
15 information that have not been located yet because
16 of these transitions through electronic systems.
17 There was no policy or procedure for bringing that
18 old information forward into the new technology,
19 and I just want to make sure that as important as
20 case management is and what you all are doing that
21 that information is being brought along with it.
22 LT. COLONEL SCOTT: It doesn't change

1 anything. This is just a tool within AHLTA within
2 that electronic health record, so it does not
3 change any of that. Yes ma'am.
4 DR. GUICE: Was there not development
5 of a standard sort of a purple case management
6 tool by health affairs that came out of LOA3, I'm
7 remembering this one tool and it sounds like you
8 all have elected to just do that data
9 capture within the AHLTA note instead of going to the purple tool?
10 LT. COLONEL SCOTT: You're talking about the clinical case management documentation tool, that is still in
11 development and we are just now at the initial test phase, the concept has been developed and we are just at
12 the initial test phase at our sites in selecting those sites where that is going to get tested.
13 DR. GUICE: So, how does that work with the-how do you see that working with the new page in AHLTA?
14 LT. COLONEL SCOTT: We will have to see
15 where that goes and where that takes us. We have
16 an immediate need right now. We've got to be able
17 to communicate now and can't wait for that future
18 note to be able to document the data and then be
19 able to extract that information out of the system
20 and our electronic health records to be able to
21 move forward. As you are aware, with the DTM we
22 are required to capture, as an example, we are

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1 required to capture case management and acuity and
2 the visits whether it is opened, continued or
3 closed and what we were finding honestly ma'am is
4 that we were not getting good consistent
5 information every time. The standardized AIM form
6 allows us that specific information to be captured
7 the same way because it prompts the nurse to say,
8 "Oh yeah, I gotta put in my E&M codes and I gotta
9 put in my G-code with every visit", so it
10 processes that and then back with our CPT if you
11 got a radio button in front of you that prompts
12 you to do it you're going to put the information
13 there and our providers also know when they open
14 up that note if they want to see what the soldiers
15 when their last scrimmage was for the CPT they
16 know exactly where to go within that context of
17 that SOAPED note same place every time. And then
18 it also allows for data pull to when we are
19 analyzing records by IDC9 code. So, this is the
20 here-and-now fix. We will
21 see where things go with CCM. Yes ma'am.
22 So, this is an initial page. When a case manager opens their standardized AIM form for case management documentation this is the screen that they see, and as

1 you can see it immediately prompts them to complete required tasks, so everything that's in blue on all these
2 forms is a required field for all of our WTU case managers to complete. The active duty tab in our AIM
3 forms captures those WTU specific data points and is designed to communicate the risk assessment comprehensive
4 transition plan to that clinical team. And then
5 if you note that the risk assessment in the upper
6 left hand corner will give us with every visit
7 they are going to give us their current assessment
8 of that soldier for their risk assessment and then
9 if there has been a change whether or not they
10 have talked to the PCM and coordinated with the
11 specialty care providers on that. And then we also
12 have in the center comprehensive transition plan
13 when it was updated and reviewed and then the
14 lastwhen that transition review board has been
15 scheduled and the results of that if it has been
16 conducted as we work through that. And then we
17 have also go a place for comprehensive transition
18 plan goals to be placed into this note as well to
19 be able to link the overall CPT with the clinical
20 plan when we are walking through this. And then
21 we have a component for the nursing care plan to
22 be included in the note and then we also have a

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1 indicator and prompt to be able to remind the
2 nurse to print this out and ensure that soldier
3 agrees to this as well, because that is an
4 important component of this. As you know, if
5 it's, if they don't agree to it and it's not
6 theirs- it's just a piece of paper. So, we've,
7 we've got that included in this process as well.
8 DR. GUICE: Can I ask you how the, you said
9 this captures acuity, but I don't see how that, I
10 don't see how a score
11 is derived or what part of that captures "the acuity".
LT. COLONEL SCOTT: Yes ma'am. And, so those were the,
12 that was the SO section of your AIM form note. The acuity
portion is captures in the AP section of the note. We
13 have a um, which you don't have as part of this sample.
What we- and we're working on um, what we have is on this
14 slide is some um, specific notes, um, that outline the
directions and the DTM for scoring acuity. Um, and that's
15 on this slide here in the bottom, in the bottom section.
So it talks if, if the um, if acuity levels in their
16 note um, how to score that and where to put that
17 in there. We are in the process of developing a
18 second templated um, AIM form note. It's, it's-
19 we've actually got a developer staffing it with
20 the different regions. And then that'll be another
21 standardized process. Just pull in the templated
22 note into your AP section and it'll help calculate

1 that as well. Uh, we're, we're not there yet.
2 We're just in the process of staffing that. We've
3 got it working at 4 facilities and if it works
4 well then we'll expand it out to every place out.
5 But right now, they do have these directions here.
6 So, and then it also gives them directions on how
7 to print, um, to give a copy of the care plan to
8 the soldier so that he can have a copy of that as
9 well um, when we work through that. So.. Now, we
10 just mandated use of this by all of our case
11 managers in November. So it's February. I have not
12 done a complete data pull to analyze how well
13 we're doing at all of our WTU's. I had um, a
14 medical management folks called me last Friday and
15 said that her initial screen she was looking at 1
16 WTU. And her initial screen of that 1 facility
17 said we had made uh, significant improvements in
18 our data capture process for the acuity codes
19 there. But I need to look at it across the
20 enterprise to see how well we're doing in terms
21 of; has this made an overall improvement across
22 the entire enterprise? But I think it

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1 will because you've got the prompts there to help you work through that process.
2 Okay. And then, to walk you through, we talked a little bit about brining you around the back side of this in
3 terms of measures of effectiveness and outcomes measures by talking to you, by bringing that last slide in first;
4 so, some WTU unique identifiers to be able to measure effectiveness, our, really our length of stay and looking
5 at that by diagnosis and by grouping and clusters of soldiers. And also, looking at uh, our return to the
6 force rates. Um, and then, from a clinical
7 perspective our utilization of direct and purchase
8 care and tying that back into the clinical
9 practice guidelines and what it says we should be
10 doing for those, um, for each of those particular
11 diagnosis. As General Williams mentioned we're in
12 the embryonic stages of this. We've completed the
13 proof of concept that I've showed you the slide on
14 to show that yes, we can pull the data that we
15 need out of M2 to be able to conduct this
16 analysis. We can see that we have some pockets of
17 excellence and some areas of improvement. Um, but
18 now we need to take it to the next level and bring
19 it to those um, those critical diagnosis groups.
20 What does this look like for our amputees? We have
21 a CTP for that. What about PTSD and TBI? Because
22 we've got clinical pr- DoD VA clinical practice

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1 guidelines for those particular diagnosis as well.

2 So, we're, we're getting there sir. And we're

3 moving forward with that as we work through this.

4 We do have a mechanism in place as we've put into

5 place our automated CTP. We have some capability

6 of looking at both the macro and micro level of

7 how we're doing in terms of our warrior transition

8 unit. Now, um, as- as we talked about earlier

9 today, our warriors complete a self assessment in

10 um, in their comprehensive transition plan across

11 18 domains. And there are several that are

12 clinically relevant. As an example in the bottom right hand side of your slide, you'll see some of these broken

13 out here. And you'll note here that one of the things that we ask our soldiers to do is rate, um, rate how well

14 their doing in terms of pain management. And, you'll see that 69% of our soldiers are rating themselves as amber.

15 So, that, you know, that is consistent from what we were seeing with the earlier data that was reported by Dr.

16 Gliner as well. The beauty of our compreh- our automated comprehensive transition plan is that we can now drill

17 down to the individual soldier, and look at his

18 status of, for that particular um, we can-we can

19 drill down and look at individual soldier for pain

20 or by any of these individual domains. And we can

21 also drill down and look in terms of how they're

22 doing for risk. And if we see a soldier whose

1 being assessed as black, we can drill down and
2 look at: ok. What are we doing for that soldier to
3 be able to mitigate those risk pieces and how has
4 that changed over time? For that pain question,
5 you know, you can drill down to the individual
6 soldier- how have they assessed themselves over
7 time and have we seen improvement and what are we
8 doing to help effect that improvement? And then,
9 um, medication management is another piece of
10 this. Asking them how are- are you, is the
11 medication management that you've got, being
12 effective? And we can correlate those too for the
13 individual soldiers as well. So, we're able to
14 look at that both holistically in a larger picture
15 and across the organization and then down at the
16 individual soldier level as well. So this is
17 really exciting. This is still in its infancy
18 stages. Our G6 rolled these reports out and made
19 them available, most of them available just
20 earlier this month. So, this is a new exciting
21 tool that we've got available to us. So, and then
22 you saw my, my slide from hell that we're working

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1 on (chuckle) cause we ran ten on. So, subject to
2 your questions, I'm going to turn it over to Ms.
3 Dailey to move us forward from here.
4 MS. DAILEY: I think we're up for a 15
5 minute. Break. Okay, alright. I need you back here
6 at um, 3:30 please. We have TBI and the uh IDES
7 for the uh, for the later afternoon to still go
8 through. COLONEL CASSIDY (continued): This is the
9 integrated system laid out from referral to
10 transition and VA benefits that includes the five
11 phases, up to a year in treatment prior to, prior
12 to going through the process. You can see from
13 there, just, just it's a 227 day process, with
14 ten major hand-offs. The time between the referral
15 and the fitness decision is just using the DoD
16 goals and we're not meeting those goals, there's
17 115 days. That equates to uncertainty. Also
18 because the decision's made at the end of the
19 process, we don't really allow give soldiers the
20 opportunity to full access to various transition
21 programs that the service has, the VA has,
22 vocational rehab, an employment program requires

1 that PEB make a fitness decision the flash from
2 the fitness decision to the bang of transition is
3 so short that soldier's only have the opportunity
4 maybe to receive counciling on that program versus
5 what we think in our proposal. The other thing
6 about this, it does divert a lot of medical
7 evidence or medical resources away from treatment
8 and care to do this administrative process. Could
9 I get the next slide. This is our proposal, a
10 fitness focused decision. I said earlier that we
11 found 93 percent of the soldiers unfit last year.
12 Generally, that shows us that generally the
13 referral into this process from the medical
14 department is right 93 percent of the time. It
15 results in an unfit decision where we spend a lot
16 of time and energy is around those individual
17 conditions. What we propose is that the medical
18 retention determination point that referral would
19 equal an unfit decision in the Army if a soldier
20 failed retention standards and were not able
21 through treatment and care to improve them
22 conditioned within a reasonable amount of time to

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1 restore them back to a point where they meet
2 retention standards, so they go into the DS so a
3 referral would equal an unfit decision. If the
4 soldier accepted that decision, they'd go right to
5 the VA and go through the claims proc just the
6 way it is laid out right now, go through the VA
7 claim, the exam, and the VA rating and then the
8 service, the Army would just accept the VA rating
9 to make its disposition at the end. I have the PAB
10 running simultaneously with that because there's
11 still going to be decisions to be made whether or
12 not the condition's combat related or not, line of
13 duty, we still have presumption of fitness
14 requirements for individuals that already have a
15 length of service retirement eligibility in place.
16 Anyway, so those processes would go down and we'd
17 think we'd have a 75 day process assuming VA can
18 meet their obligations and their requirements of
19 the DoD process. It's very much like a benefits
20 delivery discharge process for somebody that's
21 going to get out and has 180 days, they go to the
22 VA and go through this process, so 30 days after

1 they get out of the service, they do have VA
2 benefits in hand just like this process. If the
3 service member disagrees with that finding, they
4 can go to a physical evaluation board, the
5 physical evaluation board could direct that an
6 independent medical review be made because that is
7 a requirement of law if the soldier wants it, we
8 could just give that to them. And using that
9 evidence and whatever performance evidence, they
10 could now come to the physical evaluation board
11 and argue that they are fit and return to active
12 duty. Did you have a question there? I saw a hand
13 up.
14 MASTER SERGEANT MACKENZIE: I do. Where
15 does the COAD COAR process fit into your
16 redesigned --
17 COLONEL CASSIDY: The COAD COAR, thanks for
18 that, right at the very beginning. Right now,
19 COAD COAR decision is made 115 at that PEB finds
20 the soldier unfit at the end of the process. If
21 we find the soldier unfit and the soldier agrees
22 but still wants to continue to serve, they could

1 just say, okay, I'm going through the VA process,
2 but I want to put in my COAD application and we
3 could run that concurrently with the VA process so
4 there's no additive time to it and if the
5 decision's favorable, they just go back to active
6 duty when they're done. If it's not favorable,
7 they just continue on the process and we keep the
8 soldier moving through this process and they know
9 the decision a lot earlier. Again, that the COAD
10 decision's another level of uncertainty that goes
11 on after the board's decision, so we could reduce
12 that as well. They could also go right into the
13 VA. Yes ma'am?
14 DR. GUICE: Does this fit with you know the
15 VA has a legislative requirement for a duty to
16 assist, I think its 90 days. Does this fit with
17 that?
18 COLONEL CASSIDY: It could. I mean I
19 understand they do have a duty to assist and
20 notify. It's the same in this program now. If
21 those conditions or those cases worked up, those
22 individual cases might take a little bit longer.

1 But we're not dealing with the whole population
2 taking that long, so we would handle it by each as
3 like a formal board process.
4 DR. GUICE: But for VA, it's just a standard
5 legislative period. I believe it's 90 days, I
6 don't remember exactly. So that has to be built
7 into VA's entire process because it's a time
8 requirement, but my concern with this is that as
9 you kind of shorten that DoD time, one of the
10 things that was fixed in the IDES compared to
11 legacy was the income gap.
12 COLONEL CASSIDY: There is no income gap there.
13 DR. GUICE: But you might be recreating it
14 if you're not if you haven't walked that VA due to
15 assist time on top of this and make sure that
16 you're not recreating an income gap.
17 COLONEL CASSIDY: Again, we would have to
18 wait for the VA rating to come back to us before
19 we could make a disposition decision, so just like
20 it is in the current proc this is the current
21 process. All's we've done is taken the, the hand-
22 offs between the military out of it and just

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1 aligned VA activities. The MSC does the claim,
2 goes and schedules the exams, the exams are
3 conducted, they are handed off to a VA rating
4 activity just as they are now. If it was a duty
5 to assist, the issue the VA board could not render
6 a proposed rating to give back to the PEB to be
7 able to finalize the particular case, so we can't
8 go forward until that process is complete. So
9 it's the same, very same process we follow now,
10 though we take out the medical evaluation board
11 because they're making the decision on the front
12 end and we're assuming that the physical
13 evaluation board, that they made the right
14 decision unless the soldier contested. The VA
15 processes run just as they would normally run.
16 Actually I did brief this to VA on the VBA side
17 and they didn't have any issues with it and one of
18 their one of the things they pointed out as one
19 of the issues they have is are the return to duty
20 rate that we presently have at the end of the
21 process where we return soldiers, they in many
22 cases consider that a wasted VA resource. That

1 they went all the way through, took the exams, and
2 this particular model, that wouldn't occur because
3 if the soldier contested it, they'd go to the PEB
4 to make a determination before they went back. I
5 think its this determination before they went
6 through the VA process, so virtually it wouldn't
7 completely eliminate those exams on return to
8 duty, but it would reduce them considerably. What
9 we thought about the duty to assist and it's
10 embedded in the current system and it's also
11 embedded in this system and that the process can
12 move forward unless the VA rating specialist makes
13 that determination that we have a good rating and
14 that can send it back to the services for
15 completion. Does that No, and there's no, again
16 a soldier doesn't transition until all that's in
17 place so there's no income gap, no benefit gap,
18 following services. The conditions are set to
19 receive their VA benefits 30 days after.
20 DR. GUICE: I'll, I'll check with the VA, but my
21 understanding that 90 days is before they can even
22 do a rating, so the 90 days would have to be that

1 way instead of over this way, so I think it is
2 just a double-check of that where that 90 day
3 lay-over is put on top of your process.
4 COLONEL CASSIDY: Okay. I never heard it
5 put that way before but I'll go back and ask.
6 That's our proposal. What we think this does is
7 eliminate that dual duty case and that perception
8 that we're trying to minimize the soldier's
9 effort. It does come with a price tag that we're
10 working out now. That and more additive costs to
11 military retirement fund and DHP funds, but it
12 does allow the soldier to focus on transition to
13 whatever their future is going to be. Right now,
14 we are constrained because our JAG came back and
15 said that Congress had implemented this law. They
16 actually legislated what was DoD policy. We don't
17 think that the intent of that particular paragraph
18 was to restrict us. The overall 1216 alpha has to
19 do with the VA schedule for rating disabilities
20 and ensuring that we did consider all conditions,
21 we think it was inartfully written, so we're kind
22 of asking Congress right now what they really

1 meant and if they meant to restrict us, fine we'll
2 go through UBL process. If they didn't, maybe they
3 could change it a lot quicker and take that
4 inartfully written language out, that language
5 that's underlined there out. Next slide. And I
6 guess that's it. That the Army's been working on
7 this proposal now for about a good six months.
8 Again we see this as both an issue with soldiers
9 and service members going though this process and
10 a readiness issue. We have an Army division right
11 now that's in the DES process. We are on top of
12 that. Soldiers that are not medically ready
13 because they're going through, they have a
14 temporary profile, they still can't deploy. That's
15 another 10,000. I mean that's the non-medically
16 ready population that our Chief of Staff has
17 struggled with and it affects in strength, it
18 affects our temporary wartime allowances, and the
19 t- the I can't remember the other account that
20 these soldiers are counted against in there, but
21 subject to any questions. We have socialized this
22 with all the other services and we've also

1 socialize it with VA and we're continuing that
2 process now. Happy to get out of here. Thank you
3 very much.
4 MS. DAILEY: Sir, I'm going to turn it over
5 to you for the wrap up comments or deep sighs.
6 GENERAL GREEN: We were thinking brain dead
7 pretty much sums it up. A busy day, lots of
8 information, lots of good things headed our way, I
9 don't know that I have any summary comments. We
10 have another day tomorrow, so I honestly think the
11 folks need some rest, so tomorrow morning I think
12 we start roughly the same time. Is that correct?
13 MS. DAILEY: Yes. My members, you need to
14 be here at 8:00 o'clock. Our public forum will
15 start at 9:00, so there's an hour there and our
16 first briefing will be at 9:15.
17 GENERAL GREEN: So let's everybody get some
18 rest and we'll tomorrow morning kind of discuss
19 where we are for the day, okay. So dismissed.
20 Thanks everybody.
21 WHEREUPON, deposition was concluded at
22 approximately 5:25 p.m.

CERTIFICATION OF TRANSCRIPT I

certify that the attached transcript of the DEPARTMENT OF DEFENSE TASK FORCE took place on February 22 in the year of 2011 in Washington, D.C.

I, the undersigned, do certify that this is a true, accurate and complete transcript prepared from the electronic recording taken by Mark Mahoney of Beta Court Reporting on the aforementioned date and that I have verified the accuracy of the transcript by comparing the typewritten transcript against the verbal recording.

Mark Mahoney

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