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
(the Task Force)
5 Washington, D.C.
6 Wednesday,
7 February 23, 2011

8 U.S. Department of Defense

9 Embassy Suites, DC Convention Center

10 900 10th Street NW

11 Washington, DC 20001

12
APPEARANCES:
13
Non-DoD Task Force Members Present:
14
Dr. Karen S. Guice, M.D., M.P.P., Non-DoD Co-Chair
15 Mr. Ronald Drach
Dr. Russell A. Turner, M.D.
16 Dr. Steven Phillips, M.D.
Mr. David K. Rehbein
17 Ms. Suzanne Crockett-Jones DoD Task Force Members

18 Present:

19 Lt. General Charles B. Green, DoD Co-Chair
Major General Karl R. Horst
20 Major General Richard S. Stone, M.D.
Master Sergeant Christian S. MacKenzie
21 Commander Timothy A. Coakley, M.D.
Lt. Col. Sean P. Keane
22 Staff Present: Denise F. Dailey, PMP, Executive

Director Larry Nisenoff, MBA, PMP, Director of Operations James B. Wood, Records Manager Ryan Heist Lakia Brockenberry Philip Karash Stephen Lu Bella Gonzales Joseph Jordan, Events Manager Cassandra Grey Edward Hsieh Masheva King
Randolph Wagner
DeQuetta Tyree
Research Team Present:

Suzanne Lederer, ICF
Jessica Jagger, ICF
Allen Bediako, ICF
Brad Booth, ICF
Cathy Hanna, AECOM

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P R O C E E D I N G S

DOCTOR TURNER: I would like to say is for everybody going to San Antonio, I've talked to Ikea, you're going to be put up next to the airport. The night that you come in I'm going to host a little dinner for everybody so we can get together before we show up the next day so more on that coming but expect a dinner the night before the visit and I'll make the arrangements and I'll take care of all that being the local guy.

DOCTOR PHILLIPS: Put me down for San Antonio.

1 DOCTOR TURNER: Except for you.

2 MASTER SERGEANT MACKENZIE: Sir, we actually --

3 we've had some correspondence going back and forth

4 in our group and we did attempt, at one point, a

5 conference call to try to get prepared.

6 Unfortunately, schedules conflicted. We had a bit

7 of a challenging time but we are working through

8 those technical difficulties and with everybody's

9 schedules to try to get some good working stuff before the visits.

10 GENERAL GREEN: Really I keep telling Denise that

11 we need a little time for just us so that we can

12 talk. Some of it is just the socialization that

13 goes on around the coffee pot and the rest of it

14 is if there's anything that we picked up on

15 yesterday, for instance, that we think we need to

16 have some follow up. So from my perspective, it's

17 important we have that informal time where we can

18 kind of talk amongst ourselves and say look we

19 heard this but you know we really need to know

20 something behind the scenes. I'm not sure we're

21 going to get some of that until after we do some

22 of the visits and talk with some of the families

1 out there but that's what these times are for. So
2 if there's anything on your mind or something you
3 want to bring up, please let's chat. If there's
4 nothing yet, then we can go back to having coffee
5 and relax and talk in smaller groups but that's
6 kind of what I want to use this for.
7 MASTER SERGEANT MACKENZIE: I noticed on the
8 agenda how things were going yesterday but one of
9 the things I found was that the presentation of
10 the TBI tracking and how they're working with
11 stuff down range, although interesting and good to
12 see, I don't think covered the bigger problem
13 which was what do we do states side? I
14 just spent two weeks in Atlanta at the Shepherd Center going through my own assessment at the SHARE Program and
15 it was a painful realization that there's no
16 comprehensive collaboration in how we deal with
17 the diverse areas of TBI, especially in the mild
18 to moderate range, within the military structure.
19 You know we have access to all these resources but
20 there's no -- you know you could see one
21 specialist and although they uncover stuff that
22 deals with them, there's no dedication to

1 communicating with the other people involved with
2 that team to say hey you need to take a look at
3 this.
4 DOCTOR TURNER: I would agree with that. I think
5 something that might be more additive is like
6 that's great what they're doing in the front but I
7 think probably we need to focus more on maybe the
8 long-term care. We were doing it like there was
9 not a lot of mention of the hyperbaric TBI program
10 that they've got, I was kind of waiting for that,
11 so I think if we could have some follow up on the
12 TBI. What are we doing long term, what are some
13 of the hyperbaric protocols, how do people get
14 involved in that, what's the follow up and maybe
15 more. I enjoy the technical and that's great, but
16 I think this is more strategic than the issues
17 we're looking at.
18 GENERAL GREEN: I just got back from Afghanistan
19 so let
20 me tell you kind of what I do know. The programs that
they're outlining that the commanders are now having to
21 fill out after any blast event is not completely
22 automated yet but even in some of the far forward

1 areas with the Marines, the commanders have very
2 clear guidance and are actually reporting that so
3 that's huge progress. The follow up in terms of
4 immediate treatment is actually in place over
5 there as well down in Kandahar and actually out
6 even to Bastion and down towards Dwyer. There's
7 some very interesting interventions going on
8 trying to keep people in theater and do the
9 preventive stuff that probably should have been
10 done years ago. The other problem that's coming
11 up, and this is why I think you're still seeing
12 this, is there's diagnostic criteria. I started
13 to ask yesterday when they said they had 86,000, I
14 think, mild TBI is, I did ask I think, how they
15 were doing and they're just simply anybody who's
16 put in an ICD9 code with that on it, they were
17 just presuming that that's correct but there's no
18 clear diagnostic criteria for mild TBI right now
19 which is actually very problematic and several
20 studies that are coming out showing huge overlap
21 in PTSD and MTBI. So in terms of what's going on
22 back here, the DECO probably gave us a touch of

1 what's happening. On the

2 hyperbaric's front, the first data has still not come out of that the study that ended at Brooks in January and so

3 that one is due out some time in March, first of

4 March, and the other study is just starting in

5 terms of the enrollment of candidates with that

6 almost $50 million that they put into hyperbarics.

7 So my guess is if you're looking for results,

8 it's way too early right now to know whether the

9 hyperbarics is going to show anything yet.

10 DOCTOR TURNER: Well again, I think we need to

11 understand that there's that program out there.

12 Again, I think we usually know, just that as an

13 example, that there are a lot of programs out

14 there and what do they got -- just exactly like he

15 was saying is when people come home, what are they

16 doing for them long term?

17 DOCTOR PHILLIPS: Well, that's why I brought up

18 yesterday the civilian component. Again, this is

19 just really, at this point, just hearsay talking

20 to my colleagues who are family practice

21 physicians out in Iowa and other places. They

22 really need some guidance as to what to do when

1 they run into the retired, especially the Guard
2 folks, and as Mack was saying, I think they need
3 an advocate, like a primary care physician, to
4 direct all the therapies and cares and
5 communications between the different specialties
6 and I don't know if it's above, you know, our
7 mandate, but to recommend perhaps some sort of
8 program in
9 concert sort with the Academy of Family Practice Physicians or one of the large societies to come up with
10 some sort of simple program that they can be
11 educated as to what this is and how is it managed
12 in medium and long term. There's a lot of
13 unknowns, they say scientifically there's a lot of
14 unknowns but at least to sort of coordinate with
15 them.
16 DR. PHILLIPS: That's why I brought up yesterday,
17 the civilian component and again this is just
18 really at this point this is just hearsay, talking
19 to my colleagues who are at family practice
20 physicians out in Iowa and other places. They
21 really need some guidance as to what to do when
22 they run into the retired, especially the guard

1 folks. And as Mac was saying I think they need an
2 advocate, like a primary care physician, to direct
3 all the therapies and cares and communications
4 between the different specialties. And I don't
5 know if it's above, you know, our mandate but to
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7 with the academy of family practice and physicians
8 or with one of the large societies to come up with
9 some sort of simple program that they can be
10 educated as to what this is and how it's managed
11 and what's the medium and long terms. There's a
12 lot of unknowns, as they say scientifically
13 there's a lot of unknowns, but at least to sort of
14 coordinate with them.
15 GENERAL STONE: The position you're taking is very similar to, I think where one of the G. A. L. reports was, in one
16 of the G.A.L. reports said this is too big for the
17 military and the geographic dispersion requires a
18 partnership with many areas and this goes exactly
19 along with that. From my standpoint, I guess I'd
20 like to see that as a tickler in the future when
21 we start writing of, you know, how do we reach out
22 to the rest of the care delivery system that's not

1 uniformed.

2 DR. PHILLIPS: And I think the civilian medical

3 group would welcome, would welcome the guidance

4 and the connection.

5 GENERAL STONE: You know, this is very similar to

6 some of our mobilization platforms that don't have

7 organic military treatment facilities. We reach

8 out in the immunization process earlier in the

9 war. The immunization process we reached out when

10 we began giving small pox immunizations of here's

11 some of the potential side effects; here's the

12 things you may see in the delivery system.

13 DR. PHILLIPS: And not to take too much time, but

14 there is precedence. I mean all the trauma care,

15 it transfers back and forth military, civilian,

16 and the whole emergency system that we have is

17 really based on the military experience from World

18 War Two and World War One.

19

20 DR. GUICE: The Defense and Veterans Brain Injury Center has a coordinating function. They are supposed to

21 be tracking these individuals who are diagnosed

22 with TBI across the continuum out into, back to

1 civilian so I would suggest that perhaps we ask
2 them specifically to come in since this seems to
3 be at least something we're interested in and give
4 us an idea of how they're doing that; how
5 effective it's been; what their challenges are and
6 if they have any recommendations for where they're
7 going with that particular program. But I think
8 we've got a program that's supposed to be doing a
9 coordinating function and we need to understand
10 that a little bit better.
11 MASTER SERGEANT MACKENZIE: There's one thing, one
12 thing I that noticed although my purview is very
13 narrow, is just experienced documentation. Being a
14 member of the hyperbaric treatment in 2009 part of
15 that test program, I found that the reason I
16 wanted it coming out of the Army was that, the
17 Marine Corps was the biggest supporter. The
18 preponderance of candidates for that program was
19 the Marine Corps. You know, got nominated had to
20 work through the wickets, but as an active duty
21 guy, my abilities at the SHARE program at the
22 Shepherd Center were far greater than the majority

1 of the candidates they

2 had there because they had already been out to veteran status. They had already been discharged from the

3 military and although that program is supported by

4 the Home Depot, a lot of the stuff that they do up

5 there is by donations to support the funding

6 because the VA doesn't, in some of these areas

7 they don't fund it, whereas I pretty much had cart

8 blanch written appropriately. All the

9 authorizations I needed through Tricare, I was

10 covered up there. But once again, I go to the

11 share program for two weeks and I find that most

12 of the candidates are Marines; it's like where is

13 the Army in this play. This is an outstanding

14 program, they're doing some really, really great

15 things, but it's, like I just said very, very

16 narrow, but it's like, okay, here's a recurring

17 situation where I roll in for my own treatment. I

18 find it where the majority is Marines. I roll

19 into another location, the majority is Marines. I

20 don't know why, it's just an observation that I

21 saw.

22 GENERAL HORST: Do you think that's part of the

1 BUMED system where they tend to send their
2 patients out, either to private facilities or to
3 VA, whereas the Army tends to stay in house and
4 treat most of theirs in their own facilities.
5 Mike or Rick, what do you think?
6 GENERAL STONE: Colonel, I'm not sure if this is
7 cultural.
8 I think this is a hesitancy on the part of the
9 Army to
10 move forward with a treatment until there's real evidence based. The Sergeant General has been adamant that we do
11 evidence based work. We've struggled mightily
12 with some of our spinal cord traumas and the use
13 of stem cells and there have been some publicized
14 things where people have been sent out to other
15 countries or have gone on their own time to other
16 countries on some stem cell work just because of
17 some of the laws here. I think that we have taken
18 an approach very similar to the Air Force of
19 waiting for the data. I think the frustration in
20 the Army leadership and General Giarelli was
21 adamant about this that it takes too long for us
22 to move from data collection and good medical

1 information to really put things into effect. He
2 talked about the eight years that it's taken us to
3 make some decisions on this type of therapy for
4 traumatic brain injury and recognizing the
5 diagnostic criteria as being a frustration.
6 Secretary Woodson, you know, has taken that on to
7 move data management faster and get it in use of
8 the Tricare system. I think that may be an area
9 that we really want to examine as how long it
10 takes the military system. I actually think that
11 system is faster than on my civilian side, which
12 can take well over a decade to get medical
13 information into standard practice.
14 GENERAL GREEN: Thank you. I said in a lot of
15 these
16 meetings if we're talking hyperbarics, okay because we need to narrow this down. But I mean, I'm not as
17 familiar with the share program, but I sat in on
18 meetings with the vice chiefs when they were
19 talking about this; very strong lobbying effort,
20 particularly for Mississippi because of where some
21 of the initial work was done. And the difficulty
22 was that it wasn't really publishable work. So I

1 won't cast a vote one way or another. I'm
2 obviously an airspace medicine guy, I've seen
3 hyperbarics do some good things, but I don't have
4 any idea whether it's going to work with TBI. And
5 of course, my biggest worry with all of these
6 different interventions is we don't have specific
7 diagnostic criteria, so what may work for one may
8 not work for the next because we don't know if
9 we're treating the same thing. So I guess I'm
10 back to where you are: If we stay with the
11 evidence based, we probably should hear from
12 DIBVIC and so Denise, I would say that's an
13 important one. And if there's some private
14 program out there that you think we should hear
15 from, and again I'm not familiar with the SHARE
16 program, if that's something we should hear from
17 to see a different approach that may be a
18 reasonable thing for us to bring in. I mean, we
19 need to kind of get a little background
20 information, perhaps you could share a little bit
21 of information with us so we know what we're
22 talking about.

1 Okay?
COMMANDER COAKLEY: General, if I can, I'm actually part
2 of, I'm hyperbarist for the Navy. I've
3 participated in hyperbaric treatments and some
4 research, currently I'm working with Dr. Lin
5 Weaver, out of Salt Lake, who is actually the
6 civilian chair for the hyperbaric project and he
7 and I have been working together and just
8 tangentially on some with other stuff with the
9 Russians, particularly, because they were actually
10 implementing hyperbaric treatment far forward on
11 the combat casualties; had excellent results with
12 good research evidence as we evaluated when we
13 were in Prague and then just recently in DC. I
14 think Dr. Weaver could also give us a little bit
15 more scope, if you would, on the overall treatment
16 and delay versus acute. I think it would be good
17 just to find out where the protocols are going, as
18 he was one of the chief architects of it. But I
19 can tell you from my experience of hyperbaric
20 medicine, as well as the research and study of it,
21 that to think it will, in my opinion, have a
22 pretty good outcome if it was far forward and

1 immediate. I'm not too sure as you are as far as
2 the outcome from the delay treatments but I think
3 Dr. Weaver, he's, he's one of my mentors in
4 hyperbarics. He actually trained me back in the
5 90's; it would be my recommendation for the
6 committee and have him come in to
7 give us an oversight on that. Because it does effect obviously long term treatment and therapy for our wounded
8 warriors.
9 GENERAL GREEN: I just think the numbers are
10 staggering.
11 And so we need to think about how we're going to
12 deal
13 with a very large volume of people who right now,
14 if you believe in numbers eighty-three thousand,
15 or eighty-six thousand that they're saying may
16 have this diagnosis and so the question is going
17 to be, I hate to get into any specific treatment
18 modality, as much as we need to think about well,
19 all right, who's doing the planning for what the
20 long term care is going to be for such a large
21 volume of people who may have a problem and how
22 are we going to get to a specific diagnostic

1 criteria, which is where the DIVBIC comes in. I
2 think because now we're talking about if we have
3 specific diagnostic criteria, we can now at least
4 start saying what are the recommended
5 interventions for those diagnostic categories.
6 That's my approach, now I am medically trained so
7 I mean for some of the others, if that seems too
8 conservative, I understand. I mean it's a
9 fascinating thing we get into a lot of, you know,
10 everything from crystal therapy, to think back to
11 lay-a-trail, you know, long ago. I mean there's
12 lots of things that when you don't apply some
13 scientific rigger to, you can go down some paths
14 that create problems as
15 well. Somewhere in there there has to be, you know, we have to know what we're treating and then we can look at
16 what has hope for being an intervention that will
17 make a difference for people. A lot of anecdotal
18 experience on the hyperbarics. I've heard a lot
19 of anecdotal and very strong lobby; Congress is
20 very interested in that particular modality. But
21 I think the issue at hand is we talking about
22 something different within TBI or are we talking

1 about variant of post-traumatic stress and a
2 diagnostic category that people are more
3 comfortable with than talking about post-
4 traumatic stress. So there's a lot of work being
5 done to try and iron that out and hopefully we'll
6 get some answers.
7 DR. PHILLIPS: I really agree. Just to emphasize
8 what you're saying. We really have to nail down
9 the diagnostic criteria. And I don't think
10 anybody has does that. We have an ongoing project
11 with the DoD related to, even defining post-
12 traumatic stress disorder, combat fatigue, shell
13 shock. I mean we're back to our records to the
14 Civil War trying to find out, you know, are there
15 any identifiable criteria that transcends all the
16 different terminology and we have not really come
17 up with anything yet.
18 MASTER SERGEANT MACKENZIE: My recommendation to
19 the task force for being as we go out and see this
20 stuff, and we
21 run across programs, like the SHARE program, I'd say we bring them in and we find out what is it that they're
22 doing and why they're having successes or failures

1 or the design behind the program and how do we
2 recommend that back to the DoD and to say maybe we
3 need to put more emphasis on looking at what these
4 guys are doing. As a, you know, mild to moderate
5 TBI guy and gifted in some aspects and damaged in
6 others, there's the comfort of going out there for
7 just a two-week assessment and being able to break
8 apart, going I'm good here, this is broke but what
9 I'm doing is the right thing and here's what you
10 need to fix. I find a lot of times with dealing
11 with TBI it's that confusion of where do I go?
12 This seems to overlap into this, and this seems to
13 overlap into this and I can't seem to find my way
14 out. And somebody that's willing to put all that
15 together with all the specialties that apply, to
16 be able to figure out those issues, whether their
17 treatment plan is correct or their diagnosis fits
18 what we're looking at, I don't know. I'm a
19 knuckle dragging, helicopter guy, I'm not a
20 medical guy, but the reality to it is it's a
21 process that seems to be working quite well and
22 may be something we need to look at to bring back

1 to the DoD and say are we looking at stuff like
2 this, are we, why is this successful and how can
3 we participate in this to help our guys?
4 GENERAL GREEN: You know, even the approach to a patient may be useful in terms of how we reach the end points. I
5 don't necessarily disagree, is there any other
6 besides the SHARE that you're aware of? That's
7 the other question, rather than be, again, I don't
8 want to endorse any treatment modality, and we
9 also need to be careful not to endorse a specific
10 entity, not knowing if there are others that are
11 out there. And so I don't know if there's a way
12 to canvas what may be available out there. That's
13 what the DECO is supposed to be doing. And so why
14 don't we hear the DIVBIC and SHARE if that's the
15 only one we know about and then maybe we want to
16 come back to the DECO ask there, or the DIVBIC and
17 ask --
18 DR. GUICE: Well, the other group that, this is a
19 Tricare you're getting this through your Tricare
20 benefits. May be the thing to do is go to Health
21 Affairs and ask them how they sort out and decide
22 which of these they are going to support and

1 therefore, pay for. So we understand the entire
2 process and use that as the -- because they'll
3 know about the other programs that people
4 participate in that you may not be aware of or
5 that may not be aware of. But kind of ask for
6 that, just the lay down how they do that and what
7 are the criteria they use for bringing a program
8 online so to speak for reimbursement.
9 GENERAL GREEN: Is VA, just one other question, I understand the health affairs link, is VA also doing
10 external sourcing for this type of activity?
11 DR. GUICE: VA has a kind of a combination so we
12 have a lot of in house kind of things and when we
13 have where we don't have a program that meets the
14 individuals' needs because of geographical
15 location or because they've got a unique needs,
16 then we do sort of feed basis out, but we can ask
17 for an a TBI team at VA, we can ask them to
18 participate as well to provide that other part of
19 the --
20 GENERAL GREEN: So we may want to devote a half
21 day and have several different speakers come in
22 talking about their approach to TBI and see if we

1 can get there that way.

2 MASTER SERGEANT MACKENZIE: And it's no specific

3 endorsement. It's just something I became aware

4 of; my community became aware of. I just bring it

5 up for consideration, it's not endorsement

6 whatsoever. I just happen to feel really good

7 about the results I went through personally. So

8 that's why, let them speak to their

9 professionalism and how they do it and what they

10 see and the challenges. I do know that when they

11 were working up for me to go up there. There were

12 a lot of challenges because the program itself as

13 a whole is not covered. But you have to break out

14 all the individual

15 specialties in order to -- they had to do in order for me to get the funding for me to go up there. So, it's

16 certainly a challenge and I didn't try to create

17 that, but like I said it's just one of the things

18 to consider.

19 DR. TURNER: I would agree. I would agree that we

20 just need to find out what's out there; what's

21 currently going on, which is the VA and these

22 other programs. And I think I'll have to agree

1 with Dr. Guice's, what's actually more important
2 is what the government actually paying for? So
3 what is available to these heroes that have been
4 injured? So I think that's good. So it's what's
5 out there and what are we paying for?
6 GENERAL GREEN: The other issue that clearly is,
7 that was kind of highlighted by our last briefing
8 yesterday is questions that are arising with the
9 disability evaluation system. I don't know if we
10 want to get involved in this at all. I mean, in
11 private conversations there are a lot of concerns
12 regarding incentives for recovery and so if you're
13 diagnosed, I'll use PTSD. If you're diagnosed
14 with PTSD and you're remuneration, okay, is
15 basically tied to your continued diagnosis of
16 PTSD, does that drive you to not necessarily want
17 to get better. Now that's a little harsh and I
18 don't really mean it quite that way.
19 GENERAL HORST: But it is what it is.
20 GENERAL GREEN: But it's an interesting problem
21 in terms
22 of how we do our disability and so I don't know if we
want to spend any time looking at that because we're

1 talking a five year look at recovering warriors
2 and if we're creating incentives for them not to
3 get better, the question is how do we address
4 that?
5 DR. GUICE: Well, it does happen and we at VA
6 know it well. The disability compensation for
7 PTSD is not tied to treatment and we have had
8 instances where the veteran is the worried about
9 whether or not, you know, his re-exam for comp and
10 pin is going to affect his income stream because
11 if he gets better from PTSD, the money goes you
12 down. And so, then, we've set-up a perverse
13 incentive almost and somehow I think that's, it's
14 just something we should look at, because have we
15 set-up barriers to treatment inadvertently through
16 the way we handle our disability compensation.
17 MR. DRACH: Excuse me. There was an article in
18 yesterday's post, which I didn't see the entire
19 article but it talked about what you just said Dr.
20 Guice. And I saw this among the Vietnam
21 generation is that you give them a rating, and
22 PTSD and other behavioral health issues that the,

1 that are better recognized by the VA as service
2 connected are based in part on social industrial
3 adaptability. So someone with PTSD relatively
4 severe, you get him or her into a job, they start
5 out with maybe
6 a one hundred percent disability rating, which is probably somewhere in the area, close to three thousand
7 dollars a month. And then you say okay, we want
8 you to go to work. We want you to get back into
9 society. Then they go back and then they lose and
10 their next rating maybe goes down to seventy
11 percent, which is a significant drop in money.
12 And I'm for the fold that in some cases, it's a
13 tough, sensitive situation no question about it,
14 you get somebody one hundred percent from the VA,
15 and they get SSDI. They may be getting anywhere
16 from thirty-five hundred to five thousand dollars
17 a month tax free. They live in Groundhog, Idaho,
18 they maybe one of the highest income people in the
19 county. How do you balance that? How do you
20 encourage them to go back to work? Get jobs? And
21 yet lose their tax free benefits.
22 GENERAL STONE: It's going to be difficult for us

1 to tackle the disability adjudication system,
2 except in one area, I think we can take a position
3 that it must be fair and it must be efficient.
4 And that the inefficiency creates demands upon the
5 delivery systems that we saw yesterday. And once
6 a decision is made that there's been a
7 maximization of recovery, there must be an
8 efficient system that processes this service
9 member to the next stage of their life. I thought
10 General Williams was very articulate in saying
11 that my job is to get people moved
12 on to wherever their life is going to be. That's fairness. And so efficient is something that we have to
13 look at in fairness but I think for us to tackle
14 the complexities of this system that has so many
15 processes would be a full-time job and when you
16 look at the, at Frank's studies and the various
17 other studies that have looked at this, I'm not
18 sure we'd be value added to this except to demand
19 those two things.
20 DR. PHILLIPS: There is a component to the civilian
21 disability system and I'm not sure it would be
22 applicable, but if you are disabled you have the

1 option to take your money long term or just settle
2 right there. I don't know, again, if that would be
3 applicable to what we're talking about but that
4 might be a way around this long term coasting for
5 my taking the money, statisticians if they figure
6 out the amount. It's a flat amount and then
7 you're gone.
8 MR. DRACH: There was a recommendation along
9 those lines in the Dole-Shalala report that was
10 dead on arrival in the hill. One of the problems
11 with the veterans services organizations who were
12 in opposition is you get, particularly young guy,
13 man or woman coming out, and you offer them a lot
14 of money up front, that's a settlement. A lot of
15 times they'll take it and buy that new Corvette
16 that they want to buy. As this is happening and in
17 some
18 cases with the TSGLI, but the problems the veterans organizations had with that was because of the VA system,
19 you can reopen your claims at some later date for
20 an exacerbation of your condition or a secondary
21 condition. If I take that lump sum, what the Dole-
22 Shalala's recommendation was I'm done? The VA is

1 done with me; I'm done with the VA. So for
2 example, an amputation, if somebody develops a
3 secondary problem with the remaining limb they
4 have a system under the current law paired
5 extremities. So you can get service connected for
6 with the injury or the condition of the second
7 remaining limb.
8 Under that idea, which is, you know, I couldn't
9 get that
10 secondary condition.
11 MR. REHBEIN: I wanted to follow up a little bit
12 on what Mr. Drach was saying about PTSD
13 reevaluation. Yes, we take, we may bring them and
14 reevaluate them and the percentage goes down. I
15 don't think we can simply say, now go get a job.
16 I think we have to provide support and how they go
17 about getting that job. One of the things I had
18 looked forward to in yesterday's presentation that
19 we didn't see was the voc-rehab because a lot of
20 these folks are going to be coming out of the
21 military. They no longer, if they had a career
22 prior to the military, they are no longer are able

1 to work in that career. They need to develop a
2 new area of expertise and that's where
3 voc-rehab comes in. I'm hoping that we can keep that particular part of the agenda on a future meeting so that
4 we understand more about what's available for
5 them, what's their potential once they do leave
6 the military, once the reevaluation happens, help
7 them develop that new career so they become self-
8 sufficient out there in civilian life.
9 MR. DRACH: In light of that, I think we should
10 invite the VA, the VR&E people. Dr. Ruth Fanning,
11 I'm not sure if she's a doctor or not because as I
12 read it yesterday what we're going to hear was the
13 Army's involvement with the VA, what they're doing
14 with the wounded, ill and injured and one of the
15 problems you have while on active duty, VR&E can
16 only do so much while they're on active duty
17 because until you're a veteran, they can only
18 start the process. They can't really go forward
19 with the process unless, and it's very
20 complicated, unless I get a memo rating which
21 doesn't happen very often. So what are the
22 barriers with the voc-rehab? It's not as similar

1 to what was talked briefly about yesterday with
2 the adaptive sports equipment. You know, while
3 they're on active duty they can't get it, but once
4 they get out, they can.
5 GENERAL HORST: I think General Williams'
6 presentation was pretty instructive yesterday
7 because he outlined what his number one priority
8 was and that's the comprehensive
9 transition plan. And then he gave us the three pillars of his program and I think those should serve as
10 benchmarks as we go out and look at these Army
11 facilities and ask those questions in the focus
12 groups, telling them about the comprehensive
13 transition plan and how is it being executed here.
14 Because that's his number one priority. He said
15 that's the most important thing for me. And then
16 those three pillars of treating the CADRE,
17 education of the wounded warriors, and then the
18 third piece which gets to Dave's points which is
19 employment after the military. And I think, I
20 agree we didn't get to that transition from
21 employment education training for wounded warriors
22 and transitioning into VA, vocational training at

1 that. But I think that's the path that General
2 Williams was trying to take us on yesterday or at
3 least inform us what he wanted to do. I thought
4 it was very instructional, in terms of
5 articulating the Army's Warrior Transition
6 Program.
7 GENERAL GREEN: I guess the other question, and
8 again I don't understand disability system well
9 enough to know is some kind of combination about
10 is to create better incentives for recovering
11 warriors to recover. Is there a combination of
12 lump sum but still the eligibility for vocational
13 rehab and even treatment for the condition for
14 which you received the lump sum? Is that a
15 reasonable
16 thing without necessarily having ongoing compensation
tied to those evaluations? So I guess, and I'm not
17 saying that I know the answer to this. What I'm
18 saying is I'm not certain we shouldn't look at how
19 do we create incentives for recovery and not
20 necessarily trying to revamp the disability
21 system, but are there better ways to create
22 incentives for everyone for the most rapid

1 recovery? And I don't know if there are or there
2 are not. I think it's important to understand if
3 there incentives to not recover, then that's a
4 huge, detriment to what we're trying to do. MS.
5 CROCKETT-JONES: Can I just say that one thing
6 I've found frustrating in the PTSD, TBI experience
7 that my husband is going through, the diagnosis
8 seems vague; it seems applied inconsistently; no
9 one is clear on -- can give you clear answers;
10 people who are having are symptomatically seem to
11 be having disintegrating lives don't get the
12 diagnosis and they're fine. And it doesn't matter
13 if their home life is falling apart, and their
14 kids get beat, I mean, all these horrible things
15 happen but that person doesn't have PTSD. And
16 another person who has all the same issues does
17 have PTSD. So it's not clear what it is. Then
18 treatment seems to be like darts at a dart board
19 and then no one, absolutely no one so far even
20 ventured to give me an answer about what the
21 recovery looks like. What does someone, how do you know
that recovery is happening? How do you define better
22 gone -- there is, there's no answers and so I, I

1 understand why we need to, why we would want a
2 system that doesn't take away the incentive to
3 recovery, but I'm not, how do we -- don't we have
4 to know what recovery is first? I'm not; I mean
5 at this point, if you know, you'd have to prove to
6 me that recovery exists just from my personal
7 experience. I haven't seen it ever. So and I
8 would also say that the roller-coaster ride if
9 someone tests my husband on a good day, for
10 instance, great. Two days later, okay. You know,
11 totally different picture. So the idea that we
12 change somebody's rating. And say no, no, you're
13 much better, that would be terrifying to me if I
14 was counting on those funds to actually address
15 some of the side issues that go along with living
16 with someone with PTSD. So, you know that money
17 might go away, and the symptoms might come back.
18 At least, my experience is that this area of
19 unknown vague nonsense. It's very frustrating.
20 And I even tried to ask a very clear question to
21 get an answer to see if there's any progress being
22 made on understanding the diagnosis, applying it

1 consistently, but most importantly have we figured
2 out what recovery looks like. And I got
3 absolutely no answer yesterday. So my opinion is
4 I would
5 think that it would better serve people struggling with it to first get some clarity on the issues and the
6 process and what recovery is before we start
7 worrying about whether we're making it hard for
8 them to recover through you know monetary
9 compensation and pulling it, when we haven't
10 really been clear that we are recovering people.
11 I mean I know people get lower ratings and
12 improve, are that all we have as a measure for
13 recovery of PTSD and its interaction for TBI. And
14 no one seems to have really good answers.
15 DR. GUICE: I think that's part and parcel of all
16 this discussion. The reason I brought it up is
17 because there is this paradox of compensation if
18 you maintain a level of disease. I think that in
19 looking at this is how do you incentivize the
20 behavior we want, which is to get better,
21 recognizing during that trajectory of getting
22 better, you will have, there are financial

1 implications. And then how do we kind of do that?
2 I can tell you a story of an individual that we
3 got acquainted with who was standing in a field
4 ready to commit suicide because he was so worried
5 his PTSD payments would go down and he said I'm
6 absolutely not going to get treated if it's going
7 to take away money. Now that to me is a travesty.
8 And a problem that should never happen. How do we
9 look at the entire package of getting people
10 better,
11 recognizing we have some very vague criteria, very vague in-points, but how do we create that incentive for
12 recovery? So I agree with General Green, I think
13 looking at that is quite possible.
14 GENERAL GREEN: And please excuse me if it
15 sounded like I wanted to remove resources because
16 that's not at all what I'm saying. I just think
17 we need to look at the best ways to create
18 incentives for recovery. We did start with the
19 diagnostic criteria and how we're going to get
20 there. I understand what you're saying.
21 MR. REHBEIN: Well there's a thread that runs
22 through a lot of this discussion. It's, you can

1 see it in the evidence based medical delivery.
2 You can see it in trying to blend the disability
3 evaluation system. You can see it in the voc-
4 rehab. We have to balance efficiency of
5 delivering benefits with effectiveness and
6 sometimes if we get too efficient, we run the risk
7 of double-dipping, to use the word what happened
8 out there in the press. But on the other hand, if
9 we worry too much about that, then we don't bring
10 these systems together quickly enough and we have
11 people that exist here in the gap and we don't get
12 benefits at all for them. I think one of the
13 objectives of this task force is to keep track of
14 how fast can we blend these systems from different
15 agencies together so that we effectively
16 provide benefits to the people that need them. But we do
it in an efficient manner so we don't get too much
17 overlap, but don't worry too much about getting
18 overlap. If that makes any sense at all. I look
19 at it from a scientific standpoint of tuning a
20 system. Sometimes you can over tune a system to
21 where it never reaches the optimum point. But you
22 can also under tune it so it oscillates badly.

1 GENERAL GREEN: I think we start the official
2 piece at nine o'clock. If we, so we may want to
3 take a break. Mac, I don't want to cut you off, so
4 go ahead and you can have the last comment, and
5 think about grabbing that last cup of tea before
6 we start officially here.
7 MASTER SERGEANT MACKENZIE: One of the things I
8 wanted to mention and part of why I chose the
9 optimizing ability piece and looking at that, part
10 of this reintegration back in the military is that
11 perceived punishment for staying on active duty.
12 Things have changed significantly over the last
13 several years but as I went through my process I
14 became more and more aware of what I was missing
15 out on because I chose to stay in. You know, had
16 I gotten out and medically retired, okay I got
17 this benefit for child coverage. I got this
18 benefit for voc-rehab, I got all these benefits
19 that are out there for me, but oh by the way you
20 don't qualify because you're still on active duty.
21 You know, and I look at it and I go I want to
22 continue to serve my country; my kids are going to

1 be out of college before I ever get the
2 opportunity to reap that benefit of being a
3 wounded warrior and serving my country proudly.
4 So as we look at this, these benefit things and we
5 look at some of this, some of how we do this, take
6 that into consideration are we forcing the
7 population out of the VA system simply because it
8 looks better being out there? We're losing track
9 of some of the amazing professionals and those
10 warriors that don't stay on active duty because
11 the grass is greener on the other side. I'm out
12 of here. So --
13 GENERAL GREEN: So we're going to take five
14 minutes so you can go to the restroom if you need
15 to, get a cup of tea, if you want to. And then
16 we'll come back and introduce Shawn since we
17 didn't get to do that yesterday.
18 And start with the official portion. I think that
19 the
20 one that has come out of here is we have decided
21 that we would like to spend a little bit of time
22 listening to some things on TBI and I'll leave the

1 other in terms of whether or not we should be
2 involved in, in terms of incentives for recovery
3 for us to consider further. Okay? So thank you
4 everybody. [Public portion of the meeting begins.
5 Time 9:15am]
6 MS. DAILEY: Ladies and gentlemen, could I ask
7 everyone to come back together and reassemble.
8 This is our public forum portion of our task
9 force. The public forum consists of individuals
10 from the public who give two minute presentations
11 to the task force. Today we have Mr. Skip Rogers
12 from Able Forces whose going to give us a
13 presentation. I'm going to bring you him up to the
14 um, uh, agenda. I'd also like to direct your
15 attention to tab uh, I. Tab I has all the
16 individuals from the public who submitted
17 statements. Not everyone requests to speak to the
18 task force, but anyone who submits paperwork, I'm
19 required to give to you for your preview and for
20 your, your base knowledge; your lexicon of
21 knowledge. And import again, that's tab I of our
22 briefing books for the uh, members of the public

1 who presented papers. And uh, right now, Mr. Skip
2 Rogers from Able Forces.
3 MR. ROGERS: Thank you. Good morning. My name is
4 Skip Rogers. I am the co founder of Able Forces.
5 I'm also an army veteran. 1968 to '70. My partner
6 Joe Cunningham is uh, also a veteran: Navy '68 to
7 I'm sorry '64 to '69. I want to thank the task
8 force for giving me this opportunity. I want to
9 talk a little bit about the work that we are
10 doing. My partner and I sold here about fifteen
11 months ago a service disabled veteran owned small
12 business to start Able Forces. Able Forces is a
13 501-C3 non profit and a cornerstone to our company
14 is that we are an ability 1 MOS community
15 rehabilitation program. I don't have time to get
16 into the details, but let it be said that ability
17 one is a federal set aside program focused
18 exclusively on the employment of severely
19 disabled. My partner and I are using this program
20 and this designation to establish the employment
21 focus of our work. Our mission is to provide
22 career oriented, high cognitive, professionally

1 focused jobs exclusively to wounded warriors and
2 disabled veterans suffering from physical
3 disabilities, PTSD, and traumatic brain injury.
4 Our focus, in terms of our work, right now is
5 exclusively and for major department areas; DoD;
6 military braches; Department of Homeland Security;
7 and the Department of State. The reason behind it
8 is: they get it. They get our program. We're
9 currently supporting six major contracts. DoD
10 contract closeout; Army simulation command; nine
11 subject matter experts down in Orlando; Special
12 Operations Command; Top Secret Cleared; FOLKS;
13 Huntsville, AL Missile Defense Agency; Fort
14 Belvoir, the newly awarded Mark Center; The
15 Federal Emergency Regulatory Commission; And we're
16 also pending the award of six additional
17 contracts. All of them are focused on wounded
18 warriors and disabled veterans. We believe on what
19 we've been trying to focus on is to establish a
20 national model that could employ literally
21 thousands of wounded warriors and disabled
22 veterans. We believe the contracts we have in

1 place provide a great foundation to evaluate to
2 see how these programs can be established CONUS
3 nationally. Thank you. If there's any questions
4 I'd be happy to answer them.
5 DOCTOR GUICE: Thanks Mister Rogers.
6 MISTER ROGERS: Thank you very much.
7 DOCTOR GUICE: Uh, we'll now hear from
8 representatives of the U.S. Air Force Um,
9 regarding their wounded warrior programs. Is that
10 correct?
11 MS. DAILEY: We need some set up time. Sorry to
12 break.
13 DOCTOR GUICE: Oh, okay. DOCTOR GUICE: Alright
14 in the meantime then, we will introduce the newest
15 member of the task force. Um, uh, Colonel Timothy
16 Franks who retired from the Marine Corp. was the
17 initial individual was that uh, I slot. Lieutenant
18 Colonel Sean Keane is now filling that uh, Marine
19 representative space on the task force. Lieutenant
20 Colonel Keane was promoted to his current rank in
21 September of '06 having joined the force in '91.
22 He served in multiple positions throughout the

1 Corp. including the CJ1 directive for personnel
2 services division at CSTC Afghanistan at Camp
3 Eggers Kabul, Afghanistan and as the chief of the
4 J5 directors' action group. Uh, Lieutenant Colonel
5 Keane currently serves as the Marine Corp.
6 veterans' affairs liaison officer of the wounded
7 warrior issues. Located at the uh, Department of
8 Veterans Affairs central office. He has a
9 Bachelors degree from the University of
10 Massachusetts and has graduated from numerous
11 military schools. Would you give us, just a three
12 minute summary review?
13 LIEUTENANT COLONEL KEANE: Sure I guess I can sit
14 down. Well, I really want to thank Ms. Dailey for
15 her efforts in getting me joined to the task
16 force. Um, I'm really surprised I'm in such a,
17 included in such an intelligent group here and I
18 believe that the reason they have the Marine here
19 is if the Marine can understand it then maybe Joe
20 Public can understand it <everyone laughs>. I came
21 into the Marine Corp. in '91. I spent my whole
22 time as lieutenant on active duty. Spent-then I

1 went to the reserves after reduction in force
2 after Desert Storm. I spent my whole time as a
3 captain in the reserves and then after 9/11 um,
4 right around as I got promoted to Major I came
5 back on active duty. So, I have 6 years of uh,
6 reserve time, uh, 14 years of active duty. Um, I'm
7 administrator by MOS. During the 6 years uh, I was
8 a firefighter in Massachusetts, so I'm firefighter
9 first responder EMT and um, administrator by MOS.
10 However, the last five of the seven years I've
11 been doing Intel there's been a need for TSSCI
12 cleared people; and um, coming from the joint
13 staff at J5 and actually advocated for this
14 position a few years ago when uh, Colonel Frank
15 was looking for a deputy and um, was screened for
16 and got the joint staff job and then three months
17 later they asked me if I wanted to come aboard and
18 be here Deputized. I couldn't because I just
19 accepted a position there at the joint staff. So,
20 in essence I'm replacing the guy that took the job
21 because I didn't accept it. And, they have also
22 taken that position away, so I'm a lone gun there

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1 at the VA. I no longer have a Deputy. But I'm
2 looking forward to the upcoming visits. Um, also
3 um, another interesting-I was glad that we were
4 able to with team four coordinate that I always
5 get the front loaded hospital visits because my
6 wife's expecting our fourth child in April; our
7 last child I should say <Everyone Laughs>. Fourth
8 in cl-maybe they don't need to know that <laughs>.
9 Thank you very much.
10 GENERAL GREEN: You're welcome, Sean. Okay, we're
11 uh, now at the starting point for our second uh,
12 meeting day here and our uh, thanks actually to
13 our Able Forces presenter. I think we're ready to
14 start with the Air Force.
15 MS. DAILEY: Yes sir. Just refer to tab K.
16 GENERAL GREEN: Okay, and so Denise if you will
17 get the Air Force up, we will turn to tab K.
18 COLONEL LEE: I'll just I'll leave it on the stand.
19 That's okay. So good morning! I'm Lieutenant
20 Colonel Wendy Lee. I'm the chief of clinical
21 medical management and good morning Doctor Guice
22 and General Green and the members of the task

1 force. Today I'll be speaking to you on Air Force
2 Clinical case management; also the DoD directives.
3 And then the following items will address areas of
4 the directives such as; staffing; training; and
5 workload; and also, how case management
6 participates in the MEB process and lastly, Air
7 Force initiatives. Case management is part of a
8 care continuum of our patients in the patient
9 center medical home model. We use this, we use a
10 team approach in Air Force case management. The
11 case management collaborates with all the
12 departments to coordinate medical appointments,
13 medical equipment, medications that our patients
14 may need. The goal, of course, that depicts here
15 in the slide is to provide a safety net under our
16 patients so that no one falls through and that we
17 have-we give our patients the right care at the
18 right time, in the right place. So these are some
19 of the case management directives that we follow;
20 The DTM, which came out in August of '09; TMA
21 memorandum which came out in March of '10; and
22 then, of course, the Air Force Sergeant General's

1 memo on case management performance measures and
2 training guidelines, and that came out in April of
3 2010. There is an AFI in coord right now, in
4 coordination. And that includes the medical
5 management policies, which also includes the
6 wounded warrior policies in case management. Now,
7 the following slides, I'll be talking about how we
8 have implemented the DTM into case management.
9 First is staffing and workload. The D-um, the Air
10 Force currently has 147 case managers. So, 20-26,
11 of those are wounded warrior case managers. The
12 case managers are resourced by population and
13 workload. And so, I'd like to emphasize that
14 point, being that um, when there is a lower
15 population of wounded warriors at an MTF, the
16 baseline case managers will care for those wounded
17 warriors. However when there's a larger number of
18 wounded warriors at that MTF, then that's when we
19 have given them, or resourced them with a wounded
20 warrior case manager. 98% of the clinical case
21 managers are contract with 2% being GS civilian
22 nurses or social workers. In FY10, there were

1 11,000 unique patients in case management; 3,000
2 more than FY09 and then also in FY10 you have
3 47,000 encounters that case management
4 accomplished, which is a 50% increase than FY09.
5 So now I would like to share with you various, a
6 lot of our various aspects of training for our
7 case managers. First is the online DoD VA
8 standardized training and then MHS Learn. Our
9 training completion rate numbers are low at this
10 time due to several factors. We are-we do have
11 though, an action plan that we intend to
12 accomplish within the next 90 days to bring those
13 numbers up. In addition to the MHS Learn, we have
14 regular training that the most consultants have
15 been- that are accomplished and then there's been-
16 there's consultants that the Sergeant General has
17 actually appointed and that involves the health
18 care integrators, the disease managers, and the
19 case managers, which make part of the patient
20 team. Our case management consultant is an active
21 duty nurse who is on the board of directors for
22 the Case Management Society of America. Each

1 consultant and myself hold telephone conferences
2 where we bring the patient team together, and
3 members like the health care integrators, the
4 disease managers and also the case managers, to
5 discuss more initiatives and-and you know, any
6 kinds of plans that they have; and then also, we
7 have separate telephone conferences just amongst
8 each member of the team to share where the new
9 initiatives and policies and directives that we'd
10 like to send out. So, and then some of the other
11 things that we discuss on the telephone
12 conferences is, for instance, The Defense Center
13 of Excellence on TBI and case management will have
14 in a subject matter expert come in and talk to us.
15 We'll also have coding guidelines that we will
16 review. And then, we have also, headquarters A1
17 will discuss the wounded warrior program. And,
18 there is e-mail groups that we have. Each
19 consultant contains their own mass e-mail group
20 which we regularly will disseminate information on
21 policies and directives, new webinar trainings
22 that happen. So, it is important for the case

1 manager to identify-and to identify patients that
2 need case management. And this that in various
3 ways such as, you now the pull-pull, the push pull
4 process. So, more specific to wounded warriors is
5 the, is the push process through Casualty Affairs
6 Notification. We also have unit member-the
7 member's unit which notifies case managers and
8 also PCM referrals. And then they have the pull
9 process, which we're pulling patients that need
10 case management that don't necessarily have a PCM
11 referral. And so, the pull process is more done by
12 patient care-you know, the patient care team
13 meetings and with all the different aspects of
14 those 3 members of health care integrators, of
15 disease managers, and the case managers meeting.
16 I'm sorry, yes. Do you have a question?
17 DOCTOR GUICE: I-I do. What are the cri-you've got
18 these sort of mechanisms to identify individuals,
19 but what are the criteria that get you a case
20 manager and then above and beyond that, what are
21 the criteria that get you one of the specialized
22 wounded warrior case managers?

1 COLONEL LEE: So, the wounded warrior's case
2 managers are often those with a wounded, ill and
3 injured deployment related injuries. And then,
4 those of, those of-that's what we go by is if they
5 have for instance, on their first deployment post
6 deployment screening if they have answered an
7 injury they have sustained, you know, while they
8 were deployed or even prepared for deployment,
9 that would again go in to a wounded warrior case
10 manager and of course being active duty, you know,
11 we'd have a wounded warrior case manager. And
12 then, those that are needing case management,
13 well, it-we'll say chronic illnesses are more than
14 those that need just you know, uh, care
15 coordination or more of the chronic illnesses,
16 people that need referrals, that need to have more
17 personalized care to help them through the
18 process. Does that answer your question ma'am?
19 DOCTOR GUICE: Actually, what it sounds like is
20 that it's a little bit more artful than it is
21 science and that here probably aren't clearly
22 defined criteria. It's sort of a anybody whose

1 wounded gets one. Uh, so anybody that leaves
2 theater for whatever reason gets a wounded warrior
3 and then the others are just kind of catch as
4 catch can. Is that it?
5 COLONEL LEE: Well, it has a lot to do with the,
6 the severity of their illnesses though too really;
7 you know, if they need to have more management of
8 their care. For instance, um, it's a lot of like,
9 if they need to have ref-you know, certain, more
10 referrals, or if they need more specialized care,
11 or if they have a live disease processes that case
12 managers can help coordinate. You know? So a lot
13 of-you know? It's just-it has a lot to do with how
14 difficult is the diseases or the injuries that
15 person has. And not everyone necessarily gets a
16 case manager. It really has a lot to do with the
17 severity of their illnesses or their injuries.
18 DOCTOR TURNER: Colonel Lee if I can just piggy
19 back on that. Perhaps I missed this, forgive me if
20 I did, what in-in a, in your 26 wounded warrior
21 case managers at the places, what is your
22 threshold for funding a case manager? Do you have

1 to have, like, a hundred patients? Two hundred
2 patients? What how do you determine the
3 requirement for a wounded warrior case manager and
4 then how are they funded?
5 COLONEL LEE: Sure thing. Yeah. So often we go by
6 a 1 to 20 ratio, right? And, so that is the ratio
7 we use, but it can't always just be that because
8 the wounded warrior population varies throughout
9 the year, throughout the month. Who's to say? But
10 you know, that's what we go by is, you know, we do
11 polls out there to our case managers to see how
12 many wounded warriors do they have and we, and we
13 allocate that every year.
14 DOCTOR TURNER: So, once you get 20 that buys you
15 a wounded warrior case manager.
16 COLONEL LEE: Correct, correct sir. For the most
17 part it is a science that always varies. I don't
18 know how else to say that, and you know that part
19 too.
20 DOCTOR TURNER: And then how is it, is it funded
21 from the base oper-the facility operating budget?
22 COLONEL LEE: No, actually that's wounded warrior

1 funded. So, that-and that's why it's a very, very
2 important distinction. When I say 137 case
3 managers, now granted, 26 of those are wounded
4 warriors, but there's baseline and then there's
5 wounded warrior funding. So, I mean, that's why
6 um, we, you know, we make that distinction.
7 DOCTOR TURNER: Uh, thank you very much. The, the
8 Army has over 500 and you have 26, so I was just
9 curious.
10 COLONEL LEE: Yeah <giggles>. Are there any other
11 questions? Sure thing. He has another. ??: Do you
12 think if you're connected it would be easy to feed
13 through now? In the courtroom? <INAUDIBLE> Oh,
14 there it is.
15 MASTER SERGEANT MACKENZIE: There it is. Okay,
16 thanks. Okay, as soon as we open the door, just
17 some of the things that uh, as-as we, you know,
18 the measures of effectiveness, the accountability,
19 some of these things that we obviously are here to
20 address and so forth. I didn't see in some of this
21 beginning and-and one of those things is it's
22 really great to have a program, but the question

1 is: how do you assure it's effectiveness? You know
2 we-we talk about the safety net surrounded by the
3 patient but yet you didn't tell us how do you
4 ensure that that always happens?
5 COLONEL LEE: Mmmm-hmmm.
6 MASTER SERGEANT MACKENZIE: Um, I'm not saying
7 that uh, you know-that everybody has a perfect
8 system. But, the reality to this is sometimes we
9 lose people. You know, how do you ensure that this
10 is actually an effective model in that-in that
11 safety net concept?
12 COLONEL LEE: So, we do pull metrics. And so a lot
13 of those metrics like I was talking about how our
14 caseload has increased over the years. It has a
15 lot to do with reflection of documentation
16 encoding and catching patients. And so, we have-
17 that's how we are judging. One of the ways we're
18 catching patients is because our encounters are
19 increasing, our caseload is increasing. And, those
20 are-that's one of the metrics that we are um,
21 keeping tabs on. You know, and then, also we are
22 talking to case managers monthly if not weekly

1 about their processes and about the different ways
2 and initiatives that, that they're improving their
3 programs too. And, so, it's really the side-I'm
4 just mentioning one metric, but it really is the
5 metric pulling. And it also, why even metrics on
6 the V code, there's a certain V code that we use
7 for wounded, ill, and injured, and deployment
8 related. And so, those numbers we keep track of
9 quarterly to see if their varying or if they're
10 decreasing. And if we see a drastic gap for
11 instance, meaning if one base says that they only
12 have one case manager before.
13 GENERAL GREEN: Can, can I interrupt?
14 COLONEL LEE: Okay, sorry sir. Yes?
15 GENERAL GREEN: Is it true that all of your
16 wounded warriors are referred to you by the A1
17 program that monitors the wounded warriors?
18 COLONEL LEE: No sir.
19 GENERAL GREEN: And so, the ones that aren't
20 referred to you by the A1 program come to you by
21 their PCM's?
22 COLONEL LEE: Yes sir.

1 GENERAL GREEN: Thank you.

2 COLONEL LEE: Yes?

3 MASTER SERGEANT MACKENZIE: The other question I

4 had too um, you know this is just, I'm a unique

5 case. So, I've been in the system now for almost 7

6 years as a wounded warrior, so I've seen a lot of

7 changes. So don't take this as me being negative

8 um, but it's-it's certainly important stuff. Um,

9 one of the things I didn't see in there was you

10 know, you-you talk about some of these wounded

11 warriors that go out to these remote areas where

12 there's not a population of wounded warriors and

13 the baseline clinical case managers are

14 responsible for taking care of them. But who's

15 training these clinical case managers? Because the

16 reality to it is, is a unique response in case

17 management when it comes to a wounded warrior and

18 you're saying, "Okay. This person can handle it

19 cause I've only got one person." Well, who's

20 providing that training for that case manager to

21 do it the right way right off the bat and manage

22 that?

1 COLONEL LEE: Yes, sir the program falls
2 underneath a lot of the chief of medical staff
3 along with the healthcare integrator. Those are
4 two active duty personnel on the patient care
5 team, and they train the members of the patient
6 care team meaning case manager, disease managers.
7 Then, also, we have the MHS Learn training that
8 has the TBI and PTSD modules, and we also have
9 monthly telephone conferences, email groups that
10 we're sending information out. There's several
11 avenues of training, and not just a sit-down
12 classroom training. A lot of it goes by the local
13 MTF and passing information down from the SGH and
14 also the health care integrator.
15 GENERAL GREEN: So, I think he's asking
16 specifically is there any specialty training for
17 those managing the wounded warriors, and are they
18 accountable to that training? Who's accountable
19 to making sure that training happens?
20 COLONEL BIERSACK: Yes, sir it. Through TMA and
21 (inaudible), so the TMA and SGS modules are
22 particular modules that deal with for example,

1 PTSD and TBI. In addition to working with our
2 consultants on PTSD and TBI, all case managers
3 across CMHS, Army, Navy, Air Force contract GS or
4 active duty have to take the same training, and
5 it's through this standardized training that Tri-
6 care is offering that we can be specific. So,
7 when we look at specific injuries related to as I
8 said PTSD or TBI, then in addition to that, as
9 they work with the inpatient coordinators for
10 those who are having, let's say a prolonged
11 rehabilitative surgery for amputations and so on,
12 again, they're working with the inpatient liaisons
13 and rehabilitation specialists. So, the answer is
14 yes they do get specialized training, and yes,
15 we're using what Tri-care management agency is
16 requiring us to use.
17 MASTER SERGEANT MACKENZIE: And, that's actually
18 leading up to my next point, just dealing with a
19 specific airman, where is the handoff between case
20 managers? You know, when I when I roll into the
21 local MTF, and I go, "Hey, by the way, I need some
22 help with this guy," and they kind of look at me

1 and go, "When did he get here?" You know, and
2 there's there is no inpatient liaison. There
3 there isn't that situation in that case, and you
4 know, I'm trying to assist. It it seems like
5 there's a disconnect somewhere in our
6 responsibility to these wounded warriors where we
7 say, "Okay, you're leaving my MTF going to another
8 facility." I need to get a hold of that MTF and
9 make sure we're covered down on this guy. Where's
10 that tracking happening?
11 COLONEL LEE: Actually, I'm going to be going a
12 lot through that, the warm hand-offs, and the
13 areas that we do want hand-offs, but there is a
14 Air Force case management liaison at Walter Reed
15 and Brooke Army Medical Center, sir.
16 MASTER SERGEANT MACKENZIE: That's my point. I'm
17 not talking about Walter Reed or Brooke Army
18 Medical Center. Literally, the what I'm talking
19 about is we get treated at all different
20 facilities. I have a particular airman at the
21 Tampa VA on active duty being treated, came from
22 Brooke Army Medical Center, and yet, there seemed

1 to have been a communication and handling
2 breakdown in that situation which we jumped in.
3 I'm not saying we didn't get it fixed, but I'm
4 saying this is part of the stuff we're looking at
5 as a task force I believe is how are we
6 accountable to these wounded, ill and injured and
7 making sure that these type of failures don't
8 happen?
9 COLONEL LEE: I do, sir, associate closely with the
10 Navy and the Army. There are rosters out there,
11 telephone rosters of all the case managers for the
12 Navy and the Army, for our case managers to
13 utilize to be in touch with case managers to do
14 warm hand-offs between the different facilities
15 that we know patients are at.
16 COLONEL BIERSACK: One additional way because the
17 (inaudible) is the use of the recovery care
18 coordinators and the family liaison officers who
19 are working with the back to the base with the
20 case managers. So, it's really an A-1. It's a
21 personnel and medical work that's supposed to be
22 happening, and in addition, I know at the Tampa

1 VA, I've actually been in contact with the Navy
2 has someone assigned there, and when he has
3 contacted me or gone through our recovery care
4 coordinators, which he has that, we then go back
5 to the case manager at that facility. So, that
6 system needs to be worked better, but we do rely
7 that's where we rely on some communication with
8 our
9 recovery care coordinators and our flows.
10 MASTER SERGEANT MACKENZIE: Thank you.
11 MR. REHBEIN: Correct me if my numbers are wrong,
12 here, but I think what I heard you say is that you
13 have one case manager for every twenty wounded
14 warriors.
15 COLONEL BIERSACK: No, that's not right. It's one
16 wounded warrior case manager, and a lot of it has
17 to do with it's not a direct science. I mean, it's
18 not just like we because numbers vary too, but
19 that's ideally what we like.
20 MR. REHBEIN: The point of my question is it
21 appears to me overall the Air Force, the ratio is
22 about ninety to one. You have something like

1 11,300 patients enrolled, and you have 137 case
2 managers. I just wonder if you looked at the
3 effectiveness I think if I understand correctly,
4 the number of wounded warriors a case manager
5 handles is considerably lower than that. I just
6 wondered what is the effectiveness of the two
7 ratios?
8 COLONEL BIERSACK: Actually, so and I think I'm
9 going to go back, just excuse me. So, I think
10 you're talking a lot about the numbers here
11 correct? This actually is to show the overall
12 case beneficiaries that were managed in case
13 management. I do have another slide to show you
14 the wounded warrior patients, the unique patients
15 that we're managing in the air force.
16 COLONEL BUMPERS: Sir, let me-
17 COLONEL BIERSACK: The number is lower than that.
18 COLONEL BUMPERS: Let me make a comment here and
19 help her out with answering the question to help
20 clarify. We have a case manager in every MTF
21 across the Air Force. A lot of our smaller MTFs
22 see very few wounded warrior. They may have one

1 to four or five. In those facilities, those case
2 managers take care of all the beneficiaries to
3 include the wounded warrior. We have a few
4 facilities that tend to have higher numbers such
5 as Kiesler Air Force Base in Travis. They
6 consistently run about fifty wounded warrior
7 patients. So, those are the facilities that we
8 have placed the wounded warrior "case managers"
9 using the funding for wounded warrior. So, those
10 facilities have above and beyond in the higher
11 numbers are where those twenty case managers are
12 placed, but in our smaller facilities, our
13 baseline case managers take care of them because
14 many of our facilities only have four or five
15 consistently.
16 MR. REHBEIN: So, if I here you correctly, what
17 you're telling me is that in many of the
18 facilities, the case managers handle everybody,
19 not just wounded warriors.
20 COLONEL BUMPERS: Correct, sir.
21 MR. REHBEIN: Okay.
22 COLONEL BUMPERS: And, we use about one to twenty

1 to staff those wounded warrior case managers case
2 load.
3 DR. GUICE: I think part of the confusion, if you
4 can go back to your numbers slide, I think part of
5 the confusion is the 11,000 and then the 47,000
6 don't represent wounded warriors exclusively.
7 They're in that number, correct?
8 COLONEL LEE: Correct.
9 DR. GUICE: It's a smaller group. That includes all
10 your chronic care management. That includes the
11 diabetes management.
12 COLONEL LEE: Correct.
13 DR. GUICE: So, and then the question I do have for
14 that is, you had a huge jump in a year. What
15 drove that?
16 COLONEL LEE: So, a lot of it has to do with coding
17 documentation correctly, and then also just that
18 we've had just a lot more communication amongst
19 the patient care team that pulling and pushing
20 processes that I was talking about just a moment
21 ago, the patient care meetings, the pulling the
22 patients in, and then also the medical evaluation

1 work group, identifying patients, just a lot more
2 identifying the patients.
3 GENERAL STONE: I think where we're struggling here
4 just a bit is you've got a ratio of case
5 management of about one to 23 are wounded, ill or
6 injured. Your other case management, I would
7 imagine may be short term case management in your
8 11,000-
9 COLONEL LEE: That doesn't-
10 GENERAL STONE: - are case managed for short term,
11 in patient stay and then discharged?
12 COLONEL LEE: It does include a lot of the care
13 coordination. We do have a lot of care
14 coordination going on, too.
15 GENERAL STONE: So, there is actually 11,300 of
16 that ninety to one? It would just seem hard to
17 believe that a case manager could effectively
18 manage 90 to a hundred patients.
19 COLONEL BUMPERS: Sir, that includes care
20 coordination where a case manager just may
21 encounter that patient a couple of times, help
22 coordinate some appointments or a visit. That

1 would not be a patient requiring full time case
2 management.
3 GENERAL STONE: Thank you.
4 COLONEL BUMPERS: We do a lot of care coordination.
5 GENERAL STONE: Thank you. Are you satisfied that
6 the twenty to one ratio for wounded, ill and
7 injured is the correct model?
8 COLONEL LEE: Yes.
9 COLONEL BUMPERS: I would like to clarify one more
10 thing when you were asking about how we ensure we
11 identify the patients. One thing we've done for a
12 long time is at check-in when every patient checks
13 in, they are asked if their condition is
14 deployment related, and coded with the V code, and
15 that's why when we sort of use that wounded, ill,
16 injured deployment related catchment to ensure
17 that we're catching all of those patients. So,
18 then at any point along that continuum, if that
19 patient has had that V code, we somebody
20 hopefully will pick it up and say, "You know, we
21 need to look at this particular patient," but for
22 a long time at every check-in, the patients are

1 asked that question. "Is this visit related to a
2 deployment?"
3 MASTER SERGEANT MACKENZIE: Ma'am, did I understand
4 you correctly when you said that the process
5 relies on somebody hopefully will pick this up?
6 COLONEL BUMPERS: Well, it's when I'm talking
7 about the team, and you were asking how we ensure
8 they don't fall through the cracks, with all these
9 people looking at these visits, if every patient
10 that checks in, you know, makes that statement,
11 then all of these people have the opportunity to
12 question and make sure that that person is getting
13 appropriate management.
14 MASTER SERGEANT MACKENZIE: Thank you.
15 COLONEL LEE: Okay, so this slide depicts the Air
16 Force total care complexity work load. So, again
17 this is the total care, all the beneficiaries, and
18 you notice that acuity means the frequency of
19 contacts and the number of medically required
20 interventions by the case manager. The majority of
21 Air Force patients are in the lower acuity
22 categories.

1 DR. GUICE: Before you leave that slide, how do you
2 actually what are the criteria that give you a
3 level one versus a level five? What are your case
4 managers actually measuring to put these people
5 into these lanes?
6 COLONEL LEE: So, it has to do with the amount of
7 visits or contacts that they have per patient.
8 DR. GUICE: So, acuity level one would be a hundred
9 contacts, or what?
10 COLONEL LEE: It would be one contact a month.
11 DR. GUICE: But, that's the case management
12 contact.
13 COLONEL LEE: Correct.
14 DR. GUICE: But, it's telling the case manager that
15 this person needs that level of contact. How many
16 specialists are involved in the care? What kind of
17 care, what kind of needs does that individual have
18 that drives that contact of once a month? Do you
19 understand the question?
20 COLONEL LEE: So, are you asking so how many
21 specialists on top of the case management?
22 DR. GUICE: I'm a case manager in the Air Force.

1 COLONEL LEE: Okay, very good.
2 DR. GUICE: I've got a hundred people at my door. I
3 need to put them into these five levels of
4 contact. How do I parse out who needs a level one
5 versus who needs a level five? What criteria have
6 you, my managers provided me to parse these people
7 out?
8 COLONEL LEE: This is all retroactive acuity
9 measuring. So, it has to do with how many
10 encounters that case manager has had with a
11 patient in the previous month. Are you following
12 me, ma'am? So, for instance, acuity one is one
13 visit in the last month, and then upward.
14 COLONEL BUMPERS: Ma'am, this is the part of our
15 standardized case management coding, the TMA DoD
16 case management coding.
17 DR. GUICE: I understand that. I'm just asking
18 COLONEL BUMPERS: And, it's-
19 DR. GUICE: - what would-
20 COLONEL BUMPERS: It's not based on patient
21 acuity. It's based on-
22 DR. GUICE: So, it's contact acuity.

1 COLONEL BUMPERS: The workload of that case manager
2 with that patient.
3 DR. GUICE: But, how do I know to give somebody an
4 acuity level one, what as a case manger am I
5 seeing that says, "Put him in a once a month
6 contact?"
7 COLONEL BUMPERS: The case managers code once a
8 month the acuity code, and they look back thirty
9 days. They look at the number of encounters
10 they've had, and that's the acuity they put in
11 once a month. And, that helps determine the
12 workload.
13 DR. GUICE: Okay.
14 DR. PHILIPS: Just to follow up so that I can
15 understand.
16 So, if this is a retroactive evaluation, for the
17 following month, would that patient be
18 automatically put into the acuity one?
19 COLONEL BUMPERS: No, sir. The case manager would
20 look back thirty days to see how many encounters
21 they had, and this was when we were looking at
22 standardizing the case manager coding. This was

1 how the coding world was the best way to do this.
2 We did not pick this. So, this was one way to
3 determine what is that workload of the case
4 managers? So, they'll look back thirty days, and
5 then once a month they put in the code for however
6 many encounters or whatever work they had to do.
7 If they had to call the specialist five times,
8 they contacted the patient three. They arranged
9 medical equipment, and then they would code that
10 because all of that has to be entered in AHLTA
11 when they do whatever interventions for their
12 patient.
13 DR. PHILIPS: So, this is not predictive criteria?
14 COLONEL BUMPERS: No, sir.
15 DR. PHILIPS: Thank you.
16 COLONEL BUMPERS: So, if right now today we pulled
17 this acuity codes, you would know for the last
18 thirty days what the workload of each of those
19 case managers had been.
20 COLONEL STONE: Could I ask that can you give us
21 some view of your 682 wounded, ill and injured? I
22 mean, how many are traumatic injuries? How many

1 are ill? Could you have some view of that? Rather
2 than to try to approach this through the acuity of
3 case management and how many visits they've had.
4 Can you give us any sort of view of those 682?
5 COLONEL LEE: So, what kind of injuries they have?
6 Is that what you're talking about specifically?
7 COLONEL STONE: Well, I'm asking you to define your
8 population of wounded, ill and injured. I'm asking
9 you to tell me are these inpatients, are these
10 outpatients, is this post acute care management of
11 some complexity? You're trying to get at this
12 population through a retrospective look at how
13 many encounters they've had. I don't think that
14 gives us a very good view of sort of what is this
15 population you're managing.
16 COLONEL LEE: Is that a question though? Is that
17 what you're wanting is? So-
18 COLONEL STONE: I'm sorry.
19 COLONEL LEE: Is that a statement?
20 COLONEL STONE: I'm not saying this very clearly.
21 I'm trying to understand what the 682 airman
22 you're managing.

1 Are they inpatients? Are they outpatients? What is
2 their
3 actual disease process you're managing? You're
4 trying to define a population for us
5 retrospectively based on encounters. I don't
6 understand whether those encounters are inpatient,
7 outpatient, specialty. I'm asking for you, and if
8 the question is not appropriate for this setting,
9 if you'd like to come back to us later or come
10 back in a written manner, I'd like you to define
11 the 682 airmen that you're managing and tell us a
12 little bit about their disease processes and what
13 you're actually managing.
14 COLONEL BUMPERS: Okay, sir, we'll have to get back
15 with you with those specifics because our
16 briefings are mainly based on the acuity.
17 GENERAL STONE: Okay, thank you.
18 COLONEL LEE: So, as you notice the Air Force case
19 manager wounded, ill and injured deployment
20 related members are from all services. There's
21 682 unique patients that the wounded warrior case
22 managers are managing, and that's a 200 increase

1 from FY'09. So, the question was earlier where why
2 how is it increased? It's improved through
3 documentation and coding, and also better
4 coordination between the medical team in pulling
5 patients into case management. Also, we do assure
6 the warm hand off to our VA partners for better
7 collaboration and continuity of care, as well as
8 collaborating with the recovery care coordinators
9 and the family liaisons.
10 DR. GUICE: Could you better define what that warm
11 hand-off to VA entails and how do you ensure you
12 actually affected a warm hand-off as opposed to
13 something else?
14 COLONEL LEE: Well, it's all to do with well, via
15 telephone conversation, and it's dialing another
16 case manager, and then also documenting that that
17 warm hand-off happened.
18 DR. GUICE: So, you can provide us with information
19 about those individuals who transitioned to VA
20 care and the number of people who actually got a
21 warm hand-off? Is there follow-up by your case
22 managers? Once you affected the warm hand-off,

1 that one phone call like five days later or ten
2 days later to ensure that that individual is now
3 embedded into that alternative case management
4 system at the VA?
5 COLONEL LEE: Well, so the follow-up care I will
6 have to get back to you on how the follow-up is
7 done. So, the wounded warrior complexity workload
8 of our wounded warrior case managers is similar to
9 the overall Air Force case managers where the
10 complexity workload is once again in the lower
11 acuity level. So, the next two slides is going to
12 depict how case managers are often involving for
13 caring for the patient. Case managers have a
14 critical role in medical evaluation process. The
15 star as you can see directs where the case
16 manager's role primarily influenced. They're
17 involved at the beginning of the process. They
18 help and identify conditions that need to be
19 medically evaluated or boarded, and they're also
20 involved in the DAWG process, and their
21 participation has a lot to do with once again
22 bringing in patients that the DAWG has identified

1 via profiles and also the PCM is identified into
2 case management. The case manager will also find
3 patients too that might need their assistance in
4 expediting the process. So, the case manager also
5 has to do a lot so, the middle part of it, a lot
6 of it is administrative where there is a board of
7 physicians that meet to determine the assignment
8 limitation code. A lot of that is administrative,
9 but the case manager does still have those
10 patients enrolled in case management, and they
11 will meet their needs as that administrative
12 process is going on, and then lastly after the
13 board has convened, either the patient will be
14 returned back to duty, the case manger will
15 continue any care needs that they may have with
16 personalized care, and then also the separation
17 where they will coordinate with other civilian
18 medical treatment facilities if that's what they
19 need or even the VA, too.
20 DR. PHILIPS: A question. Would you have an
21 average time line for this whole process to occur?
22 COLONEL LEE: So, no, sir. I'm sorry. I don't

1 have the information. I can get back to you though
2 if you'd like.
3 DR. PHILIPS: Thank you.
4 DR. TURNER: One real quick question. Is there a
5 case manager assigned to everyone who gets an MEB?
6 COLONEL LEE: Yes no, only if they need it. If
7 they're complicated enough to have a case manager,
8 absolutely, but there's not that many cases-
9 DR. TURNER: Who determines that?
10 COLONEL LEE: What determines that?
11 DR. TURNER: Yes, ma'am.
12 COLONEL LEE: A lot of it has to do with referrals
13 and how many specialists care they need, and then
14 tracking their referrals and even making sure that
15 they have the appropriate paperwork that goes
16 forth.
17 DR. TURNER: And, so the case managers are accessed
18 by their provider. The provider will say, "Okay,
19 this is complex," so they contact the case
20 manager?
21 COLONEL LEE: Well, that is one way that patient
22 will be pushed into case management. The case

1 manager will be part of the deployment
2 availability working group where they'll also see
3 patients that are very complex, and they'll say,
4 "Hey, let's bring this patient into case
5 management, too." Because the deployment
6 availability working group has a lot to do with
7 the MEB process and looking at patients that need
8 to be medically evaluated or boarded. So, the case
9 manager is intimately involved in that group of
10 discussions and people meeting the PCM.
11 DR. PHILIPS: Is there an opportunity for a patient
12 to say, "I'm having difficulty? I don't know
13 what's going on. Can I request a case manager?"
14 COLONEL LEE: Absolutely, absolutely.
15 MASTER SERGEANT MACKENZIE: First, being a joint
16 environment, obviously we're coming out of
17 different services. Some of this information like
18 what is an Air Force form 469 or what is an
19 example of this DAWG, and it would be good if we
20 could get that provided to the team, as well as
21 the when I'm looking at your chart and I see this
22 MEB board, and I see assignment limiting code

1 being a separate item, sometimes that's post-med
2 MEB board as well, and also how does that apply to
3 limited assignment status versus assignment
4 limiting code? Are those two different things, and
5 does a case manager work with that as these guys
6 are trying to get back on active duty perhaps in
7 another region? Is the case manager helping at all
8 with that process?
9 COLONEL LEE: So, limited assignment versus
10 assignment limitation code is that what your
11 verbiage was? I'm sorry.
12 MASTER SERGEANT MACKENZIE: Yes, the limitation
13 assignment status where a wounded warrior is
14 although found medically unfit initially is
15 returned to active duty to perform duties in a
16 limited assignment status to stay on active duty,
17 similar to the Army's co-ed process and so on and
18 so forth.
19 COLONEL LEE: The assignment limitation code which
20 is also limited status too, but it has a lot to do
21 with whether they can deploy or not deploy.
22 MASTER SERGEANT MACKENZIE: That's what I was

1 asking.
2 COLONEL LEE: They both seem to be very similar to
3 me, sir. The case manager either way has will
4 always care for the patient and their needs, if
5 they are enrolled in case management, or even if
6 they aren't enrolled in case management and they
7 need the coordination of specialists' care, of
8 medication, equipment. Anything they need for
9 their problems will be there for them. That's how
10 they deal with patients that have been given
11 assignment limitation code.
12 MASTER SERGEANT MACKENZIE: Thank you.
13 COLONEL BUMPERS: I think on this slide, those two
14 blocks represent the official process which the
15 case manager is not involved with. Those are the
16 physicians and the people on the boards making the
17 decision. That's the administrative piece. The
18 case manager is involved at the beginning, and
19 then coordinating getting the patient ready for
20 that board, and then afterwards whatever the
21 transition is.
22 MASTER SERGEANT MACKENZIE: That's what I was kind

1 of getting at is the case manager is not involved
2 in any of this process in the middle.
3 COLONEL BUMPERS: Not that official process in the
4 middle.
5 MASTER SERGEANT MACKENZIE: It's all up to the
6 board.
7 COLONEL BUMPERS: That's strictly the board,
8 correct.
9 MASTER SERGEANT MACKENZIE: And, they have no
10 involvement with the patient on that aspect
11 whatsoever.
12 COLONEL BUMPERS: Correct.
13 MASTER SERGEANT MACKENZIE: Okay. MS. CROCKETT-
14 JONES: Okay, I have a question that you may have
15 to get back to us on us. There seems to have been
16 something which triggered you to want to pull more
17 wounded, ill and injured into case management.
18 There seems to have been a reason that you were
19 doing more pulling, and I'm wondering what that
20 reason is and if having done so, you are seeing
21 the results you expected. If case management and
22 increased focus on case management has produced

1 the results that you were expecting and what
2 results were you expecting? That's information I
3 think that would help us.
4 COLONEL LEE: Okay. So, I'll get back to you on
5 that, sure thing. So, there was a question earlier
6 on what kind of warm hand-offs the case managers
7 do, and how do they coordinate with other areas of
8 the patient team, family liaisons. So, I want to
9 talk you through an example of what one case
10 manager has done in her job. Her name is Kaye
11 Creasman, and she's an Air Force Special
12 Operations she's assigned to Special Operations
13 Command case manager. So, for instance, a patient
14 is injured. He's brought from Bolad back to
15 Laudstahl, and then eventually Walter Reed. The
16 casualty notification is made, and the unit, the
17 member's unit is notified. Kaye Creasman is based
18 out of Holbrooke Field where Special Operations
19 command is. She will be notified by the member's
20 unit, or she was notified by the member's unit
21 that this patient is coming home and going to
22 Walter Reed. Before the patient's arrival, Kaye

1 notified the inpatient case manager at Walter
2 Reed, and also the Air Force Special Operations
3 liaison to prepare for the patient's arrival. So,
4 again, personalized care and preparation before
5 the patient even arrives back into Conas.
6 MASTER SERGEANT MACKENZIE: If I may real quick,
7 I'm very familiar with this process because we're
8 part of the architect of this process with AFSOC.
9 First of all, is it looked at as a best practice,
10 and is it being standardized as a way of doing
11 this throughout the Air Force because obviously it
12 is incredibly effective and incredibly positive
13 results to the wounded, ill and injured coming off
14 the battle field?
15 COLONEL LEE: So, well, all case managers
16 understand the different liaisons we have
17 available, may it be the family liaison, the Air
18 Force Special Ops command, but Kaye is the only
19 case manager at the MAJCOM at the Air Force
20 Special Operations command, and we're all
21 supporting her position as she continues to be
22 there. So, as far as best practice, I'd say it's a

1 practice that we feel is very effective.
2 MASTER SERGEANT MACKENZIE: That's what I was
3 getting at because the it's you look at what is
4 the best way we do business. We're constantly
5 evaluating and assessing, and this is one of those
6 best practices. I know Kaye very well. I know the
7 process very well, and there's quite a bit of
8 collaboration between Special Operations command
9 and Kaye Creasman, and the support for her
10 position and what you guys have done just through
11 my recent conference with her has been very
12 promising for that major command. But, the reality
13 to it is with you know the Air Force liaisons that
14 we have in some of these critical areas, you know,
15 they don't fall under the same chain of command.
16 COLONEL LEE: No.
17 MASTER SERGEANT MACKENZIE: The reporting process
18 doesn't necessarily go through the same routing
19 process. One of the things that having this case
20 manager in the functionality that she fits helps
21 to close that gap in the timeliness of this stuff
22 happening. So, I was wondering, is this something

1 that Air Force case management is looking at
2 going, "This is a great model. This is a great
3 idea. We need to involve these other commands in
4 this realm," or is this just one of those, "Hey,
5 here's one of the good ideas we have, but that's
6 as far as we're going with it."
7 COLONEL BUMPERS: We have not looked at expanding
8 this right now mainly because of the uniqueness of
9 special operations. You know, this is the only
10 place right now we do it and has been extremely
11 effective because of the type of mission you have,
12 and because you are scattered around in small
13 numbers. It has worked extremely well. That's not
14 to say that we won't look at it in the future,
15 but-
16 DR. TURNER: She's the only command level case
17 manager.
18 COLONEL BUMPERS: Correct.
19 COLONEL LEE: Correct.
20 COLONEL BUMPERS: Correct, at this time.
21 DR. GUICE: Colonel Lee, can I have you go back to
22 your slide where the title is the Air Force

1 Clinical Case Management? I'd give you a number,
2 but there's not a number on the slide. It's about
3 the third one in. There you go. That's it. So,
4 for the individual in this center, and obviously
5 depending on the complexity of that individual's
6 medical problems and social needs, this slide sort
7 of tells me that we have the case manager
8 affiliated with the medical home family health
9 team, which is one level of case management. They
10 can have the case managers in red, which are I
11 would assume sort of your inpatient transient case
12 managers, or the wounded warrior case manager, a
13 referral manager, utilization manager, and
14 potential multiple disease managers. This is the
15 hard balancing act, and I think it is at the heart
16 of what your diagram shows. This is why some of
17 our families and service members go, "I have so
18 many case managers. I have no idea what they do. I
19 don't know what they do for me. I'm totally
20 confused." Can you kind of walk us through perhaps
21 a triple amputee in the middle of this? The
22 patient's a triple amputee. He's single. He's got

1 his mother taking care of him.
2 COLONEL LEE: So, now, the PCM will often be
3 referring that patient to the case manager, or
4 even so then you also have the post deployment
5 screenings and things like that the PCM will then
6 be informed. So, you have that happening. Direct
7 referral to the case manager. The health care
8 integrator, she's tracking a lot of the well,
9 she's doing a lot of the statistics that are
10 supporting the whole team, the utilization
11 manager, the disease manager, and the disease
12 manager has a lot to do with chronic diseases
13 asthma, and diabetes, or even it's just being of
14 assistance to that triple amputee and all their
15 disease processes that they may need also, and the
16 referral manager is there too to help.
17 GENERAL GREEN: Let me help. Although all these
18 people exist in support of medical home the
19 reality is in terms of who touches the patient
20 here, the only one that would touch the patient
21 here is the team, the provider, nurse and medical
22 techs and the case manager. Referral manager,

1 utilization manager, disease manager actually,
2 the disease manager could function in that light,
3 but unlikely in this scenario that you gave us,
4 and the health care integrated, chief of medical
5 staff are all supporting functions, but not
6 actually dealing directly with the patient. So,
7 the direct patient contact is through the
8 provider's team and the case manager or if it
9 wasn't the case as you've pointed out, probably
10 the disease manager might be working with them.
11 So, if that helps to understand. The problem is
12 that the recovery care coordinators are an
13 overlapping piece to this that are supposed to
14 provide and make certain that we don't have warm
15 transfer fall-offs. And, so we'll have to see as
16 the A-1 briefs the backdrop in terms of how the
17 wounded warrior program works, they can answer the
18 questions regarding the warm transfers and making
19 certain that we don't lose people from one
20 facility to another, but that's kind of the safety
21 net is the recovery care coordinator, which should
22 lead back to your answer to your question. Even

1 there, the recovery care coordinator's contact
2 with the patient would be far less than the case
3 manager if they're actually involved in case
4 management.
5 MASTER SERGEANT MACKENZIE: That is what I was
6 getting at sir, but also it's the irony that
7 example that you gave us had to do with Kaye
8 Creasman, because that's one of the things I see
9 her do on a regular basis is she is communicating
10 with those case managers at all those individual
11 locations going, "Hey, are you tracking on my guy?
12 Where's my status?" She has a responsibility to
13 the
14 MAJCOM commander to see to it that these things
15 are happening and so my question was more that is
16 this going Air Force wide, or is this just one of
17 those things where we're doing really good, but we
18 could use the Air Force as a whole could use some
19 improvement and perhaps in other best practices.
20 DR. GUICE: I think that what you're observing is
21 that security of having one individual who sort of
22 watches you across the continuum, and you're

1 interaction with all the types of systems and
2 facilities until you finish your recovery and
3 reintegrate into whatever system you reintegrate
4 back into. That is the defined scope for the
5 recovery care coordinator. So, it was noticing
6 that what these individuals really need is that
7 consistent point of contact because what we had
8 previously were a lot of warm hand-offs between
9 facilities, and among facilities, and sometimes
10 anytime you make a transition is a time for things
11 to fall apart. So, I think part of that recovery
12 care coordination function and that particular
13 program is really to emulate that kind of
14 functionality to loop it all together and provide
15 that overarching or supporting safety net.
16 MASTER SERGEANT MACKENZIE: And, that's the but,
17 unfortunately, the recovery care coordination
18 piece only covers a certain demographic, and
19 that's where I was getting at was that there is
20 other people in similar situations that don't get
21 a recovery care coordinator. Where is that piece
22 for them to make sure that doesn't full through?

1 COLONEL BUMPERS: I'd like to stress one thing,
2 though. In the Air Force, our members stay
3 assigned to their home unit. So, our case
4 managers in the home units are tracking their
5 people. They do this. They're expected to do
6 this, report to the commander, report to the
7 members' unit commander, talk to the liaison. So,
8 it's done at a local level, AFSOC being special,
9 and having all these individuals out there around
10 the world doing secret missions makes that kind of
11 unique. But, in all our facilities, our case
12 managers do that with the patients.
13 GENERAL STONE: Yesterday in the Army's briefing,
14 they discussed the comprehensive transition plan,
15 what they do find is their CTP, and also medical
16 decision points. They had some difficulty defining
17 populations, and whether they were meeting certain
18 guidance or were meeting various benchmarks.
19 Because of their large population, they really
20 were not able to articulate a number of disease
21 processes. Do you develop a comprehensive
22 transition plan? Do you develop medical decision

1 points? Do you benchmark in any manner?
2 COLONEL BUMPERS: Well, sir, the case managers do
3 the care plans. I don't think I haven't seen that
4 Army's plan, but I don't think we have something
5 quite like you're explaining.
6 GENERAL STONE: How do you know if an airman is
7 progressing in the manner that you think they
8 should or has fallen off track for some reason,
9 some complicating reason. How do you know when
10 you have maximized recovery?
11 COLONEL BUMPERS: Well, again, sir that falls
12 within that MTF, the case manager, the PCM and
13 that team that takes care of that patient, and our
14 patient care teams.
15 GENERAL STONE: Do you have any data that you can
16 present to the committee?
17 COLONEL BUMPERS: No sir.
18 COLONEL LEE: Okay, so, you're familiar with what
19 Kaye has done. Actually, sir, I know what Kaye has
20 done. However, she does, after the patient is
21 stabilized at Walter Reed, she communicates with
22 Brooke Army Medical Center, and the Air Force case

1 manager, inpatient case manager there at Brooke
2 Army Medical Center to prepare for the transfer
3 for rehab. She also will help coordinate warm
4 hand-offs between inpatient providers with Walter
5 Reed, and also Brooke Army Medical Center. Kaye,
6 in the meantime, there's a lot of administrative
7 work that goes on behind the scenes and she's
8 coordinating medical TDI orders for the patient.
9 She's also communicating with the patients' needs
10 and supporting them with emergency family orders.
11 Eventually, the patient was stabilized and then
12 could return home. She was communicating
13 throughout this time at Holbrook Field with the
14 PCM. SO, the PCM is aware of the patient's needs
15 and aware of all the treatments that the patient
16 was receiving, and now the patient was brought
17 home. Before he actually arrived home, they made
18 sure that he had equipment, the referrals were all
19 coordinated to supply that personalized care. I'd
20 like to just talk about some of the initiatives
21 that the Air Force has undergone. So, the Air
22 Force of course has the standardized Images Case

1 Management Training, and also standardized coding
2 through the Tri-care service working group. In
3 some of the Air Force initiatives is staffing
4 initiatives like I mentioned earlier, having a
5 case manager at Brooke Army Medical Center and
6 Walter Reed. Also, we were the first service to
7 develop an electronic medical record, which allows
8 for the intake and initial screening,
9 documentation of the care plan, and also the
10 standardized embedded coding within that
11 electronic medical record.
12 GENERAL GREEN: Are those the AIM forms that are
13 being used by all the services now?
14 COLONEL LEE: So, no, I think the Army presented on
15 one, and then we have our own, sir. So, it's not
16 standardized as in all services, but the Air Force
17 has their own that we've used for the last two
18 years, the AIM one.
19 GENERAL GREEN: So, how do you have best practice?
20 COLONEL LEE: Well, it's more of an initiative, and
21 it's best practice because it's something that we
22 have we were the first service to develop.

1 MR. REHBEIN: Is that something that's transferable
2 to VA?
3 COLONEL LEE: It's only in AHLTA. So, I don't think
4 VA uses AHLTA.
5 MASTER SERGEANT MACKENZIE: The question I have is
6 although once again, opening that door stepping
7 up, doing the thing initially, but is there an
8 initiative within the Air Force to get that
9 program where it's transferable between the
10 services as we go to this more joint medical care
11 team and we're dealing with joint facilities where
12 you know my Air Force case manager can see my Army
13 case manager who's working at the MTF that same
14 information even though they're using two separate
15 forms.
16 COLONEL LEE: Yes, there is something called a CCM
17 tool Clinical Case Management tool, and that is
18 being now discussed at TMA. It is something
19 that's joint, and it will have the care plans
20 within it. It's a new tool, and it's still under
21 development though, but that is the intentions.
22 MASTER SERGEANT MACKENZIE: My other question to is

1 as we come up with these initiatives, where is the
2 follow-up to these initiatives. The Air Force
3 medical liaisons came about in 2007. Has there
4 been any look back that says, "Hey are we being
5 effective? How do we fund this? Are we changing
6 where this comes from, or is this.?" I'm just
7 saying, is there a trend there? You mentioned the
8 initiative. I'm just wondering if you know
9 anything about that.
10 COLONEL LEE: So, no, I don't. Initiatives as far
11 as staffing initiatives or training initiatives?
12 We constantly are evaluating the staffing and how
13 case managers are doing at the local facilities,
14 and how wounded warriors numbers are changing over
15 time, and then the POM, POMing in relation to the
16 staffing needs and patients' needs. As far as
17 training goes, we are for instance, TBI and with
18 the Defense Center of Excellence, we constantly
19 share webinar trainings that are happening over
20 time with the case managers through telephone
21 conferences.
22 MASTER SERGEANT MACKENZIE: Thank you.

1 COLONEL LEE: Okay, that's all I have. Thank you
2 for this opportunity.
3 DR. GUICE: Thank you. Do people want to take a
4 quick break now or move to our next presentation?
5 I'm seeing quick break. Quick break. Okay, thank
6 you.
7 DR. GADSON: Next slide please. As mentioned the
8 AFW-2 Program is a sub-set of the Air-Force
9 Warrior and Survivor Care Program that initially
10 did start as that Palace Heart Program that I
11 talked about, hence why the Air Forces still had a
12 section of our Warrior and Survivor Care program
13 that focuses and tailors services to our Combat
14 Wounded. But they really come in at the tail end
15 of the reintegration piece, so as they are
16 reintegrating in and being identifying as people
17 or individuals who are going to meet an MEB, they
18 step in and this is done from a central hub in San
19 Antonio. So, all of our AFW-2 Consultants sit in
20 San Antonio and meet that requirement, again
21 coordinated through the Recovery Care Coordinator
22 because of that trust and bond that is built there

1 in the months or years that lead the family from
2 the Recovery and Rehabilitation piece into this
3 reintegration side that allows them to have that
4 liaison to these folks who are trained experts and
5 have the capacity to reach back to the Air Force
6 Personnel Center to meet specific needs of
7 transition. So, they will really highlight the VA
8 transition pieces as well as working with the
9 Federal Recovery Coordinators that have been
10 suited up under the DoD program that are a
11 tremendous asset to what we do as a service, and
12 also focusing on that transition whether it be
13 back into Air Force or back into the civilian
14 community. Next slide please. Right now we are at
15 a Care Manager number of 17 with 4 Admin Staff and
16 what we are doing. One of the things that we are
17 doing, that General Jones, our new A1, has
18 established -- is many of the programs -- because
19 a lot of it was driven by the NDAOA Legislation --
20 have driven programs within the Air Force that we
21 stood up, but we have never really identified the
22 support tail piece and Manpower to meet those

1 requirements. Air Force has been very supportive
2 through the half-corporate structure in getting us
3 the positions that we need to be able to meet the
4 needs of recovering service members, but we are
5 now -- have a formal opportunity to work through
6 our A1 Leadership as well as the PMT panel and the
7 Manpower folks to really now build the Air Force
8 organization that supports all of this structure.
9 I can honestly say out of our headquarters there
10 is three of us and a contractor that do what the
11 Army Warrior Transition Command does in our AFW-2
12 side; for that life-long care and outreach, we
13 have 17 Care Managers who manage that case load.
14 I will get into some specific numbers of what
15 these demographics look like in the following
16 slides.
17 DR. GUICE: Before you leave this slide, can you
18 -- your Olympic Ring Chart showed an overlap with
19 the RCC's and the AFW-2's, so if you have got
20 someone who is combat -- who takes primary
21 management of that individual? Is it AFW-2 or it
22 the Recovery Care Coordinator and how do they

1 balance that crossover, that overlapping ring
2 portion?
3 DR. GADSON: Ma'am, great question. As I
4 mentioned in the beginning, there is ovals I had
5 on there that really should be laying on top of
6 one another. The Recovery Care Coordinator if the
7 overARCing -- because they are going to have that
8 combat wounded individual from the time that they
9 enter the MTF. The AFW-2 Program brings in that
10 member when they are now gone through their
11 recovery and rehabilitation working back into a
12 reintegration phase. So when the members been
13 identified to meet an MEB, is really when the AFW-
14 2 Program steps up for our combat wounded to take
15 over that case management perspective. So, there
16 is a warm hand-off from the RCC several months or
17 years into the process to our AFW-2 folks that
18 then carry it forward through the transition back
19 into military community or into the VA and the
20 civilian community. The AFW-2 Consultants have
21 taken on a lot of real responsibilities, again,
22 through growing the program and seeing what that

1 consistent need is of our families. So, much of
2 what they do is from an advocate perspective in
3 making sure that our members needs' are met and
4 that things haven't fallen through the cracks --
5 would we do MEB's. I will give you an example.
6 Being aware of the members case, often times we
7 will find that a member goes through an MEB, is
8 found unfit for duty, goes on to the PEB and has
9 just been recently diagnosed with TBI. That
10 information may not yet be in that medical package
11 for the board to evaluate on where they are at, so
12 as the AFW-2 Consultants sitting in Air Force
13 Personnel Center and working hand in glove with
14 the DES team, they are able then to say "Okay,
15 here is a member that we need to reassess. We
16 have just gotten this diagnosis, let's step in and
17 do it", versus what we had been seeing happen in
18 the past where the member would be discharged,
19 transitioned to the VA, and then the TBI would
20 treated through the VA and maybe not aggressive.
21 So we are capturing all of those things through
22 this management piece on having the partnership

1 between the programs but having an actual case
2 manager who is familiar with the MEB-PEB process
3 and the requirements that are available to
4 providing that board that is making the decision,
5 all of the medical information that is pertinent
6 to that member at the time. You look like you have
7 a question, Ma'am?
8 DR. GUICE: Where is the PEBLO in all of this?
9 DR. GADSON: The PEBLO is still very much
10 forefront within the SG community as well as
11 within the DES community. They again are the
12 individuals that provide that support on walking
13 through this process. Often times when they are
14 walking them through the process, what they will
15 do is they will provide what the requirements are,
16 what we need to go forward. They will provide
17 that information specific to the family and then
18 the AFW-2 Consultants in partnership with the
19 Recovery Care Coordinators still may be involved
20 and engaged can help to build the package that the
21 PEBLO lays out for that family. So, while we may
22 say "Here is your briefing. Here is what the

1 PEBLO provides. Here is what you are going to go
2 through." They get their checklist, but those
3 AFW-2 Consultants in conjunction with the Recovery
4 Care Coordinator will take that family and say
5 "Okay, you have got the checklist, what is the
6 first item?" "Here's the form, let's sit down
7 together and fill this form out". Let's sit down
8 together with the comprehensive team so that we
9 can go forward to make sure that the member may be
10 PTS or TBI, who may not have captured all of those
11 things in themselves, have a complete package to
12 go forward.
13 DR. GUICE: So yesterday we heard that the Army
14 has done a survey within their WTU's, and the
15 individuals who are more satisfied with the MEB-
16 PEB process are those who have better information.
17 So have you looked at -- because now you have got
18 a whole group of people who are dedicated to
19 providing the service member and family with good
20 information. Have you looked at whether or not
21 this is an improvement in satisfaction with your
22 MEB-PEB process?

1 DR. GADSON: We are working to develop those
2 metrics, ma'am. In fact, we included some
3 questions in the latest customer feedback survey
4 that went out under the A1-S umbrella. So, we are
5 waiting for that data to come back in. The
6 generic questions at this point -- and I will talk
7 a little bit more about this too when we get to
8 measures of effectiveness -- but right now as
9 again, because we don't have Warrior Transition
10 Unit's where we bring everybody together under one
11 line of authority, most of our patients stay
12 attached to their local units at the local
13 installation level. We do have some that are
14 attached to patient squadrons if their care is
15 going to be done away from their duty location.
16 When we pull those folks together, DES falls under
17 a separate area that doesn't fall under my
18 purview. But the partnership that we work with
19 them -- Colonel Les Hargate runs the program and
20 the boards that run through there. Between him,
21 me and Colonel Biersack and Mr. John Beckett, who
22 you are probably familiar with who is our program

1 manager of Air Force Warrior and Survivor Care, we
2 have sat down to say "Okay, how can we better
3 partner between the RCC's, the PEBLO's, and this
4 MEB-PEB process?" Colonel Hargate is on the path
5 to driving we think an ASO 21 event to kind of
6 drive to where we look at -- but they definitely
7 have a working group in place now to assess and
8 they pulled in members to provide panel
9 information and then are working to assess how the
10 program can be altered to make sure that we are
11 meeting that need. It is obviously a very
12 adversarial role when you have a board that is
13 deciding whether you are fit or unfit for duty.
14 We are trying to drive that to where we are
15 educating through the PEBLO piece as well as the
16 Recovery Care Coordinator's that while you may be
17 found unfit, there is still a process for us to
18 bring you back into duty assignments -- more on a
19 physical condition piece than it is on your
20 ability to still perform a service within the Air
21 Force. So, there is much being done ma'am on that
22 realm. I don't have actual hard numbers or

1 statistics at this point, other than that the
2 anecdotal information that we were getting and the
3 direct feedback we were getting told us that the
4 system was not working at its full capacity to
5 providing gold medal service. So we have
6 identified those things. Again, we are working
7 through working groups as well as telecoms to see
8 how we can better move forward to improve that
9 process.
10 MASTER SERGEANT MACKENZIE: Are you finding along
11 the way that the -- one of the things I noticed
12 from what I do is that personal interaction.
13 Although effective at the personnel center and
14 looking at these things -- I wish I had one when I
15 went through the process. But, you need to start
16 sending this guys out as this hand-over begins to
17 happen.
18 DR. GADSON: Well, actually again the beauty of
19 our Recovery Care Program and what we have elected
20 to do as a service is that because the Recovery
21 Care Coordinators already have that tie to that
22 family that is going through this process, while

1 the AFW-2 Consultant may be working their packages
2 and their programs and helping and having
3 interaction by telephone, if at any point along
4 the way there is still communication going on
5 between the AFW-2 Consultant and the Recovery Care
6 Coordinator. So, what we have the AFW-2 folks do
7 is we don't pick them up and send them TUI to go
8 and meet with the individuals. They contact the
9 Recovery Care Coordinator and say "Hey, this
10 person is confused on the process and doesn't
11 quite understand where we are at. We need that
12 face to face piece. Someone needs to sit across
13 the table from them and then the Recovery Care
14 Coordinator can pull the resources at the
15 installation level, the PEBLO, the Airman and
16 Family Readiness Consultants, and bring them into
17 the piece where they sit across the table with
18 them and again walk them through the phases. So, I
19 think we have really captured a lot in making sure
20 that it is that dynamic, face to face contact.
21 And again because our numbers are small as a
22 service, we can provide individualized care a lot

1 more than our sister services can do. You have
2 follow-on?
3 MASTER SERGEANT MACKENZIE: I do understand that,
4 and trust me my AFW-2 has been instrumental not
5 only in myself but in other cases I am working.
6 But I will tell you I am going to go meet this guy
7 face to face before I put my full trust in him,
8 just because that's the way warriors interact is
9 face to face, and sometime I find that I think we
10 put a little too much credibility in that
11 interaction over telephone and email. That's why
12 I ask questions.
13 DR. GADSON: Sure. Next slide please.
14 Information resources -- as I mentioned we are
15 small staffed. We stood up a program; we have got
16 a lot of folks out there.
17 So, our philosophy is we don't need to partner
18 with the
19 Warrior Transition folks and all of the great
20 things that they are doing to launch programs. We
21 have got some things rolling with Dr. Guice on the
22 IT initiatives, those types of things. The Air

1 Force -- we feel that we need to fully participate
2 into those programs so that we truly have a purple
3 perspective on the things that can be purple in
4 developing some of the information resources
5 because we don't have dedicated staff to go out
6 and provide information on private organizations,
7 or someone to specifically work funding that's
8 available out there to families. So, we rely
9 heavily on the DoD-VAL and the Department of Labor
10 Resources, but obviously we try to pool those and
11 having that Recovery Care Coordinator. What we
12 like to do is not just provide those links to the
13 Airmen and their families, because a lot of these
14 links -- the National Resource Directory for
15 example -- there is 3000 hits in there that are
16 willing to help our wounded, ill, and injured and
17 so the member still has to go through the seARC to
18 find the specific requirement for them. So what
19 we do is we make them aware of those resources but
20 they identify again through the comprehensive care
21 plan what their requirements are and then our
22 RCC's will come back and utilize this information

1 to try to find the one's that fit best for those
2 family members so that we can provide them the
3 service needed that is not being performed by the
4 active duty component -- that we have our
5 communities, our non-profit organizations and
6 outside organizations that are able to provide
7 that support. Right now we are working on quite a
8 few initiatives. There is the education/employment
9 initiative that the Wounded Warrior Care
10 Transition Policy Program has kicked off so we are
11 big advocates of that program and standing in to
12 support and develop that. The IT initiative -- for
13 working our VA record transition piece from active
14 duty into the VA. We are actively engaged on that
15 front. We are also standing up at this point a
16 program called AFWIICMS -- Air Force Wounded, Ill,
17 and Injured Care Management System. Air Force to
18 date has had different systems that have tracked
19 our wounded, ill, and injured. They may have been
20 Access databases, Excel spreadsheets, things that
21 we all -- maybe some smart mind puts together and
22 it is only as good as that person sitting in the

1 chair. So we have contracted to develop a system
2 where -- we are due to go IOC at the end of MARC.
3 Keeping my fingers crossed that we are going to
4 get there. But, I think there were some questions
5 for the medical team on how we were going to roll
6 forward and make sure we don't fall through the
7 cracks. Right now we have been doing that by
8 establishing safety nets by having contact from
9 several different fronts to make sure that we are
10 capturing everybody that may not be identified in
11 a casualty report. You will see some slides here
12 and some of the challenges we have and that is one
13 thing. But this system will allow us to 1) ensure
14 that we are capturing right off the bat from our
15 MILPDS and our DSIPS and systems and that it flags
16 us that there is someone out there that we can
17 immediately make contact to determine if they need
18 assistance from a family liaison officer, or a
19 Recovery Care Coordinator. The gamut of what we
20 provide. Right now that is focusing on a non-
21 medical piece. There is access that the medical
22 team will have and the Medical Case Manager will

1 have to refer to us on that side if they find
2 someone that is doing that. Our long term vision
3 of this is we are going to what the Army is now
4 currently underway and assessing is bringing the
5 ALTA piece into the program too so that we have
6 that connectivity way to go before we get there.
7 That is kind of the brainstorm picture, but
8 working through this contractor trying to connect
9 all of our system problems so that anybody who is
10 providing service to that family member through
11 Access Rights could look into the system and sees
12 that they just talked to the Recovery Care
13 Coordinator an hour ago and their financial plan
14 has changed. I have been working this issue for
15 six months and now all of the sudden they want to
16 go a different direction. Because a lot of times
17 we see our recovering service members, you know "I
18 want to stay in service, I want to get out of
19 service, I want to stay in, I want to get out".
20 So, we tailor. We tailor. The Air Force has the
21 luxury of being able to change with them, to
22 rapidly evolve into what that family's

1 requirements are. Sometimes we want to pull our
2 hair out because we have changed so many times but
3 again the focus is on what is right for that
4 family at the time when they are making the
5 decisions. Next slide please. I don't know how I
6 am doing on time, I haven't really been paying
7 attention ma'am. I mentioned demographics -- so
8 here I am highlighting that combat wounded
9 population.
10 I do have a slide that is going to talk our ill
11 and
12 injured piece a little bit too. And again, as
13 Master Sergeant Mackenzie mentioned, we are
14 evolving this program. So our demographics and
15 our data collection are also evolving as we grow
16 this. So currently right now as of the 31st of
17 January, 975 Air Force combat wounded warriors
18 that we are tracking under the Air Force Personnel
19 Center Program -- 975 is tied to that life-long
20 commitment that our Chief of Staff has said that
21 we will have for any combat wounded individual. So
22 from this population you can see the break out of

1 regular active duty, the Guard and the Reserve,
2 but you can also see the predominance -- actually
3 I think it is on our next slide. I am sorry; it
4 will be on the next slide. So let me hit this
5 first before we move on. But the predominance of
6 this population is no longer active duty. They
7 have transitioned back into civilian communities,
8 but we are still providing that outreach and
9 support to them because that is where the majority
10 of our USAF help information comes in, the 1-800-
11 help line we have is that it is a veteran who has
12 transitioned back into the community and maybe
13 because there hasn't been that face to face AFW-2
14 Consultant piece, the Consultant calls up and says
15 "How are you doing?" "I am fine, I don't need
16 anything at this time, I am good. I will call you
17 if I need something". Click. Let me check off in
18 our little box that we made contact. Sounds
19 great, and the next thing we know maybe that
20 something tickles in the back of that AFW-2
21 Consultants mind that says you know I think I want
22 to engage the Recovery Care Coordinator in this

1 piece and maybe the VA Medical team and find out
2 what is really going on with this airman because
3 he just keeps telling me "Fine, fine, fine", and I
4 got a call from dad saying maybe he isn't so hot.
5 The Recovery Care Coordinator goes out to his home
6 and finds the foreclosure notice on the door. So
7 things aren't going well for this veteran so hence
8 our outreach into this program and the tie again
9 bringing that telephone piece into the face to
10 face piece that the Recovery Care Coordinator
11 provides. We have pulled many folks back into the
12 system and be able to go to Colonel Biersack and
13 say we have got someone who has maybe been on a
14 PDRL for four years and is on their fifth year and
15 didn't make their appointment.
16 How do we get them back in the system so they
17 don't fall
18 through the cracks? So they don't become
19 homeless, so they don't become financially
20 destitute. The reason why I bring those things up
21 is because the majority of this population as you
22 can see of the 975, 595 of them are psychological

1 injuries so this is our PTS category
2 predominantly. 576 of those are the ones most
3 likely to tell you that everything is fine,
4 because 1) they already have a distrust of the
5 service, they have reintegrated into a community
6 and often times feel like they have been kicked
7 out of the service, and so these support
8 structures are there to make sure we capture them
9 to ensure that the medical team -- that they are
10 still getting their meds, that they are still
11 doing the things that they can do to be successful
12 within the civilian population. We are tearing a
13 lot of our programs with employment and other
14 things and we will get into some of those hear too
15 and focusing on this group as they transition. TBI
16 -- 380 are physical injuries. Then, just to
17 highlight that case management piece, we mentioned
18 17 Case Managers and 4 Admin on this front and
19 that is in addition to the 32 Recovery Care
20 Coordinators that we have. But on average we are
21 identifying about 28 wounded warriors a month.
22 Some of that is because we are now developing the

1 systems to capture folks who fell through the
2 cracks. And I will give a good example of what I
3 mean on that perspective. With our PTS, they may
4 have deployed and their PTS may be result of a
5 combat situation that they were engaged in but
6 they stayed in theater, never identified anything,
7 and didn't have any issues. Come back, redeploy
8 home and six months later they can't sleep at
9 night, their wife calls and is concerned to the
10 first sergeant and a need is addressed. Sometimes
11 they self-refer to the medical community for help
12 in getting through what may be PTS issues. Our
13 medical folks are fabulous on this front, and I
14 think the numbers now are about 80 percent are
15 actually returned to duty PTS. They go and they
16 get the behavioral health that they need, they
17 move forward, and they reintegrate into their
18 units. The unit commander is never even aware
19 that they are receiving behavioral health help.
20 So, it is those ones that are identified for the
21 MEB process that cannot get over the hump in their
22 care plans with the medical community that then

1 are identified that we may not be capturing until
2 that point because there is no casualty report
3 done on them, they haven't come out of theater on
4 an Air evac Mission, and they are seeking help but
5 now they have had months of help and not made any
6 progress. So, we are really focused on this piece
7 of it as we look at what our population of our
8 combat wounded warrior folks is, and being able to
9 identify earlier on if possible if some of that is
10 tied to HPPA. Some of that is tied to what we can
11 do to make sure they are seeking help. We don't
12 want to create an obstacle to where they don't.
13 Yes sir?
14 GENERAL STONE: What models are you using in order
15 to reach out to that population for late arising
16 Post Traumatic Stress Disorder? What is your view
17 of those models and how effective are they? Can
18 you show a timeline that you are contact at 180
19 days or 365 days as the appropriate time?
20 DR. GADSON: Well sir, great question. While that
21 doesn't fall necessarily under my realm, I can
22 talk to two things. And I have an expert here

1 actually and he is doing quite a bit with what we
2 are doing. A1 has just directed the A1-S within
3 about the last 8 months, stand up and Air Force
4 Resiliency Program, and tied to that Resiliency
5 Program it is not just preventing and making
6 airmen resilient although that is one component of
7 it. It is developing a program and a process where
8 we can grow resilient airmen who are comfortable
9 seeking not only the physical healthcare but the
10 mental healthcare that is required to be an active
11 duty member. And tied to that --
12 GENERAL STONE: I am sorry. That is not my
13 question. My question is what tools are you using
14 in order to reach out to the population that is
15 deployed? You mentioned that there is six months
16 later the onset of the complaint of Post Traumatic
17 Stress Disorder.
18 DR. GADSON: Yes, sir.
19 GENERAL STONE: Is that coming from some sort of
20 survey you are doing? Is that coming from Primary
21 Care?
22 DR. GADSON: Yes, sir.

1 GENERAL STONE: Do you have data on that
2 population when that arises in the post deployment
3 process?
4 DR. GADSON: Yes, sir. Under the building of this
5 Air Force Resiliency Program, one of the subsets
6 of that is the Deployment Transition Centers. So,
7 what is being done now is Lieutenant Colonel
8 Dickey's watch and many of the team from the SG
9 community, is when folks are redeploying out of
10 theater -- and right now we are focusing on
11 certain career fields -- and I say "we're", this
12 doesn't fall under my gamut. It really falls
13 under what the SG community is doing with this
14 program tied to the Air Force Resiliency team
15 under the A1 hat. But what they are doing is they
16 are focusing on their population sets, and you
17 will see some demographics here in just a moment
18 that show that our Security Forces members, for
19 example, have significant rates of PTS. So, what
20 they are doing is they are capturing those career
21 fields in this Deployment Transition Center and
22 capturing as they come out of theater and tracking

1 them at increments to ensure that while they may
2 be made aware of information, or they may self-
3 identify that they have an issue, that we have
4 them into a database and then we can have their
5 local medical treatment facilities follow-up with
6 data to ensure --
7 GENERAL STONE: Is that coming --
8 DR. GADSON: Yes sir, under the building of Lt.
9 Colonel Dickey's watch.
10 GENERAL STONE: Ok -- my so --
11 GENERAL GREEN: Let me try and help.
12 MS. DAILEY: We do have a briefing on TBI and
13 PTSD. We have a complete briefing on it.
14 GENERAL GREEN: Right. And so, let me see if I
15 can clarify myself. I think that the majority are
16 coming from the PDHRA, okay, which is the real
17 question you are asking. The other issue that I
18 have is you are showing 576 in AFW-2, but as I
19 look forward to the next briefing we have much
20 higher numbers of PTSD diagnoses. So, are the 576
21 only people who have been discharged with that
22 diagnosis?

1 DR. GADSON: Sir, this number is those that are
2 tied to combat wounded specifically, that have
3 been enrolled in the AFW-2 program that are facing
4 MEB-PEB.
5 GENERAL GREEN: So, it is 576 that have other
6 uncommented injuries?
7 DR. GADSON: Their primary diagnosis is PTS. They
8 may have other injuries, but again these folks are
9 ones that are identified and our meeting at MEB.
10 I think many of the numbers that are being tracked
11 on the SG side are diagnosis, so they may not be
12 facing MEB at that time so the delta comes from
13 that.
14 GENERAL GREEN: So 576 then are from people who
15 are meeting in MEB, is your criteria.
16 DR. GADSON: Or have been discharged, yes sir.
17 GENERAL GREEN: Or have been discharged. Okay.
18 MASTER SERGEANT MACKENZIE: Ma'am, the 28
19 identified a month, is this all new cases or what
20 is your effectiveness in capturing the old cases?
21 And have you reached that higher percent that --
22 we have now implemented this program and we have

1 captured all of our previously identified wounded
2 warriors?
3 DR. GADSON: It is a little bit of both. Some are
4 new cases as we see PTS manifest itself, but a lot
5 of this is a result of the Recovery Care
6 Coordinators. One of the tasking we gave them was
7 to go out into the communities, go talk to the
8 Guard and the Reserve Units. So some of this are
9 folks that are out there being serviced in our
10 Guard and Reserve that we are now capturing and
11 pulling back in and saying "Okay, you have some
12 things that are definitely combat related that we
13 need to get you back into the system for to help
14 you to get through your combat related injury. So
15 some of it is catching that safety net now that we
16 have those RCC's out there. Some of it is just
17 the new case loads that we have been getting, and
18 I can't say with 100 percent firmness that this
19 catches everybody up.
20 We feel strongly that the AFWIICM's data
21 management and
22 tracking system that we have is going to help us

1 capture those onesie, twosies that we have missed,
2 but we have definitely taken leaps and bounds and
3 strides forward to making sure that we are
4 capturing those folks. And again, from a total
5 force perspective, not just the active duty. What
6 we have also done in conjunction with many of the
7 programs that are going on on the PTS side of the
8 arena, is making sure that when a member is
9 identified, there is an awareness there that if it
10 combat related working with the medical team that
11 our office is made aware so that we can capture
12 them on that front too when they are coming to
13 that MEB phase and then trying to identify it at
14 an earlier time if at all possible. But again,
15 sometimes that is related to the medical are
16 piece, the HPPA, and the Privacy Act information.
17 Next slide please. So this gives you the total
18 population that I started to talk -- the total
19 population, the 975 -- the majority of them is
20 already retired and separated, 730. But again,
21 the consultant reaches out and manages their cases
22 for the length of their -- as long as they need

1 us. Now, that case management obviously becomes
2 less and less. It is driven by the member, but we
3 do highlight and focus those cases, again, the
4 majority -- PTS and PTI to where we are making
5 that constant contact to ensure that things are
6 going well. If we are not able to get in contact
7 with an individual, we deploy the Recovery Care
8 Coordinator to make sure there is someone knocking
9 on the door and physically checking up on the
10 individuals. Of that population set, 202 right
11 now are in the MEB-PEB process. We do have a
12 return to duty rate right now of 4 percent. These
13 are folks that are found fit for duty and return
14 to duty. We also have a population set now through
15 our Limited Assignment Status Program where if a
16 member is found unfit for duty, they can come in
17 through the A1 and request to be returned to duty.
18 Right now to date, we have had seven people who
19 have elected to do that and we have found them
20 work within the Air Force still wearing the
21 uniform. Tech Sergeant Israel Del Toro is
22 probably someone several folks are familiar with

1 -- eighty percent of his body burned, significant
2 trauma during a combat incident -- but he took
3 several years to recover and rehabilitate to live
4 through. He came on board and was found unfit for
5 duty, applied for the Limited Assignment Status.
6 We were able to work through his functional chain
7 to where now he is an instructor at the Tach P
8 school, and who better to teach other Tach P's on
9 what the real life and danger piece of going out
10 and doing that mission is and that you can survive
11 and there is an Air Force structure that is going
12 to support you and your family as you go through
13 that tragedy and that recovery, rehabilitation,
14 and reintegration phase. So, he is one of seven
15 that we have had come back and utilize the Limited
16 Assignment Status, and that was put into policy
17 for the Air Force in '09. Next slide please. This
18 just gives you a picture of gender count.
19 Obviously predominance of what we are seeing is
20 male.
21 MASTER SERGEANT MACKENZIE: Can I ask a quick
22 question too? On that Limited Assignment Status,

1 how does that relate or are you prepared to talk
2 about the Wounded Warrior Air Force Specialty
3 code? Is that in your briefing or --
4 DR. GADSON: I didn't have that in here, but I can
5 talk that really quickly. Anybody that is
6 identified in the AFW-2 program as giving a
7 personal identifier code of 9W, which then allows
8 us to track those members within the personnel
9 system for policies that were implemented in '09,
10 that were driven by the length of care and the
11 amount of time folks were in the rehabilitation
12 phase. So what we saw happening for our
13 specifically more the combat wounded because the
14 life-cycle of an ill and injured member is much
15 shorter than what we see for our combat wounded,
16 is we develop policy 1) for the Limited Assignment
17 Status, develop policy for promotion and for
18 evaluation reporting so that those folks weren't
19 penalized while they were in a recovery mode and
20 held back against their peer group. Because many
21 in the communities where the injuries are
22 occurring want to continue on active duty service.

1 They are not typically ones that want to
2 reintegrate back into the community or back into
3 civilian life. So through these programs we have
4 been able to help them to stay on par with their
5 peer groups based on past performance and the
6 performance that they have been doing through the
7 recovery and rehabilitation phases. Many of the
8 folks that are long-term patients become speakers
9 on behalf of our program and tour with me to wing
10 and group commanders' courses, tell their stories,
11 give a perspective of what they can do as
12 individuals within that chain of command and
13 supporting them and how we have evolved as an Air
14 Force program. I can tell you Israel Del Toro,
15 when he came online much like Sergeant Mackenzie,
16 Master Sergeant Mackenzie; there weren't a lot of
17 these things in place when they started. So we
18 have taken their lessons learned, and we have
19 built programs to make sure that we don't let the
20 things that happened to them happen again. So we
21 have captured quite a bit of that. Does that
22 answer your question? Next slide please. So sir

1 as was mentioned with the DTC's focus, and I
2 should have just kind of said "That is not my
3 expertise; I am going to pass it on". But we have
4 been able to look at those numbers from the AFW-2
5 populations and determine where the predominance
6 of those injuries occurring within our combat
7 wounded folks is. So through the Air Force
8 Resilience Program and what is being done with the
9 DTC's, they can target those areas as a test
10 population base for potential expansion to the Air
11 Force across the board. Next slide please. So
12 accumulative totals -- this just gives you a
13 picture of how we have grown from the Palace Heart
14 Program standing up in '05 to what we are now
15 servicing in the AFW-2 program. Our Guard and
16 Reserve populations are growing in there, not
17 necessarily because more injuries are happening
18 but because we are capturing those that may have
19 had injuries that occurred in prior years that
20 weren't getting the services that they required,
21 that now we are able to make sure we are reaching
22 out and catching them up to speed with everyone

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1 else. Next slide please. So obviously there are
2 challenges coming in here. One, we have already
3 identified, the PTS piece. Often times they are
4 not redeploying out of theater in an air evac
5 status. Those issues are popping up after they
6 are back home stationed. So working with the SG
7 community and through the assessments that are
8 done on timely bases, they are able to capture the
9 population set that is in danger and enable them
10 now to refer individuals back to the A1 community
11 to help them with things that may be tied to
12 preventing disciplinary actions within a squad or
13 those types of things that we see across the
14 services as being issues. We have been able to
15 capture them early on to make sure we are working
16 with those unit commanders to be aware of some of
17 the things that you need to be looking at in an
18 individual who may be a top performer and then all
19 of the sudden falls by the wayside and maybe
20 seeking help that the commander is not aware of
21 that leads to disciplinary actions in performance
22 because they are having outburst, or not showing

1 up for work, and those types of things. So I feel
2 -- we still have a ways to go. We are still
3 working through working groups, and working with
4 DoD on how we better define and how we can reach
5 that community from a total service perspective
6 across the DoD, but within the Air Force we are
7 taking leaps and strides within the medical team
8 to get that identification early on and meet those
9 needs of that recovering service member as they go
10 through the behavior health side of the house and
11 recovering. We have got a ways to go, but we have
12 captured quite a few. We do run into challenges.
13 The Guard and Reserve side -- just because of the
14 way we do business -- is different. A lot of times
15 with our Guard and Reserve, what we are seeing
16 especially on the PTS and TBI side is again
17 because they are not air evac-ing out of theater,
18 they come back, they go off of orders because now
19 they are back into their civilian jobs and they
20 start to manifest the symptoms of PTS in those
21 environments and they may not have that unit
22 connection for several months at a time or may

1 just on their drill weekends, so the unit may not
2 see it as much. So, we are really making efforts
3 with the Guard programs and again the Wounded
4 Warrior Care and Transition policy overARCing is
5 helping with all services across the board on
6 meeting that Guard and Reserve population and how
7 we can better identify. We are tying into their
8 programs. It will be reiterations of our AFWIICM's
9 program -- the Air Force Wounded Ill and Injured
10 Care Management System -- to be able to pull those
11 folks in. And with the medical community and the
12 ARC forces we are really working to bring those
13 members back on order to get the medical needs
14 that they have taken care of once we have
15 identified that they slipped through the crack.
16 GENERAL GREEN: We are struggling a little bit
17 with your numbers. When you say 60 percent PTSD,
18 you are talking about the 575 as a subset of your
19 A1 --
20 DR. GADSON: Of the 975, yes sir.
21 GENERAL GREEN: Okay, and since you are only
22 identifying people who have a PTSD diagnosis at

1 the MEB --
2 DR. GADSON: That's not all.
3 GENERAL GREEN: That's not all?
4 DR. GADSON: No, sir.
5 GENERAL GREEN: In terms of your ill and injured,
6 there is no other tracking system for ill and
7 injured, correct?
8 It is just the AFW --
9 DR. GADSON: No. I do have some numbers for ill
10 and injured but I don't have them broken down in
11 this same category sir. With the Recovery Care
12 Program that we have just launched, we are now
13 developing all of our metrics and out business
14 practices on how we do that. So, we are working to
15 get to these same numbers that we can I.D., but
16 the majority that we are working with now on the
17 RCC front of the PTS group is already members that
18 are identified for MEB. So, again it is that
19 identification challenge of when we get them to
20 the RCC's. Most of what our RCC's are dealing
21 with is the types of things that are Cancer --
22 we've got things such as back injuries from

1 theater -- some of them combat, some of them just
2 -- we have a gentleman that fell off of a loader.
3 So the majority of the cases on the ill and
4 injured side are not tied to PTS. It doesn't mean
5 they are not out there. We are trying to work
6 that identification piece prior to the MEB phase,
7 but there are a lot of things we have to work
8 through on that front.
9 MR. REHBEIN: Colonel, one more question on the
10 PTSD. If I understand it right this 60 percent is
11 where PTSD is the primary?
12 DR. GADSON: Yes, sir of the 975 --
13 MR. REHBEIN: The other 40 percent may manifest
14 some symptoms of PTSD, but it is just not their
15 primary?
16 DR. GADSON: Yes sir. You are correct.
17 GENERAL GREEN: We are up here talking about --
18 that really is misleading to say that Air Force
19 reality is 60 percent PTSD, and 60 percent of your
20 AFW-2 program, right?
21 DR. GADSON: Yes sir.
22 GENERAL GREEN: Okay.

1 DR. GADSON: Of the 975. I will make sure that I
2 update the size that we present on anything else.
3 GENERAL STONE: As you identify the population in
4 the Guard and Reserve, can you talk about the
5 orders and how they are generated to bring airmen
6 back into the system to allow them to access care?
7 DR. GADSON: Sir, that question really is not my
8 purview level of expertise. Where we have engaged
9 is where we have had to become advocates for the
10 Guard or Reserve member to get them on orders, but
11 that process falls outside of the realm of the A1
12 community. I know that Colonel Biersack and
13 Colonel --
14 GENERAL STONE: So, whose realm would it be? I
15 mean, you talk about not compatible with current
16 realities -- I guess I am not understanding what
17 you are saying then.
18 DR. GADSON: From my perspective as an advocate of
19 the patients, our systems that we utilize for
20 placing members on orders for the active duty
21 side, CED, is pretty uncomplicated on what we are
22 doing. But for our Guard and Reserve because

1 their orders are generated through the ARC side of
2 the house and they are continuing medical orders,
3 they are done through a different process and a
4 different headquarters approval level. Sometimes
5 that approval is lengthy in time for us to be able
6 to meet those further needs, and I think Colonel
7 Biersack can probably speak more --
8 GENERAL GREEN: Yes. The answer to your question
9 is that if they weren't identified as a wounded
10 warrior when they came back but then after coming
11 back identified something that was related to
12 deployment, they are followed in a medical
13 continuation cell -- that's down at [Inaudible
14 0:37:42.1], correct?
15 COLONEL BIERSACK: Yes, sir.
16 GENERAL GREEN: And so all of their continuation
17 and tell us whether it is line of duty and what
18 the injuries are. That is all tracked and followed
19 down in one of our medical headquarters. Cathy,
20 do you know the numbers right now they are
21 tracking?
22 COLONEL BIERSACK: We just talked about that it is

1 too bad. I don't have that --
2 GENERAL STONE: Okay, let me tell you the source
3 of my question. The Army has a major problem with
4 identification of PTSD late in the process. Tamp
5 benefits expire at 180 days. Our contact at the
6 PDHRA can occur late in that process and there is
7 not time to bring soldiers back on orders, and so
8 therefore it can take as much as six to nine
9 months to bring a soldier back on orders to allow
10 the access to care and benefits. My question
11 relates -- and you can answer it later or in
12 writing -- my question relates to does the Air
13 Force have a similar problem to the Army in
14 managing this population?
15 COLONEL BIERSACK: I don't believe so, sir, but I
16 will answer that -- I will get that in writing. I
17 will work with our Guard and our Reserve
18 counterparts. Typically, what happens is I get a
19 phone call and Dave, if there is something else
20 that you have to add to this -- if I get a call, I
21 work with our Guard and Reserve liaisons and then
22 get a call down to our MEDCOM cell at FMO in San

1 Antonio, I have not heard of the problems that you
2 are mentioning but I will ask that question and
3 get back with you.
4 GENERAL STONE: Thank you.
5 DR. GADSON: Next slide please. Measuring success
6 -- to me there is two phases of this, what metrics
7 can drive -- there is measuring success, there is
8 measuring effectiveness. What we have done in
9 standing up our programs recently is mostly a very
10 subjective approach to how we are doing. It is
11 that face to face contact; it is the communication
12 with your recovering service members, and that
13 information coming back from the family members
14 telling us that we are meeting their needs. We
15 have identified -- we stood up the programs
16 quickly and we did that without really laying
17 business practices in place and without truly
18 identifying what metrics we were going to use. So
19 at this point, we are really looking at measuring
20 successes while you have seen those numbers rise.
21 And for most you would think that is not a
22 successful measure; in our mind it is because what

1 those numbers tell us -- the rise of the combat
2 wounded that we have now captured and identified
3 in 28 more a month on average now -- is that we
4 are putting systems in place instead of capturing
5 those folks who weren't identified when they
6 should have been. So, we are getting to the point
7 to where we are stabilizing our numbers in care
8 and now we are assessing on what those specific
9 metrics we are going to use from the data we are
10 now being able to collect, and what we will be
11 able to pull under our AFWIICM's IT Solution set
12 to be able to truly nail down what our stats are
13 telling us. Still utilizing the panel forums and
14 open feedback session from our customers to
15 determine what drives our programs. So, when we do
16 this we do feel that we have captured folks. We
17 are providing MAT care beyond duty perspective.
18 We are doing that long term outreach for our
19 wounded,
20 ill, and injured both those returned to active
21 duty and those going into the local community, and
22 we continue with that ongoing assessment. At this

1 point though that again is really based on calling
2 up the members and saying, "How are we doing?"
3 "Are we meeting your need?" It is not based off of
4 numbers driven other than the few things that we
5 have started tracking. For example, one of the
6 things we consider a success while it may be a
7 small number of 4 percent that return to active
8 duty, with the additional 7 members coming back
9 through the LAS program -- that number is growing.
10 So, we look at that as being a successful metric
11 on where we have come in establishing these
12 programs and where we are growing to bringing
13 people that wish to stay on active duty. In
14 measuring the successes, when we start looking at
15 the metric realm, there is some challenges in and
16 of itself because again as a service we drive
17 individualized care. So while our numbers may be
18 only 4 percent, it is 4 percent of -- that may be
19 100 percent of everybody who wished to come back
20 on active duty. I am not saying that is the stat
21 here, but just as an example. So while we may
22 measure those numbers growing, a low number does

1 not necessarily mean that we are not meeting a
2 target. It may mean that we are meeting the
3 population that wants to come back to active duty
4 status. So we are looking at those metrics and we
5 are trying to drive it not just by showing huge
6 numbers, because when you have lots of numbers you
7 can make the numbers fit and drive metrics that
8 can make sense before our small population does --
9 so that we have to be smart in the metrics that we
10 line up so that we are truly capturing not just
11 what the numbers may represent, but what those
12 numbers mean in the population set of our Air
13 Force folks whether the combat wounded side or the
14 ill and injured side. We put the quote down here
15 on the Recovery Care Coordinator comments. We
16 have honestly had individuals come up to us after
17 briefings, presentations, those kind of things
18 that have said "If it was not for my RCC or my
19 AFW-2 Consultant, I had a gun in my hand and I was
20 going to commit suicide, but they stepped in and
21 them my need".
22 And a lot of this is from our folks who have

1 already
2 transitioned into the civilian community. That is
3 a measure of success but it is not something that
4 we really drive or capture with numbers. So, we
5 feel in just those saves that we have had, that
6 saving one is a success in our front and obviously
7 we want to save all. We want to integrate all
8 back into communities with successful lives,
9 continued family success, as well as being able to
10 move on from their injuries and illnesses whether
11 it is combat related or not. So, with measuring
12 success when we take a look at measuring
13 effectiveness, some of the stats that we have done
14 -- to the next slide please -- again are based off
15 of the numbers that we are now able to collect at
16 this time. So we just did a comparison from '09
17 to 2010 and in our combat wounded area, we have
18 increased that population by 35 percent. Again,
19 we can look at that metric and say "Oh my gosh,
20 you have increased by 35 percent. What is going
21 on in the Air Force?" But what we like to look at
22 that is that we have put these programs in place,

1 again, we have captured those folks who have
2 fallen through the cracks before. So, we are
3 going to see a steady increase in percentages, we
4 think, until about the '13/'14 time frame while
5 our RCC's are able to go out there and meet with
6 our total force communities and identify those
7 folks that have long since separated that still
8 maybe have a need or may need to have their
9 medical pieces reassessed. So from that
10 perspective we anticipate that we will stabilize
11 and we think that our data system will help us to
12 stabilize those numbers too and so that metric
13 will change. Then we may not be so successful
14 that we are seeing it increase, we may want to see
15 it stay at a steady state. So, outreach and
16 referral efforts have improved that increased
17 piece. This is specific to the numbers in the
18 Guard and the Reserve. So, while we have had an
19 overall 35 percent, you can see big jumps on the
20 Guard and the Reserve side. Again, the PTS cases
21 have increased because we are working through that
22 earlier identification with those folks. Because

1 when they meet that MEB or when they are
2 identified and meet the MEB, a casualty report is
3 not driven, and that is what we are utilizing
4 right now to be our initial contact piece to let
5 us know there is someone out there. So through
6 the education piece and the partnership with the
7 medical community, we are now getting that
8 notification or that referral from the medical
9 case managers, so we are identifying them a lot
10 earlier on. Our retention rate has increased by 8
11 percent from our 2009 numbers. Of those -- I
12 don't need to read the slide to you. You can see
13 on the MEB and PEB process in 2010, 57 percent
14 were returned to active duty or limited active
15 duty status verses in 2009 our numbers were not as
16 high. 975 warriors -- and now of the Recovery Care
17 Program itself, we have started a tracking system
18 that is separate and distinct from the AFW-2
19 tracking but there is overlap in this. Because as
20 I mentioned, the combat wounded in the processes
21 that we have placed now for the Recovery Care
22 Coordinators, is lying directly to them coming on

1 board with the Recovery Care Coordinator at the
2 time of injury -- the MEB phase for the AFW-2
3 program. So there are some duplication in numbers
4 in what you are seeing here, but 805 is what we
5 are tracking right now in the Recovery Care
6 Program and that is a very dynamic number because
7 that includes the ill and injured side. It
8 includes some of the NSI that may need assistance
9 or some help with case management. The majority
10 of those that they are servicing fall into that
11 ill and injured case side of it. We anticipate
12 that we are going to see those numbers continue to
13 be constant on the ill and injured while
14 eventually when we pull out of theaters, we will
15 see our combat numbers reduced.
16 DR. PHILLIPS: A question?
17 DR. GADSON: Go ahead.
18 DR. PHILLIPS: I am sorry. You probably haven't
19 done this yet, but noticing the improvement in
20 returning to duty, 57 percent, are there any
21 predictive in the process -- early in the process
22 -- that might be able to help you track those

1 people even faster or be able to increase that
2 percentage because you know ahead of time what
3 characteristics exist to allow that to happen?
4 DR. GADSON: Yes sir, and again this is where at
5 first perspective is you know "Let's not reinvent
6 the wheel; let's use the brain trust that is
7 already out there in our DoD community". So,
8 right now one of the things that we are working
9 through on the VA transition piece and Dr. Guice I
10 think is very heavily involved with this -- is
11 identifying those that have an ability for voc
12 rehab or those types of things through VA programs
13 and bringing them on prior to separation so that
14 we can tailor and do components. And you will see
15 some things in our employment area too that helps
16 capture that front to retain that number. So of
17 that 805 that the RCC program is tracking, 574,
18 this is the only numbers you will see at this time
19 on our ill and injured side that are not combat
20 related. Yes, ma'am?
21 DR. GUICE: I actually would not have put
22 "Measures of Effectiveness" on top of this slide.

1 I would have put something more like "Better
2 Defining our Population" because I think that is
3 what you have done here. You are getting to a
4 better fidelity about who gets your services. You
5 haven't told me if your services are effective.
6 That is a different question. The other thing
7 that I am a little worried about with the
8 retention rate, you know, we do know that people
9 are referred to the MEB that probably didn't need
10 to go to the MEB so I don't know how you parse out
11 that population that probably would have been a
12 return to duty anyway, versus a return to duty
13 because of something you did.
14 DR. GADSON: Yes ma'am, I see what you are saying,
15 but that percentage is based only on those numbers
16 of the 975. So I agree with you ma'am.
17 GENERAL GREEN: One of the things I think we are
18 struggling with having seen two services programs
19 is "Who is in, and who is out?" So it is unclear
20 to me how you decide somebody is going into the
21 AFW-2 program versus who is in the ill and
22 injured. And then I look at your numbers and your

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1 percentages and it makes everything somewhat
2 suspect. And we will get the briefing on the PTI
3 and the PTS and the TBI, but I guess I am kind of
4 wondering so -- I mean I know that roughly we have
5 been watching about 1200 people down in the
6 continuation for the reservists, okay? And I
7 don't know if some of those 1200 actually shift
8 into your AFW-2 program as decisions are made in
9 terms of their injuries, etc. or if it is PTS, or
10 if it waits until the MEB. It is one of those
11 things where it is very hard to know the
12 effectiveness if you don't have any idea of the
13 denominators --which is driving me a little nuts.
14 DR. GADSON: Yes, sir.
15 GENERAL GREEN: -- which is driving me a little
16 nuts. Not just with the Air Force program --
17 DR. GADSON: Yes, sir.
18 GENERAL GREEN: -- but also with the Army program
19 yesterday. The denominators are very difficult to
20 discern.
21 DR. GADSON: I think that in answering the
22 question on the denominator side. For Air Force

1 Warrior and Survivor Care we are counting members
2 in our numbers that range anywhere from NSI to
3 combat wounded in the gamut of that perspective.
4 So when we talk the 805 that are here, this is
5 still on active duty that fell into any one of
6 those ranges. So from an Air Force perspective,
7 because our numbers are small, we utilize the
8 Recovery Care Program to provide that service to
9 every Air Force member on a case by case basis.
10 Our target -- the mandate is seriously and very
11 seriously ill and injured on that side, but if a
12 member who is not seriously injured comes to us
13 and needs help with case management, we don't turn
14 them away. We have that Recovery Care Coordinator
15 help and assist in that front. And an example of
16 that would be maybe somebody who is going to be
17 discharged for sleep apnea. It is not going to
18 show as an SI or a VSI, but may need some case
19 management in helping get them through an MEB
20 process.
21 GENERAL GREEN: Which is back to the PTS that you
22 quoted earlier, the 575; were those SI or VSI to

1 get into your program?
2 DR. GADSON: Those sir, if they are giving a
3 diagnosis of PTS or TBI they are automatically in
4 the program no matter what it falls in that gamut
5 of NSI, VSI, or SI.
6 GENERAL GREEN: But you understand why we are
7 having trouble --
8 DR. GADSON: Yes, sir. I do.
9 GENERAL GREEN: -- it would be nice to have kind
10 of clear guidance on what is in and what is not
11 in.
12 DR. GADSON: Yes, sir.
13 GENERAL GREEN: Thanks.
14 DR. GADSON: From the perspective of -- so the
15 denominator piece I think -- we try to capture
16 all. Anybody who falls into the category of ill
17 and injured or combat wounded, we try to capture
18 all. From a measurement of effectiveness piece,
19 and what we do with those numbers as a service, we
20 rely again mostly on subjective data flow and how
21 we are doing. So what we are garnering with the
22 IT Solution that we are developing on the AFWIICM

1 side is trying to figure out how we can get to
2 some numbers that help us to determine what we are
3 doing. But again, keeping it in the perspective
4 of what is the number, what is the metric
5 measuring? It is like I mentioned? Our return to
6 duty -- that may -- 4 percent may be a high number
7 because only 6 percent of the population wanted to
8 return to duty. So we have got to use those
9 measurements in a smart way to truly utilize them
10 to benefit and improve the program. We have got a
11 long way to go on that front, sir. We have stood
12 up the programs, we started servicing members, and
13 we say we'll worry about metrics later. The Senior
14 Oversight Committee, as you are aware, at one
15 point had been driving a standard metric system on
16 how we were doing and it has a little bit gone by
17 the wayside. But we have built upon that, on the
18 Air Force perspective on "how can we get there to
19 make our numbers be meaningful?" And the same kind
20 of metrics that you can pull from Army's
21 information, now that we have the Recovery Care
22 Program support service system that the WWTCB

1 folks have put together, their data is going to
2 look very different from us pulling the same
3 numbers that may make their program look
4 successful and ours not look successful, but it is
5 just because of the number population set -- which
6 goes again to the denominator.
7 GENERAL GREEN: Well each of the services, AFW,
8 the Army AW2 program had a certain number of
9 people that they were going to track for a period
10 of time, whether it is five years or for life is
11 still unclear, but so each service seems to have a
12 W2 which is your serious and VSI and then others
13 that seem to be added periodically. Then there is
14 a second category which is those in the ill and
15 injured, which happen to be -- you know get
16 captured now in a new program called the Wounded,
17 Ill, and Injured. But then there is a third
18 category that basically is being handled out in
19 the medical groups, etc. for normal routine,
20 MEB's, etc. that is not making it into either of
21 the programs and so you kind of look and go
22 "Alright, so if we are really about ill and

1 injured, are we defining the ill and injured as
2 deployment related or pre-deployment related? I
3 don't think so, because you are getting Cancers
4 and seizures and disorders, etc. into this.
5 DR. GADSON: Right.
6 GENERAL GREEN: So, it is very unclear who is in
7 and who is out? And this is now two services --
8 DR. GADSON: Yes, sir.
9 GENERAL GREEN: -- that we have had the same
10 problems understanding. But there seem to be
11 three clear categories: that W2 category which
12 seems to be more seriously injured or VSI and then
13 another group that is the ill and injured that
14 have kind of been linked into the Case
15 Coordinators and then another group that is not
16 linked in to the same perhaps lesser injuries, I
17 don't know -- but still may be facing MEB. So it
18 is not clear to me how we are differentiating the
19 three groups.
20 DR. GADSON: For the Air Force I can say that our
21 demographic in the denominator piece for the Air
22 Force Warrior and Survivor Care Program is all.

1 Anybody who is receiving medical treatment that is
2 not routine. If I go in for a cold, we are not
3 tracking that individual. But if someone breaks a
4 leg, breaks an arm, is in an NSI status, SI, VSI,
5 or combat wounded, they fall under our purview of
6 care of Air Force Warrior and Survivor Care and
7 will be tracked under our new AFWIICM's program
8 and that is where we have gone above what the DoDI
9 has layed out in the Recovery Care Program on
10 going beyond the category one's and two's. We are
11 pulling in our category three's under that area,
12 again, because our numbers are small. We can
13 support on that front. Where we break out that
14 denominator is in the AFW-2 program specifically.
15 So in the AFW-2 program, that population set or
16 just those that are identified as combat wounded.
17 DR. GUICE: I think one of the -- this is a very
18 troublesome area for all of us -- defining
19 populations and having the data sets that then
20 support an operational focused implementation of
21 that definition. When we were doing the Recovery
22 Care Coordination Program knowing that we had all

1 sorts of different types of resources, we divided
2 things into sort of three administrative types of
3 groups. So the category one's are those -- and I
4 am a bit surprised that you are including people
5 with just simple fractures in this -- because I am
6 not sure that they actually need all of this
7 additional support. So the category one's are
8 those simple things that are going to heal, people
9 that are going to recover, you know a normal post
10 partum delivery, a simple fracture, six weeks out
11 of the cast, do a little rehab and you are back to
12 work. So those would just need the support of
13 their medical teams, the local providers, and they
14 would be fine. They would go back to work. They
15 have their support system. The category three's
16 which were those individuals who you could kind of
17 eyeball and go "Hmmm, probably not going to go
18 back to duty", most likely going to have a
19 trajectory out of the service. Those are those
20 individuals with a spinal cord fracture at C3, you
21 know, very catastrophically injured people --
22 severely injured people -- with injuries and

1 illnesses as well.
2 DR. GADSON: Yes, ma'am.
3 DR. GUICE: So people with metastatic cancer;
4 people with strokes. And then the category two's
5 which are much harder to define -- as sort of
6 anybody in the middle. So to define that you said
7 we would need at least six months of sort of --
8 you are not going to be able to go back to your
9 job for six months. A higher likelihood of going
10 back to duty, smaller likelihood of being put into
11 an MEB process.
12 DR. GADSON: Yes, ma'am.
13 DR. GUICE: So --
14 DR. GADSON: Our mandate -- I am sorry, I am
15 rudely using terminology on just the ill, the
16 seriously ill, and the very seriously ill. I
17 equate those predominately to our category two's
18 and category three's. So our mandate is the DoD
19 guidance that service will be provided and we will
20 reach out and pull in and track the categories
21 two's and three's. The category one's -- we will
22 provide service on a referral basis. If they come

1 to us needing assistance or if they are referred
2 by their medical team, we won't deny them service.
3 DR. GUICE: My next point was going to be that
4 there is no such check box on anybody's record of
5 Cat 1, Cat 2, Cat 3.
6 DR. GADSON: But there is -- on the casualty
7 reporting side -- there is the SI, VSI, and that's
8 --
9 DR. GUICE: And that generally means that somebody
10 made the qualification to be air evacuated.
11 Whether or not they are actually meet the Cat 2
12 and Cat 3 definitions I think is a bit suspect and
13 probably maybe an assumption that needs to be
14 validated.
15 DR. GADSON: You are right, ma'am. They don't
16 equate exactly. One does not equal the other, but
17 in our casualty reporting realm those that are
18 identified as SI or VSI are indicators to us that
19 they have got significant injuries that are going
20 to allow them to either have the EFMT orders that
21 are driven as well as the support through the
22 family liaison officer and Recovery Care Program.

1 So we use that as -- because we are utilizing the
2 casualty reports as the initial driving factor for
3 kicking off these programs.
4 MASTER SERGEANT MACKENZIE: But ma'am, what she is
5 getting at although I do agree, because those
6 casualty reports are suspect just from the sheer
7 data entry portion of it and we have talked and we
8 have integrated on some of these cases -- both
9 myself, Mr. Beckett, and several other members of
10 the team are going "Hey, we have got to change
11 this and change it now". So to use that as a
12 governing force when it has a potential to have
13 such gigantic holes through it, I agree with what
14 you say is that that category needs to be -- both
15 needs to be accounted for.
16 GENERAL GREEN: And clearly the question I think
17 we are asking is, not what is the right thing to
18 do but what is it actually that you are using as a
19 discriminator? I think that that may be part of
20 what we have to look at in terms of what may be
21 the right way to go after this. But for the
22 services, we may need to understand what you are

1 using as indicators to pull people in. So for
2 your ill and injured, are you pulling in everyone
3 who is going through an MEB process?
4 DR. GADSON: Yes, sir. We do have the ability to
5 do that piece, but what the Air Force is using as
6 the initial indicator for when we are pulling
7 people in is driven by the casualty report. So
8 the medical team identifies the person that we
9 have got someone the casualty report is being
10 driven on, then that casualty report comes
11 directly to me when it is sent out to the world.
12 I get that casualty report and if it shows SI or
13 VSI, I automatically engage with the MAJCOMS, for
14 the family liaison officer piece, and the Recovery
15 Care Coordinator piece. If those come in as NSI,
16 we put them in a hold status and we say "Okay,
17 there are not identified. There is a casualty
18 report being driven there". And so would we go
19 forward with that if they are referred to us, then
20 we have that data that we can pull into. It is
21 definitely one of the challenges of our program
22 sir, because as Sergeant Mackenzie said there have

1 been cases where we may have an individual who is
2 showing NSI but has requirements that are going to
3 require EFMT. And so that is one of the things of
4 us being aware of -- the individual -- the
5 casualty report that we receive every day, we
6 automatically will send that to our Recovery Care
7 Coordinators and say "There is someone coming to
8 your facility. Give them the eyes over and if it
9 drives that we make a change, then we can work
10 that realm. And so again, we are fortunate in the
11 Air Force that we are small enough numbers that we
12 can look at each case by case but it is not an end
13 all/ be all solution set to make sure people
14 aren't falling through the cracks. So we have been
15 working with Air Force Casualty to try to identify
16 how we can better capture all of those, because
17 some are never going to have a casualty report
18 done. If you have a member that may be SI but the
19 injury occurs at their home base, and they go
20 their local MTF for care and they stay there for
21 the duration of their care, we may not know about
22 them until they reach the MEB phase. So again, I

1 go back to the beauty of our Air Force program
2 while we are not -- there is lots of room for
3 improvement. We all know that -- how we track
4 numbers and how we identify. Because we have small
5 numbers, the partnerships we have between the SG
6 community, the A1 community, and the DES processes
7 allow us to have that multidisciplinary team that
8 is assessing each of those individuals and saying
9 this person needs these requirements met, whether
10 that is a flow, an RCC, just the medical case
11 management side, we are able to assess each on an
12 individual basis So I feel like we are capturing
13 those folks but it is by the communication realm
14 and the partnership that we have within our
15 communities. Next slide please.COLONEL
16 DEMMONS: Best practices, you know, it's hard to
17 say, we can come as a service and say, we think
18 these are the best practices. But, unless somebody
19 else tells you that they are it becomes
20 challenging. But, one of the things that we have
21 highlighted as a best practice, and I think
22 several of the services are doing this, but we

1 have actually gone out to RAND on several
2 different studies. And right now they're getting
3 ready to co- to kick off this June um, a subject
4 research piece on how we're doing with integrating
5 our folks back into community. What drove this was
6 really that PTS issue with the homelessness piece
7 that the VA is already tackling as well as with
8 the financial strains that we often times see with
9 the PTS individual. Who, they may be employed when
10 they leave the service, but because they missed
11 their meds or they aren't making their
12 appointments it's-it has an effect on their
13 employment. And, what we're doing to truly capture
14 of, we send them off successful, but what are we
15 making sure to continue that success within the
16 community? Not just for the short time of the 6
17 to1 year point, but for the lifetime point. So,
18 we've partnered with RAND. We've done a couple of
19 other studies with them already to help grow our
20 own programs and steer where we're going. The
21 other thing that we've done is we've become
22 integrally, integrally involved with our A-9

1 community; that's our lessons learned community
2 within the Air Force. And, we've utilized them on
3 several fronts so, 1) that they just were
4 completed in October of '10. They did a best
5 practice um, assessment and this is just from a
6 lessons learned perspective of all of our sister
7 services to find out what their, their programs
8 were doing and they've come up with 5 over our
9 team actionable items that the Air Force can do.
10 Not that we weren't providing good service, but
11 that we can capitalize on from our sister services
12 employing forward programs that can benefit the
13 Air Force as well. Some of that information we're
14 utilizing also to drive to the Wounded Warrior
15 Care and Transition Policy folks; to where we
16 think that some of it may be joint applicability
17 vs. just within the service. And, as I've
18 mentioned several times, we believe in not redoing
19 work. And there's a lot of effort being done under
20 the WWCTP area with the staffing that they've
21 brought on, that we can capitalize in and partner
22 in to make sure that we're leveraging what's out

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1 there without struggling with the ability of
2 increasing our own staff numbers. One of the big
3 things that we have done recently in just this
4 November, we launched the Air Force Mentorship
5 program for our wounded, ill and injured. Again,
6 this is not just combat wounded; it's any that
7 fall into the gamut of the wounded ill and injured
8 side. And what we're doing is, is folks that have
9 gone through the process are being trained
10 professionally through a private organization that
11 already provides the service to become mentors of
12 those that are having similar circumstances. So,
13 we have through our recovery care coordinators and
14 the AFW2 consultants, identified folks that could
15 be potential mentors. We reached out to them and
16 asked if it was something that they would be
17 willing to do. Those that have said yes, we have
18 brought into a training session, provided the
19 training on the basic requirements of a mentor
20 program and then now have partnered them with
21 people who are going through the recovery and
22 rehabilitation process right now. We call it RAMP:

1 Recovering Air and Mentorship Program. And we just
2 launched this solely. We've also just launched
3 customer feedback surveys. We're trying to capture
4 the metrics up front on this part vs. an after the
5 fact thing. So we've, we've sent out mentor
6 surveys now to both the mentor and the mentoree on
7 a, on a nondisclosure basis so that we can get
8 feedback on how we can grow the program. But...
9 MASTER SERGEANT MACKENZIE: As part of this USOCOM
10 already has this in place. Have you reached out to
11 them to contact them into how they're managing
12 this mentorship program and their successes and
13 shortfalls through this?
14 COLONEL DEMMONS: Yes. Um, Mr. John Beckett has
15 worked with the team. We meet weekly on Thursdays
16 with all the sister services and so this has been
17 one of the items that we've guarded. And, it was
18 identified as a best practice. Mr. Bob Rudney from
19 the A-9 community did go out and interview the
20 USOCOM folks on the program that they were doing.
21 There's much of the USOCOM community that we could
22 marry up against from an Air Force perspective in

1 what they're doing. But, obviously, from being in
2 those types of things drive some things that
3 USOCOM is able to do that we aren't. But, if we
4 can model a program USOCOM definitely has one that
5 we do need to obviously reach out and partner.
6 And, even with the RCC piece, USOCOM is working
7 right now to bring on their own recovery care
8 coordinators. We provide that service across the
9 board, but it'll, in addition, be a partnership.
10 There are some that are already out there. The VA
11 Polytrauma Center in Florida is one area where we
12 do have a USOCOM RCC. An individual whose taken on
13 the job title had been given something else
14 previously, but great coordination going on there
15 between our component and that MAJCOM. Next slide
16 please.
17 LT. COLONEL KEANE: Colonel.
18 COLONEL DEMMONS: Yes.
19 LT. COLONEL KEANE: Can you list the best
20 practices of Assisted Services?
21 COLONEL DEMMONS: Um, I'll try to do them off the
22 top of my head and I'm sorry I didn't bring the

1 report today. Uh, one of the first areas was on
2 just personnel members and what they're able to do
3 in strategic communication planning. They have
4 dedicated staff that do their STRATCOM that do
5 their outreach to nongovernmental organizations.
6 The VET organizations that are- want to come into
7 the services. Colonel Demmons.
8 MS. DAILEY: Colonel Demmons and Colonel Keane
9 uh...
10 COLONEL DEMMONS: How about if we get her to put
11 that on paper for us and send it back and not go
12 through it here. I can, I'll provide a cop of the
13 lessons on report.
14 MS. DAILEY: Yes. Yeah.
15 COLONEL DEMMONS: It's important.
16 MS. DAILEY: That would be great. That would be
17 great.
18 COLONEL DEMMONS: And then one of the things that
19 I want to highlight as a best practice that we
20 have been identified for is our employment program
21 that we have under the AFW2 program. We have been
22 able to establish a central salary account under

1 the Air Force realm that allows us to create 30
2 positions across the DoD to transition our wounded
3 warriors and our ill and injure into. Right now we
4 focus this on an ill and injured side, but what it
5 does is it allows a unit to identify they have a
6 need that can be met by one of our wounded
7 warriors. And so they can establish a temporary
8 position for two years that's centrally funded
9 from the Air Force that allows that member to go
10 in and work and work within the unit to transition
11 that into a full time equivalent position as they
12 grow too. It doesn't provide the money for that,
13 but we give the two year window so they can go in,
14 work their POMing processes to establish the
15 position on their books to allow these folks to
16 come in, in a transitory period, receive the
17 training that they need to be successful in the
18 job, and then roll forward into it as a permanent
19 position. 30 positions out of 975 with 200 and
20 some that are still on active duty that would
21 utilize these. I know it's a small number. We're
22 working to try to grow that central salary

1 account, but um, that's where we're at right now.
2 Yes sir?
3 MR. DRACH: That's great. I appreciate that. Do
4 you have any of your members that are involved or
5 enrolled in the Operational War Fighter Program?
6 COLONEL DEMMONS: Again sir, I don't have numbers
7 to be able to back anything up, but I can have our
8 folks pull where we're at with that front. Again,
9 not reinventing the wheel, we reach out to a lot
10 of those organizations that are already providing
11 that service. Under the Air Force Realm with our
12 intelligence community, they have now developed a
13 program for our wounded warriors as well to work
14 security clearances because many of our folks have
15 that. And so they're working with contractors to
16 allow our wounded warriors that are able with the
17 security clearance to do some of this work with
18 our contractors because there's a big gap in being
19 able to provide an Air Force need because of the
20 length of time it takes to get clearance. And so
21 we're working programs internal to the Air Force,
22 the central salary account, and then we're also

1 employing on the E2-I: the education employment
2 initiative that the WWCT folks have launched. One
3 of the aspects on this front, again, goes back to
4 how we're supporting these folks once they get
5 into these positions. And, I can say for the 30
6 that we have we do a good job of job coaching the
7 individuals, of getting them the support they need
8 from community and civilian aspects and
9 specifically like job coaching type of individuals
10 that help them. But, I think where we need to grow
11 the program and our next launching point is, is
12 that same support to the individuals that are
13 doing the hiring. There's, I think we set the
14 member up for success in our employment pieces,
15 but I don't know how well really we are setting
16 the units up for success in doing that; because
17 obviously there's a lot of things they're going to
18 deal with that they don't deal with, with the
19 active duty member that's coming in without PTS or
20 TBI. And so, we will-are now starting to try to
21 grow and we've put together a working group to
22 identify what we can do to support the hiring

1 authorities and the supervisors of those folks
2 that we're bringing back into the active duty, or
3 into the civilian community. So we've made that,
4 we've stressed that with the WWCTP employment and
5 education initiative program that they've just
6 launched off to. Because I think that all the
7 services have been focusing on getting people back
8 to work, but I don't know how much focus any of us
9 have really put on supporting those units that are
10 bringing them back in. The next slide is just a
11 hoorah slide and I'm wrapping up. Um, we do do
12 several warrior events that are tied to, not just
13 to what we do internally to the active duty
14 component, but what we partner with out there in
15 the civilian communities. Um, a big thing that we
16 have coming up in May is our, our uh, Warrior
17 Games that is hosted by the United States Olympic
18 Committee. We will have 25 Air Force members that
19 actually just went through a training camp in San
20 Antonio last week, um, participating in those
21 events. That's our quota or we would have even
22 more. But we're branching off of this program

1 because it's an adaptive sports program. The
2 objective of this isn't to create peril Olympians,
3 but it's to introduce folks that are wounded, ill
4 and injured, and this is open to all; it's not
5 just associated to combat wounded, um, that they
6 are not out of the fight just because they have an
7 amputation or they have PTS or any other kind of
8 related injury or illness. That adaptive sports
9 allows them to continue to do the things that they
10 loved to do before. So, launching from the Warrior
11 Games Program we are now establishing through our
12 outdoor recreation and our sports programs within
13 the Air Force, adaptive sports programs that will
14 not only meet the needs of our wounded, ill, and
15 injured, but also help our exceptional family
16 member program as well. Meet requirements for the
17 families that have children out there um, with
18 special needs. Next slide please. In the future,
19 we, we have much room to grow. Uh, we've, we've,
20 we're trying to assess- we're trying to look back
21 at where we've come since the 2005 error to where
22 we're at now. Um, there were many things on the

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1 front that we know we want to change as a service
2 and how we can conduct our business; one being an
3 IT solution that I've already mentioned; but also
4 being the structure of our Air Force Warrior and
5 Survivor Care element. And so, here in the near
6 future in San Antonio, we will be staying at the
7 Air Force Warrior and Family Operations Center
8 which will help us to link. We're kind of trying
9 to model off the Marines a little bit to be able
10 to have that call center piece where folks will be
11 able to call into where we can meet their need,
12 and roll through, but again, more from a call
13 center management side than anything else. We're
14 also looking at the overall restructure of the Air
15 Force Program and how we incorporate um, at a
16 policy level, all of the entities that are
17 inherent in an Army structure under 1 chain of
18 command. So, while we're not saying that we want 1
19 chain of command, we want representatives from
20 those other organizations that we partner with on
21 a daily basis to be a part of this overarching
22 cell that they can drive the need into our

1 separate chain of command um, levels.
2 MASTER SERGEANT MACKENZIE: I do, I do have one
3 question.
4 COLONEL DEMMONS: Yes.
5 MASTER SERGEANT MACKENZIE: Something that came
6 up. A little bit of round table discussion this
7 morning and so on and so forth and it just, you
8 may be able to give me an example, you may not.
9 Um, you take an individual who is VSI, goes
10 through the process, found unfit for duty, medical
11 retirement eligible decides to stay in and gets
12 approved for limited assignment status. 4 years
13 down the road he goes: I can't, I can't deal with
14 this anymore. I want out. Now, from a personnel
15 standpoint, is that person still going to be
16 medically retired or are they just going to be
17 separated because they've lost that opportunity to
18 take that medical retirement?
19 COLONEL DEMMONS: The way we have set up the
20 program, so I'm going to answer your question in a
21 round about way cause we haven't experienced that
22 yet, um, but we have had a situation where

1 someone's wanted to come onto the LAS and months
2 down the road has said, it's more than I thought
3 it was going to be. I can't handle it. The process
4 that we put in place right now is that they are
5 reevaluated under an MEB process and go through
6 that phase again. Um, and then that would make the
7 determination of whether it would be a medical
8 retirement, a separation. For those that are
9 retirement eligible, my assumption is that the
10 process would be the same because that's how we
11 built the system to be. But the member would have
12 an opportunity if their retirement eligible to
13 retire vs. facing the MEB. Did I miss your
14 question?
15 MASTER SERGEANT MACKENZIE: Yeah you did. I'm not
16 talking about people like myself who are
17 retirement eligible. I'm talking about somebody
18 that VSI 8 years time of service. Goes through the
19 process of 10 years would qualify under medical
20 retirement, but says I'm not done serving my
21 country. I'm applying for this limited assignment
22 status. Get's retained on active duty and gets a

1 job working X, Y, and Z and then says: you know
2 what? This is really isn't cutting it. I'm not
3 getting what I need. I'm at the end of my service
4 commitment, but not retirement eligible. Is he
5 still eligible for that medical retirement he once
6 was?
7 COLONEL DEMMONS: He would go through the MEB
8 process again.
9 MASTER SERGEANT MACKENZIE: He would?
10 COLONEL DEMMONS: Yes.
11 MASTER SERGEANT MACKENZIE: Okay.
12 COLONEL DEMMONS: He would. He would identify that
13 he no longer wanted to be retained on active duty
14 service. We would reroute that and identify it
15 through the medical team. And right now the way we
16 have the policy set up, is that he would be MEBed
17 again for that determination to be made.
18 MASTER SERGEANT MACKENZIE: Now, obviously this is
19 just starting because you do have a particular
20 case where that did happen and with a, with a
21 staff sergeant within the Air Force. So, so the
22 question is, are you guys relooking at those

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1 cases? Are you starting to make sure it works
2 correctly and then going back?
3 COLONEL DEMMONS: Going back we're capturing when
4 they're identified to us. So when it's referred to
5 us, we're pulling that front-sorry that gave me a
6 startle too <laughs>-um, we're marching forward
7 and for anything that's back it's something that's
8 referred to us. And then, when it's referred we
9 tackle it and we drive and do the right thing by
10 the member. So, if you're aware of somebody that
11 I'm not aware of give me a name and we'll go back
12 and follow up.
13 MASTER SERGEANT MACKENZIE: I'll meet with you
14 later but thank you.
15 DR. GUICE: I think that uh, concludes. Thank you
16 very much. You were very patient with all of us
17 and we appreciate it.
18 COLONEL DEMMONS: I appreciate your time and I
19 appreciate what you're doing because obviously,
20 taking care of our recovering service members is
21 the bottom line up front thing that we do on a
22 daily basis and without oversight and somebody

1 making sure we're doing what we say we're doing,

2 we sometimes know that it doesn't happen. So thank

3 you all very much for what you're doing.

4 MS. DAILEY: We do- um, we do have lunch set up in the other room please. It's a buffet again. Return to your

5 places and we will have another set of briefings; but um, for the next briefings to kick off please. 1:00. MS.

6 DAILEY: Okay, we want to resume our briefing.

7 Please, continue eating since this is a working

8 lunch and good digestion, maybe. So, are we

9 ready? Can I bring you all on? You're ready to

10 talk, excellent. I would like to introduce, I

11 would introduce my next set of briefers, but I'm

12 not sure I have the briefing queued up and I will

13 let our briefer introduce himself.

14 COLONEL DICKEY: Alright, the next section

15 is on PTSD and TBI. It is broken into two

16 sections. I'm going to give the first part and

17 then Dr. Laura Baugh will be giving the second

18 part of the briefing. I'm going to be talking

19 specifically about post traumatic stress disorder

20 and the medical services for PTSD in the Air

21 Force. My name is Lt. Colonel David Dickey, I'm

22 the chief of deployment mental health in the Air

1 Force Surgeon General's office. So, what we are
2 going to go over, we'll start with some statistics
3 on prevalence of PTSD in the Air Force. We will
4 talk a little bit about prevention initiatives,
5 evidence based practices, there are some questions
6 regarding stigma and then some of the research
7 efforts that are ongoing that we are involved
8 with.
9 Okay, first of all, PTSD prevalence which has already
come up, I do want to address the question that was
10 brought up with the last presenter, sir, that you brought
up and I think my understanding of the question was, do
11 we have statistics or relative data in terms of
12 how many PTSD cases are identified at what
13 process. And it sounds like in the Army there has
14 been a problem with late identification and then
15 being able to retain folks in time to get
16 services. And some of that question is for the
17 Wounded Warrior Spokesperson, but in terms of the
18 data I'm presenting, we didn't break this out for
19 this briefing and I don't know kind of by heart,
20 so I would need to get back with you in terms of,
21 but obviously it is an interesting question. How
22 many of the PTSD cases, for example, are

1 identified with the immediate assessment when the
2 individual returns from deployment versus, for
3 example, the PDHRA that is given at six months
4 out. Percentage wise, I don't know where that
5 falls out, but can get you that information.
6 Alright, active duty airmen with PTSD is the first
7 graph that I have. This is what we would call a
8 period prevalence. So in any given quarter, how
9 many airman have at least one medical visit with a
10 diagnosis of PTSD?
11 This is pulled from our medical database that we
12 use for
13 providers, well that we use for medical records,
14 and what you can see from this, you do see a kind
15 of slight uptick
16 over time. That is not actually the point of this slide, although it is worth noting, overall, PTSD prevalence
17 rate in the Air Force is about .05 percent or if you even looking at a hard number for the last quarter that we
18 have on here, FQ3 2010, there are about 1500
19 airmen. It's a relatively small number. I think
20 we all can probably conjecture that that has
21 something to do with the different types of
22 missions that the Army and Marine Corp. versus the

1 Air Force does. So, our relative rate of PTSD is
2 pretty low, basically around .05 percent. Just
3 under half a percent of airmen have diagnosis
4 with PTSD and 70 percent of those diagnoses are
5 from deployment. Okay, I want to talk a little bit
6 about some of the prevention efforts that we
7 engage in before we present some more statistics.
8 And this is just a very small snapshot, obviously
9 we have a lot of programs, as all the services do,
10 that are designed to help with things like
11 prevention of PTSD. The Air Force has implemented
12 Airmen Resiliency Training.
13 You may have heard previously, of what was called
14 Landing Gear, which was a pre and post deployment
15 training that is given to everyone, first of all,
16 when they are going out on deployment they receive
17 it at their home station MTF before they head out,
18 and also once their deployment is completed when
19 they come back part of
20 their redeployment processing checklist they go through a briefing. Initially, it was Landing Gear, which was very
21 symptom focused, we have retooled that briefing somewhat, rerolled that out just this last November, Airmen
22 Resiliency Training, which uses a lot of the

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1 resiliency research that has been done, and again,
2 is in a small group format, both pre and post.
3 Another unique thing that the Air Force does is we
4 have our Traumatic Stress Response Teams. Every
5 installation will have Traumatic Stress Response
6 Team, also all installations in theater with Air
7 Force assets or medical assets, chaplain assets
8 will have a Traumatic Stress Response Team. That
9 is kind of like the old, if you have been around a
10 while, the Critical Incident Stress Teams that
11 respond to traumatic events consult with
12 commanders when needed, also provide some level of
13 pre-exposure training to certain select career
14 fields if it is deemed, for example, this is a
15 high risk or high exposure career field that may
16 benefit from some training before they deploy, for
17 example, or even in garrison if they are in a
18 mission set that may have more exposure, like your
19 firefighters or your security forces or some
20 population like that. It's not hard and fast who
21 gets that, it's really determined installation
22 based with consultation between the commander and

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1 TSR Team Chief. We publish a leader's guide to
2 managing personnel in distress, which
3 is really the Air Force's way of making sure our line leadership understands and knows kind of all of the
4 different facets, because as we know kind of managing folks in distress there are a lot of things that are
5 important for them to know. So, that is an
6 important publication that we have, and then the
7 Deployment Transition Center, which Colonel
8 Demmons already spoke about. Briefly, I am going
9 to go into significant more detail there that is
10 one of the initiatives we have had within the last
11 year that we have rolled out that is a fairly
12 large scale imitative and has met with a high
13 degree of success. Like I said, I will talk about
14 that in a moment. Okay, well how about our PTS
15 Symptoms by Combat Exposure. This graph is based
16 on PDHRA data on the PDHRA there is a question
17 that has four different responses in terms of are
18 you experiencing any of the following? And they
19 are PTS Symptoms I think somebody already
20 mentioned. We really like to talk in terms of PTS
21 not necessarily PTSD, because they are not exactly
22 the same thing. There are a much broader pool of

1 individuals who have post traumatic stress
2 symptoms who don't necessarily or do not ever get
3 diagnosed with PTSD. This graph, the previous
4 graph you saw was based on, "No Kidding Diagnosed
5 With PTSD", pulled out of AHLTA. These are based
6 on PDHRA. These are not folks who are diagnosed
7 with PTSD, but they have
8 endorsed at least one item consistent with post traumatic stress symptoms. And really the import of this slide,
9 which is kind of again, something I think we all know, but is demonstrated by our data, is that folks who have
10 combat exposure have higher rates, reported rates,
11 of PTS symptoms. Typically, depending on the time
12 frame you're talking about. About 4 to 5 times
13 more frequent if you have combat exposure that
14 you're reporting PTS symptoms. Again, no
15 necessarily a big surprise there, but you know,
16 knowing your population I think has been one of
17 the big themes of the morning as we have gone on.
18 Okay, so my next slide, by the way obviously Yes?
19 MASTER SEARGEANT MACKENZIE: Let me ask you
20 a quick question. You talked about how things are
21 focused towards those that is in some cases based
22 on the level of exposure. That presumptive, these

1 people are getting more exposed than others, with
2 that being said, are you fielding individuals with
3 the appropriate security clearance to effectively
4 do that in those high exposure career fields?
5 COLONEL DICKEY: That's an interesting
6 question. You know, and as we stood up the DTC
7 that's a question that came up because we have
8 different mission sets coming through. Different
9 mission sets with different security clearances
10 and that was addressed. Currently we don't have
11 any top-secret mission sets, for example,
12 coming through the DTC. If it comes to that, the guidance that we have gotten from our Air Force Medical
13 Operations Agency is that as long as individuals are not disclosing or discussing top-secret information that
14 having those providers, for example, in place. I
15 think this will become clear when I talk about the
16 DTC. It's not a medical treatment. It's a
17 training facility and so in that respect it is not
18 the same as if somebody is coming in for therapy
19 per se. But that has been considered. At this
20 point it has not been deemed necessary that you
21 match clearance for clearance. I think that's
22 what you asked? Is it or did I get that?

1 MASTER SEARGEANT MACKENZIE: It is. And
2 that's, you know, I'm sure once we get to the DTC
3 it will be a little bit more clear, but I know we
4 ran into this situation at Cannon Air Force Base
5 with the MFLIC program, where a MFLIC was put in
6 place to deal with some of the stuff and was not
7 getting any response because they had no security
8 clearance to talk to some of those individuals
9 that needed the help. SOCOM sent somebody in to
10 do that, but the question I had, as you, just
11 because you brought up sometimes that you need
12 devotion are we looking at that piece as an Air
13 Force versus relying a Combatant Commander to fill
14 that role.
15 COLONEL DICKEY: You know something that I
16 say along with that though, because you brought
17 up, I think,
18 you are kind of taking specifically, I'm assuming about the Intel folks at Creech or other places like that. One
19 of the things that we definitely have done, and kind of along with that imitative of a similar vein is the idea
20 of using resources that are familiar with the
21 population that your are speaking too. So, for
22 example, we are going to use AFSOC again because

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1 AFSOC really is a leader in many different
2 respects, and because their population is so
3 exposed to all of these things that we are talking
4 about. So, for example, they have imbedded mental
5 health assets within their units and commands that
6 have a specialized level of training, operation
7 training, in the AFSOC world at least
8 familiarization. We don't just send 'Joe
9 Physiologist,' for example, to work with these
10 units. And I think that's kind of very similar to
11 what you're talking about. Making sure that your
12 not, that you are targeting what you are doing to
13 the population that you're trying to reach. I
14 think that's a great point, one that we definitely
15 tried to go with. Alright, this slide is busy. My
16 point here is not that we're going to parce out
17 each one of these colored lines, so you can rest
18 easy and continue to digest, because that might
19 make you have trouble with that. The point here
20 is actually just take a look at the line on the
21 bottom, the dark green line that is "All Others",
22 and what this is basically prevalence of PTSD by

1 Air Force Service Codes.

2 And what you can see on the right hand side is when we look at the rates and what we see is that there are
3 certain career fields that have higher rates of PTSD than other career fields. So, you've got EOD is the dark blue
4 line and they are really way up top, well again,

5 that doesn't necessarily surprise anybody right?

6 These are the folks who go out and diffuse bombs.

7 Who are some of the other career fields that are

8 statically elevated above kind of the pool that is

9 everybody else and it's groups like security

10 forces, medical transportations, specifically

11 combat convoy, OSI, Intel, tactical control folks,

12 the point of this is not the parce out because

13 obviously there are a lot of variation in any

14 given quarter, but what you see when you average

15 these out is, and we became aware of and are aware

16 of, is that not all missions sets have the same

17 level of exposure. They don't all have the same

18 level of symptom reporting and that the majority

19 of the Air Force is very, very low, that's that

20 green line, but you do have career fields that we

21 need to be paying more attention too. And those

22 career fields typically do pay more attention to

1 their folks, but one of the things that we did
2 this year, I think, that I am going to brag on a
3 little bit was taking a look at some of these
4 career fields and saying have we looked at this
5 from a big Air Force perspective in terms of what
6 we are doing and what could be doing.
7 Okay. So, some of you may or may not have seen this pyramid. Some of the statistics that you saw that drove
8 this led some of the line community leaderships specifically the A47 folks, the EOD leadership, security
9 forces in conjunction with General Green actually
10 to kind of develop a proposal at Corona in 2010 of
11 February actually this last year approximately a
12 year ago, and one of the things that was developed
13 and actually that General Green presented was this
14 pyramid. The idea here is, and you know, you can
15 see it's kind of got resiliency all over it, it is
16 presented in that context, but it is also relates
17 to the context that we are talking about in that
18 the idea what do we want to do, how do we want to
19 target the individuals that we need to be reaching
20 that are the most in need? And the ides of the
21 pyramid is that it is a targeted and tiered
22 approach. Kind of knowledge of who it is that we

1 are looking to serve helps us enable a service
2 delivery model that really delivers the right
3 amount of care and the right amount of resources
4 to the right population. So, I will start at the
5 bottom, you have got foundational training for the
6 Air Force, you know basic tech training, ROTC,
7 Officers Training, The Air Force Academy and the
8 idea of that is we want everybody coming into the
9 Air Force to have a certain level of resiliency
10 skills that we want to ensure that they have, and
11 so making sure that our accessions
12 training contains all of that is one of the things that
we have been focusing on this year. And kind of a tier
13 up from that is everybody who is already in. And I think
we are all familiar with the Air Force and really all the
14 services have a whole lot of programs that we have
15 to help everybody with everything from finances to
16 relationships to mental health all of those things
17 so that's kind of everyday stresses and kind of
18 everyday training we provide everybody. When we
19 look at our tiered model kind of a step up from
20 everybody who's in the force or maybe our
21 deployers would be an example. People who have an
22 additional level of stress that we can identify

1 organizationally because they have either a
2 different mission or they have a different set of
3 contingencies that are working on them that we
4 want to maybe develop a product that goes beyond
5 that green level of the pyramid that is more
6 targeted that can address some of their needs.
7 So, for example, Airmen Resiliency Training, like
8 I just talked about, the pre and post deployment
9 training was developed for that. We want to give
10 it to all of our deployers. We don't give it to
11 everybody in the Air Force. We give it to the pre
12 and post deployers, because they are going into a
13 more stressful period, regardless of where they
14 are deploying.
15 It's not targeted only, for example, to people
16 going to
17 particular areas of the combat zone. We have kind
18 of set
19 a blanket approach we want to do this for all of our
deployers. Defenders at CD are kind of mental health
20 evaluations. Defenders Edge is another program I'll talk
about that was developed by our security forces folks
21 that said hey for our outside the wire security
22 forces members we need to provide some more

1 specified training in terms of how to use positive
2 behavioral health principles that have been
3 demonstrated in helping them perform their
4 mission. Then kind of that top tier is our
5 recognition that there are, especially on
6 deployment, you've got mission sets that are doing
7 things that are really qualitatively different
8 than the majority of the force in theater. And
9 these are our folks going outside the wire
10 diffusing bombs, folks running convoys, folks who
11 are forward air controllers, these kind of mission
12 sets that are very different than most of your Air
13 Force mission sets, which as you know, kind of get
14 to AOR or near an airfield and really don't go
15 outside the wire very much, if at all, and kind of
16 that top tier was what are we doing for them and
17 what should we be doing for them. So, part of the
18 initiative is part of that top of the pyramid was
19 the Deployment Transition Center. Okay. So, we
20 have got EOD, security forces, combat convoys,
21 those are kind of the 'Big Three' for us and some
22 other mission sets, special forces obviously. One

1 of the initiatives that was placed at Corona was, do we
want to create a deployment Transition Center in theater
2 on the way back from deployment, so that is why the arrow
starts in Southwest Asia, we will place it at Rammstein,
3 it will be a two-day training that we'll have
4 folks attend and then they will redeploy back to
5 either CONUS or USAFE or Japan or wherever they
6 are from, it doesn't necessarily have to go back
7 to the US, it is wherever they are from, but they
8 come through as a team. And why are we going to
9 do this? We are going to do this because in some
10 of those slides you saw previously, that these
11 folks are exposed to more, they report more PTS
12 symptoms, and so we want to provide some training
13 that addresses and one of the things that we are
14 very aware of is typically medically when we
15 address things we tend to address folks who are
16 sick. And identifying the sick and kind of
17 remediating the sick. The DTC, I think, kind of
18 embraces a lot of what is very good about the
19 overall resilience movement, which is the idea
20 that, what is it that the people who are not sick
21 who do these things and do it and thrive, what is
22 it that they do? What are the principals that

1 they live, how is it that they deal with whatever
2 they are doing and kind of putting that in place.
3 So, lightening speed at least for staff work
4 proposed in February opened in July since that
5 time, like I said a two-day reintegration program
6 another very
7 important part of this program was that it's not going to be run by medics or chaplains or airmen and family
8 readiness. As good as all those career fields are when you've got an EOD team on the ground at Rammstein and
9 you're doing training, who is it that they want to
10 hear from? They want to hear from EOD. They want
11 to hear from people who do what they do. So,
12 we've got deployed assets in place from those
13 career fields who have deployment experience who
14 are, for example, we have got EOD personnel who do
15 6 month rotations at the DTC and when a team comes
16 through we have small groups that are conducted
17 and they are largely led by the career field
18 facilitators is the term that we use for that.
19 Now, they also have chaplains or a medical asset
20 that attends the small groups because questions
21 inevitably come up about things like sleep or
22 nightmares or what if I want help or what if I

1 need a referral. We have had an overwhelming
2 response 1100 airmen have attended since July 2010
3 we are opening this up to more career fields than
4 just the initial three that we were piloting this
5 with. It's been a great experience because as you
6 can imagine it was pretty risky when we opened
7 this that you take these folks and you say we are
8 adding to your deployment by two days with the
9 program in Germany. Of course, the response
10 initially when people get on the ground is, "why
11 are you doing this to me, I don't want to be here,
12 this
13 is, I want to be home and see my family." And of course, these are all distress career fields. These are folks
14 who deploy frequently, so they are in the AOR a lot. What has been really encouraging is we do a pre and post
15 survey before and after folks are on the ground,
16 and as they are leaving out the door 85% response
17 rate. This was really worthwhile, and that is
18 based on a 5-point scale with the top 2 being, "I
19 agree with the statement this was worthwhile,
20 agree or strongly agree". So, it's really been
21 encouraging. Something that's being looked at now
22 it's interesting the Marine Corp. EOD has noticed

1 this kind of program is sending a group of their
2 EOD folks through in April. So, I think this is
3 something hopefully you have heard about and if
4 you haven't you have now. Okay. In terms of PTSD
5 interventions in addition to preventions,
6 obviously we have screening and education going on
7 primarily through the PDHRA and now with the NDAA,
8 the four face-to-face visits that you've got to
9 have to be assessed by a mental health provider.
10 We also have obviously cognitive behavioral
11 therapies are typically the behavioral therapy of
12 choice, which can include cognitive processing
13 therapy, seeking safety, exposure therapies, which
14 include prolonged exposure, EMDR, virtual reality,
15 experiential approaches like stress inoculation
16 training and then of course, there is
17 also medications, sometimes people will bring up the question of is there a medication kind of recommended
18 formulary that you have to follow, but it is more of a individualized approach utilizing usually antidepressants
19 and then symptomatic medications, but these are
20 GENERAL STONE: Are there any issues
21 regarding TRICARE coverage of cognitive therapy
22 within the purchase care network?

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1 COLONEL DICKEY: I'm not aware of any.
2 Cognitive behavioral therapy is very well
3 established and I have not, I don't know if there
4 is a TRICARE representative here, I can find that
5 out if there is not.
6 MR. REHBEIN: If I may Sir, for just a moment
7 in response to that question. What we are seeing
8 as part of the Veteran Service Organization's
9 community is that there are definite problems with
10 cognitive rehabilitation being paid for through
11 TRICARE particularly in the mild TBI cases.
12 COLONEL DICKEY: You said cognitive
13 behavioral therapy though right?
14 GENERAL STONE: Well, as a non behavioral
15 therapist I'm not sure I'm using the right term
16 COLONEL DICKEY: Okay.
17 GENERAL STONE: --so cognitive processing
18 therapy, cognitive behavioral therapy.
19 COLONEL DICKEY: Right.
20 GENERAL STONE: We have heard from the field
substantial concerns in the TRICARE delivery network that
21 there is problems, but yet, within the MTF's we seem to
be doing pretty well with this therapy and seem to
22 believe that it is very effective. Do you have

1 data that can defend the decision that this should
2 be part of the delivery network in the Purchase
3 Care area?
4 COLONEL DICKEY: Let me, if I can
5 deconflict for a moment, because part of, we have
6 mentioned two things. One is cognitive behavioral
7 therapy and one is cognitive rehabilitation
8 therapy. Cognitive rehabilitation is something
9 you will hear a lot of feedback from, because
10 most, many professionals if not most do not
11 believe that it has been validated as a treatment
12 necessarily that's been definitively demonstrated
13 as efficacious for mild TBI. Now, that's
14 different than cognitive behavioral therapy, which
15 has been very well established as an empirically
16 supported treatment for a variety, not just PTSD,
17 but a variety of psychological and psychiatric
18 illnesses. So, the only reason I'm want to
19 clarify is my assumption when you say that we are
20 getting a lot of feedback that this is
21 controversial or not working, that actually what
22 we are talking about is cognitive rehabilitation

1 therapy, which is for TBI not PTSD. To my

2 knowledge CBT for this problem and other types of

3 problems is very well established very long

4 accepted it

5 is on TRICARE and other insurance panels with a lot of demonstrated outcome studies that show efficacy.

6 MR. REHBEIN: My apologies for confusing the issue. COLONEL DICKEY: No, no, that's fine. And I can

7 kind of make sure of that because I certainly

8 don't hear kind of what is going on in the TRICARE

9 world.

10 GENERAL STONE: No, I think you answered

11 the question.

12 COLONEL DICKEY: Okay. Okay thanks. And

13 you know actually and I will just bring it up

14 that's kind of something that goes along with that

15 in our AFI on traumatic stress response we have

16 the DoD VA clinical practice guidelines which

17 endorse cognitive behavioral therapeutic

18 approaches. So, you got that kind of in premature

19 if you will. So, what about in terms of our actual

20 practices in the mental health clinics. What is

21 the, I guess you would say, PTSD load in terms of

22 what we are actually doing. Again, this is a data

1 pole from our medical database. What you can see
2 is fairly consistent, again somewhat of an uptick
3 over time, but basically approximately 5% of
4 visits in mental health clinics across the Air
5 Force at this time, at least for this latest
6 quarter, which is FY10 were for PTSD diagnosis.
7 So, it's a minority, which I think goes along with
8 the first slide that presented. In addition to
9 some of the evidence-based practice I
10 presented a moment ago the Center for Deployment Psychology is based out of the Uniformed Services and
11 Health Sciences University. They have a number of initiatives tri-service initiatives that we participate
12 in that are actually very helpful. I'd say one of
13 their better initiatives is the Center for
14 Deployment Psychology at USHS. They run courses
15 for training in PTSD service delivery for mental
16 health professionals. They do that in a number of
17 different ways. One is that they provide a two-
18 week basically kind of deployment course, which
19 covers prolonged exposure and cognitive processing
20 therapy specifically. They also have a Master
21 Clinician Development Tract that they engage in
22 with tri-service providers who want to specialize

1 in treating PTSD. Actually in the Air Force we
2 have a PTSD Fellow who is attached to the Center
3 for Deployment Psychology here in DC. The Air
4 Force sends all of our psychology and social work
5 residents to the CDP course for training in PE and
6 CPT. And this is one of a number of efforts that
7 we have in the SG community to make sure that our
8 providers are giving evidence-based treatments
9 that have been approved in the treatment of PTSD.
10 And then the CDP has three sites, three Air Force
11 MTF's where they have embedded deployment
12 psychologist who provide oversight in the care of
13 PTSD and help train clinicians and residents and
14 provide consultation. CDP also has a mobile team
15 that goes out and provides basic specific training. They trained 236 providers in FY10 and they provide weekly
16 supervision for base level providers, so, if you're in the middle of Kansas or something like that, maybe you
17 got the training but you're still kind of getting
18 on your feet CDP provides basically tele-
19 supervision on PTSD specifically to address any
20 concerns or shortfalls that individuals may be
21 having. So, right now we have got 700 Air Force
22 mental health providers who have been trained in

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1 evidence-based treatment for PTSD. We also
2 attempt to provide a certain level of education to
3 nonmedical obviously you want to get some of that
4 out there. Everyone has to take self-aid body
5 care it is one of our trainings. It is required
6 every 24 months. There is a module on PTSD that
7 is a part of the required training. If you are in
8 medical predeployment training there is a more
9 advanced level of training that takes place both
10 at the expeditionary medical support course and at
11 the combat casualty care course so that our
12 deployed medical providers have more in depth
13 level of knowledge. Like I said the VA DoD
14 clinical practice guidelines have been
15 incorporated into our AFI and use of evidence-
16 based treatments in theater. It's a little bit
17 different obviously you are talking about a
18 population that is more difficult into a clinic.
19 So, typically you are going to see 4 to 5 CBT
20 sessions
21 delivered within one to four weeks post-trauma and that has been demonstrated to enhance recovery.
22 A couple of other initiatives that we have going on. We now have 10 sites that have actually an adjunct to the

1 prolonged exposure therapy, it's called Virtual
2 Iraq and it uses multi sensory stimulation
3 including sights, sounds, smell, feel, and it is
4 developed basically for cases where your typical
5 course of prolonged exposure is not progressing at
6 the rate that you would hope it would. And so, we
7 have this at a number of facilities and they are
8 looking at expanding this for treatment also with
9 individuals with phobias and addictions. Some
10 other initiative already mentioned Airmen
11 Resilience Training, number of the MAGCOMS and
12 units that have specific initiatives you may have
13 heard that Air Combat Command and Air Mobility
14 Command have taken the comprehensive soldier
15 fitness program and mended it into a comprehensive
16 airmen fitness program, which is very similar it
17 uses a lot of the same principles. They have
18 targeted, for example, their first term airmen,
19 all the airmen going through training at certain
20 bases. It is being piloted for adoption perhaps
21 throughout other FTAC centers in their MAGCOMS and
22 then also unit specific or even career field

1 specific, like the Defenders Edge, another good
2 example is Combat Convey has integrated behavioral
3 health specialist in their predeployment
4 training to teach, again, and one of the things that we have found over and over again is that these things work
5 best when they are lying lead and they are integrated into what people are already doing. So, for example the
6 Combat Convey behavioral health specialist meets
7 with the instructors for that group before hand
8 and trains them in these principles and how to
9 deliver these principles to their cadre and that
10 program has met with a lot of success and
11 enthusiasm from the line units that it is targeted
12 too, because as we all know when mental health
13 develops a program and says hey who wants to come
14 your utilization rate is typically very poor and
15 what we found is what really works are things like
16 the DTC where your pushing to the population using
17 the population and using things that they are
18 already doing. Some other interesting initiatives
19 85 mental health clinics are receiving tele-
20 mental health VTC equipment for some of those
21 individuals or populations that may be harder to
22 reach, and then there is an initiative for Avatar

1 technology in development that would link families
2 during deployment and possibly also provide
3 virtual services, I think that's still in its,
4 actually I think it is being piloted as we speak.
5 Okay, there is question about stigma and I think,
6 you know, when you talk about stigma in PTSD it
7 always comes up because as we all know we don't
8 confidentiality in
9 mental health clinics and therefore you're are going to have a certain number of people who are not going to come
10 in and then there is just also the general perception that going into a clinic is a sign of weakness. One of
11 the things that I think is a good sign that in one
12 sense seeking treatment is not stigmatizing. Most
13 PTSD patients are treated at their base and
14 returned to full duty without requiring an MEB.
15 So that's our little pie chart on the left and
16 really the thing to notice about that is that we
17 did a data pull from basically all the MTF's
18 across the Air Force for a two-year period and the
19 outcome of a PTSD diagnosis for FY10 was 74% did
20 not require an MEB. So the vast majority of
21 individuals who have received a PTSD diagnosis
22 never get boarded, and that may go to some of the

1 questions about statistics with the previous
2 presenter, at least in some sense that my
3 impression was than these individuals really never
4 are identified necessarily as Wounded Warrior
5 because they never get to the board process
6 because they don't need too. And then of that
7 roughly 25%, that graph on the right, what that
8 showing is the majority of those individuals who
9 do end up getting a board it's not combat related.
10 Roughly 75% is not strictly combat related and
11 yes we use the word strictly because there may be
12 a component with some of those individuals but
13 it's not the primary reason for the board.
14 Most PTSD folks will never get boarded.
Of those that are boarded for PTSD the majority are
15 not combat related.
Does that make sense does everybody understand that?
16 DR. GUICE: I just have a question, the 74%
17 that don't have an MEB those are people that have
18 now left the military.
19 COLONEL DICKEY: No ma'am. So this was not
20 a longitudinal tracking this was a data pull from
21 the clinics in terms of cases of, and what this
22 chart is actually ended up is a cross section

1 between the number of PTSD cases and the number of
2 individual who were boarded for PTSD in a year.
3 DR. GUICE: So you have got 74% that 74% are
4 still on active duty but have the diagnosis of
5 PTSD in their medical record.
6 COLONEL DICKEY: Yes ma'am.
7 DR. GUICE: And they are still serving. As
8 far as you know.
9 COLONEL DICKEY: Yes ma'am as far as I
10 know. Okay. Another thing a chart that we like to
11 show in terms of level of functioning, again, is
12 this idea and this is kind of a busy slide. What
13 I say to take home form that is that at the
14 initial session the level of impairment that was
15 reported, and this is for folks who end up with
16 a diagnosis of PTSD, the estimation is when they initially start you have got major and moderate
17 comprised, and that's the red and the tan, sorry for the colors they are not the greatest, but it is basically 54%
18 of the individuals you would put in the category
19 of having what we would call at least a moderate
20 or above level of impairment. By the final
21 session or the most recent session because they
22 were not all completed at the time the data pull

1 was done, if you put again by the mild and no
2 impairment is what I would look at there, you're
3 looking at about a 66%. So you can see, or
4 actually the easy way to do it is look at the blue
5 and the yellow up top and that's good that means
6 they had either mild or no impairment and then
7 look at the blue and the yellow on the bottom,
8 what does that show? That shows that treatment is
9 largely efficacious. That the number of people
10 reporting a moderate or severe level of impairment
11 goes down that treatment helps a significant
12 percentage. MS. CROCKETT-JONES: I
13 GENERAL GREEN: Colonel Dickey, oh I'm
14 sorry go ahead. MS. CROCKETT-JONES: I
15 just wanted to know is there any way to track
16 after a time lapse, you know, that shows treatment
17 is effective while in treatment, is there any way
18 to confirm that this carries over for an extended
19 period of time?
20 COLONEL DICKEY: And that's a great question. The way that this data was pulled the answer would be no, because this was not individual specific it doesn't have
21 identifiers. So, we couldn't go back two years
22 from now and look at that, obviously that's a very

1 important question is well maybe two years from
2 now the pie goes back to that one right, maybe,
3 although, I think what you put together is the
4 treatments that we're using were validated and
5 efficacious. We are seeing evidence of efficacy.
6 We also have some studies that are ongoing in
7 terms of PTS service delivery and outcomes that I
8 think will kind of speak to some of those things
9 but not this specifically. Yes sir?
10 GENERAL GREEN: This is the first effort
11 I've seen towards diagnostics stratification and
12 so is there in your diagnostic kit back, I guess,
13 are there mild, moderate, severe, or is there any
14 way of divvying this up based on what you see when
15 you first see the patient and obviously with some
16 of the studies that are coming out now which have
17 significant overlap between mild TBI and PTS. The
18 other question would be is there now going to be a
19 stratification that gets into what we are
20 considering mild TBI, which may be a more severe
21 PTS. I just don't know if there is a way in your
22 diagnostic I'll say kit bag to help us with

1 understanding that.

2 COLONEL DICKEY: I think that is a great question. I think the challenge would be, the reason that I think
3 we were able to do this is because it was actual data pulled from the clinics where you are able to, because in
4 the diagnostic statistical manual when you make

5 the diagnosis, as you are aware, for many mental

6 health diagnoses or even non-mental health

7 diagnosis you have a severity code identifier.

8 Now technically if people use that as they should

9 you should have that data in AHLTA and you should

10 be able to pull that and cross correlate that with

11 any of these studies if you are using AHLTA as

12 your data source. The problem is sometimes that

13 you find is that you don't have to enter a

14 severity identifier when you enter a diagnosis,

15 for example, of PTSD. So, what I would conjecture

16 is you probably find that data missing if you

17 tried to do that, but certainly it is something

18 that you could do, and I think it is helpful

19 because when you talk about things, obviously like

20 TBI there is a huge difference between a mild and

21 a severe, for example, and PTSD also. A severe

22 PTSD individual is likely not going to be able to

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1 perform their duties. Mild PTSD individual is
2 likely going to be able to continue on their
3 duties and is going to require attendance and
4 treatment, but you have got a much more positive
5 prognosis obviously in a sense. Anything else on
6 this? Okay.
7 Okay, just a couple of the research initiatives that we have going on that are available of interest, RAND is
8 looking at Airmen Resiliency Training coming out to the some of the Air Force bases and interviewing some of the
9 individuals who are participating in it and
10 actually re-accomplishing that after 6 months or
11 whenever their deployment is over and just taking
12 a look at: a) Utilization and compliance and
13 then reception. DCOE is taking a looking a
14 Defenders Edge this is still in kind of the
15 formative stage, but assessing kind of outcomes
16 and as you know a lot of the times when you have,
17 for example, security forces initiating these
18 things it's really not researched per se. They
19 don't have a research arm that looks at medical
20 outcomes and so frequently you will have
21 initiatives like this that are good ideas and seem
22 to be working very well, but have not necessarily

1 been validated, and that's what we really
2 appreciate about DCOE initiative with Defenders
3 Edge is they are going to take a look and say well
4 can we put some numbers behind this that show what
5 everybody thinks is happening is happening. MIT
6 is doing a tri-service PTSD study that is quite
7 comprehensive. They are on the initial stages of
8 that going out to a variety of different bases not
9 just in the Air Force and looking at PTSD service
10 delivery, programs, models, and how all services
11 kind of attend to PTSD. And then there is the
12 University of Texas Health Science Center at San Antonio the Strong Star Project, which is another project that we
13 are in conjunction with that is joint service VA research program on PTSD treatment. And like I said that is just
14 kind of a small sample. Okay. One of the
15 questions was how does the Air Force define and
16 measure success for PTSD services. That's a
17 little bit difficult to answer, because in one
18 sense the determination it's kind of like, at
19 least in terms of the answer that we formulated,
20 it's kind of like when does a patient stop coming
21 to see the clinician. Well, it depends on what
22 the patient's estimation of whether they are ready

1 too, some people are ready to terminate services
2 when they have minimal symptoms, but they are
3 still having them right versus other individuals
4 who are not comfortable discontinuing until they
5 are completely free of symptoms. Our primary goal
6 when we are measuring effectiveness is symptom
7 reduction and level of functioning. Level of
8 functioning basically measured by worldwide
9 qualification and retention, and I think basically
10 the statistics on MEB's and the efficacy of
11 treatment are in a sense our best measures of
12 interventions effectiveness. Okay. Questions?
13 MASTER SERGEANT MACKENZIE: Yes sir. Once
14 again, and we all seem to talk about the PDHA,
15 PDHRA in multiple deploying career fields does the
16 Air Force also compare a PDHRA to a predeployment
17 health assessment for their next rotation out? And
18 there any connection between the two as they do
19 this over and over and over again?
20 COLONEL DICKEY: Right. I'm not aware of
21 that. Now, I'm not a PDHRA person to be honest
22 with you, I'm not sure. So, we will get you the

1 answer. I don't know if there is somebody in the
2 room who does know that. And just to make sure I
3 understand I think what you are saying is, is
4 there a kind of longitudinal comparison of an
5 individual's score so that you can tell if there
6 has been either increase or decrease, is that
7 right?
8 MASTER SERGEANT MACKENZIE: Correct. Does
9 those three tests that we do all the time, and I
10 know back in my deploying days with ASOP we did
11 that as well where there was a predeployment
12 health assessment, there is a post-deployment and
13 there was a follow up and then you go to rotate
14 out again and it's like here you go again with
15 another pre and another post. The question is; is
16 somebody comparing that data to identify trends
17 with exposure and PTSD in the Air Force.
18 COLONEL DICKEY: That's a good question. Other
questions? Okay, thank you very much. MAJOR BAUGH: Good
19 afternoon. Thanks for having me. I'm Major Laura
20 Baugh.
21 I'm a neurologist by training, currently serving
22 as the

1 Air Force traumatic brain injury program manager.
2 So just an overview of what we're going to discuss
3 today. First thing is just to define what
4 traumatic brain injury is so that we are all
5 talking about the same thing or on the same page.
6 Looking at the incidents of traumatic brain injury
7 in the Air Force, the services that we have for
8 those folks who sustain a traumatic brain injury,
9 defining and measuring success of TBI programs,
10 identifying best practices and then the status of
11 the directive type memorandum 09033. So starting
12 off a definition of traumatic brain injury, TBI
13 occurs when there's a structural or physiologic
14 disruption in the brain as a result of a blow or
15 jolt to the head. It can also occur as a result
16 of acceleration or deceleration movement of the
17 head without any direct impact and may occur from
18 other forces such as blast wave propagation.
19 Really the defining feature of a traumatic brain
20 injury, if exposed to any one of these types of
21 events, is alteration or loss of consciousness at
22 the time of injury. Post traumatic amnesia may

1 also occur but it's not a required part of the
2 diagnosis. The duration of
3 alteration or loss of consciousness, post-traumatic amnesia and findings on neuro imaging such as CAT scans
4 or MRI are used to determine the severity of a
5 traumatic brain injury. Mild to traumatic brain
6 injury is the same thing as a concussion. Loss of
7 consciousness less than 30 minutes, alteration of
8 consciousness up to 24 hours, post-traumatic
9 amnesia may occur for up to a day and any neuro
10 imaging that may or may not be done is normal.
11 Common symptoms with a mild traumatic brain injury
12 or concussion include difficulty thinking or
13 concentrating, slowed reaction time, sleep
14 disturbance, headache, irritability. TBI and PTSD
15 are commonly lumped together, I think, because
16 there's a lot of overlap of symptoms of the two
17 but there are some defining features of a
18 traumatic brain injury as well as defining
19 features of post-traumatic stress disorder and a
20 lot of people is that the overlapping group of
21 symptoms that they present with and then trying to
22 sort those folks out between who has a mild TBI,

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1 who has PTSD and who has both remains a challenge.
2 So the majority of people who sustain a
3 concussion will actually recover fully within days
4 to weeks. We know that people who sustain
5 multiple concussions, though, may take longer to
6 recover. This is a look at the incidence of
7 traumatic brain injury across the forces. You can
8 see that the Army has the majority
9 of the TBI diagnoses. This includes both deployed and non-deployed diagnosis of traumatic brain injuries of all
10 severities and you can see that the Air Force
11 accounts for about 11 percent. This is calendar
12 year 2010 through the third quarter and these
13 numbers have remained relatively stable since
14 2001, ranging between 11 and 14 percent of all the
15 TBI diagnoses in the DoD. Broken down by service
16 component and by severity so mostly the traumatic
17 brain injury diagnosis that we see in the Air
18 Force is mild which is really going to be the
19 focus of discussion today.
20 DOCTOR PHILLIPS: Can I ask just a question.
21 MAJOR BAUGH: Yes, sir.
22 DOCTOR PHILLIPS: Perhaps the Navy folks will be

1 able to answer that better but it's my
2 understanding that the carrier pilots encounter
3 this injury all the time, are they included in
4 this; do you know?
5 COLONEL DICKEY: The latest data generated is
6 through ICD-9 codes and the electronic medical
7 record. So this is not going to capture folks
8 that never present for treatment and never receive
9 a diagnosis of concussion or traumatic brain
10 injury of some sort.
11 DOCTOR COAKLEY: I can answer. As far as the
12 pilots and also breachers, the people doing
13 breacher training, specifically the Marine Corps
14 and some of our other
15 special operations units, they are just now starting to capture that data because they were considered
16 occupational hazards for the most part but now, at
17 least [inaudible] last eight months, they're
18 actually making [inaudible] to try to catch based
19 off recent studies from both those areas of
20 interest.
21 MAJOR BAUGH: Thank you, sir. So the approach to
22 traumatic brain injury services in the Air Force,

1 I think we have to keep in mind that the incidents
2 in the Air Force is lower than the other services
3 due to the difference in mission and remembering
4 that most of the TBI is mild and most mild
5 traumatic brain injuries recover spontaneously so
6 then the role is to identify those airmen that may
7 have persistent post-conclusive syndromes and
8 figure out who needs help and make sure that they
9 get that appropriate care. The second part of
10 that is making sure that when they present for
11 care, that our primary care providers across the
12 Air Force medical system know how to accurately
13 diagnosis them, provide treatment and refer them
14 on for additional resources when necessary.
15 MASTER SERGEANT MACKENZIE: Ma'am?
16 MAJOR BAUGH: Yes.
17 MASTER SERGEANT MACKENZIE: Under that education
18 and so forth, is there a move under foot to go
19 back and capture
20 those cases that were not diagnosed and I'll use a case-in-point of my own which was not diagnosed early on
21 in my treatment, was actually not diagnosed until
22 five years later when I went looking for

1 assistance.
2 MAJOR BAUGH: We're certainly increasing awareness
3 of traumatic brain injury. Persistent symptoms
4 that can occur, particularly from mild traumatic
5 brain injury where you might not think of that as
6 a possible etiology for the symptoms, and we've
7 made a lot of effort to try to make sure that at
8 least, especially care level and then with our
9 [inaudible] providers, psychiatry, psychology
10 providers, that they're all aware of this and how
11 it may present to help them better recognize it as
12 far as an active process to go back and look at
13 old medical records or to try to somehow tease out
14 who might have had a mild TBI that was missed when
15 they complained of their sleep disturbance, I
16 think that would be a challenging process to try
17 to -- is that not your question?
18 MASTER SERGEANT MACKENZIE: That would be an
19 unreasonable request.
20 MAJOR BAUGH: Okay.
21 MASTER SERGEANT MACKENZIE: Which is why I just
22 simply asked is that education being provided?

1 MAJOR BAUGH: Education is being provided and
2 we'll talk
3 more about the training and education efforts here in a moment. So first up there was screening and again, in
4 the effort to identify folks that may have
5 sustained a concussion, so if they're medically
6 evacuated for any reason to [inaudible] regional
7 medical center, 100 percent of those folks get
8 screened for traumatic brain injury. If they
9 screen positive and are symptomatic from that,
10 meaning they haven't fully recovered from the time
11 of their injury, then they're assigned a regional
12 care coordinator from the Defense and Veterans
13 Brain Injury Center to ensure continuity of care
14 when they get back to the home station. I think
15 you're all familiar, by now, with the post
16 deployment health assessment and the post
17 deployment health reassessment given upon
18 redeployment and then again three to six months
19 later. Screening questions were added to both of
20 the --
21 GENERAL GREEN: Laura, can I interrupt?
22 MAJOR BAUGH: Yes, sir.

1 GENERAL GREEN: I'm a little confused by your case
2 definition so if you say that mild TBI usually
3 recovers in weeks, okay. If it doesn't recover
4 and there are persistent symptoms, why is it still
5 mild? In other words, help us with the diagnostic
6 criteria here.
7 MAJOR BAUGH: Okay, so the diagnosis is based on
8 the alteration of consciousness, loss of
9 consciousness, post
10 traumatic amnesia and neuro imaging. Those are four
things we use to define whether or not it's mild,
11 moderate or severe. It doesn't take into account
12 persistent symptoms like headaches, which may last
13 for months in some people, difficulty with
14 reaction or thinking. Those symptoms aren't part
15 of the severity breakdown for the diagnosis.
16 GENERAL GREEN: But those are also the same things
17 that create problems with PTSD.
18 MAJOR BAUGH: Right. Aside from things like
19 headache, you may see more specifically in mild
20 traumatic brain injury not PTSD, nightmares you
21 might see specifically in PTSD but not in TBI. A
22 lot of that overlap though as is in the cognitive

1 difficulty, reaction time, irritability.
2 That's where we get stuck in trying to separate
3 these
4 folks out and figure out okay, how much of this is
5 related to the concussion you had or the three
6 concussions you had or the five you had during
7 your deployment and how much of this is
8 unrecognized or unwilling to admit it's post-
9 traumatic stress disorder?
10 GENERAL GREEN: The huge problem so the Army
11 briefed yesterday as many as 86,000 with mild TBI,
12 okay, and so if 86,000 with mild TBI had exposure
13 but are recovered in weeks, that's not a big issue
14 for us. But if 86,000 people out there require
15 some type of follow up, that's a
16 much bigger for us and so that's kind of why we asked for any type of clarity that can be provided regarding
17 diagnostic criteria.
18 MAJOR BAUGH: Right. I agree. I don't think that
19 we have the data to say how many of these folks
20 are still symptomatic. I mean if that data is out
21 there I haven't found it or I'm not sure how to
22 even get that because of the way the data's pulled

1 through the Armed Forces Health Surveillance
2 Center. They base it strictly by the first time
3 you get an ICD-9 code that matches their search
4 criteria which is various codes that may be
5 associated with traumatic brain injury. There's
6 no going back to look directly at the charts to
7 see how that person's doing. I mean I think
8 that's what it requires, actually going back and
9 looking at a sample population to say hey, are
10 they still symptomatic, are they well, was it just
11 the diagnosis and they recovered? I mean I agree
12 it's an important question to ask because it does
13 make a difference. So 86,000, I don't know if
14 that's 86,000 symptomatic or 86,000 had a
15 concussion and they're well. So you heard
16 Lieutenant Colonial Dickey talk about the
17 Deployment Transition Center. Recognizing that
18 this high risk population is also the same group
19 that is more likely to be involved in events which
20 may cause concussion or other traumatic brain
21 injury, we felt it's
22 important to implement a process to screen these folks as well. Another opportunity to try to make sure we're not

1 missing anyone particularly if they're at higher
2 risk. We're actually starting that process in
3 March and the actual details of it are still a bit
4 a work in progress because this is not a medical
5 encounter and we don't want to turn it into that
6 and we want them to still be comfortable at the
7 DTC doing what they're supposed to do in terms of
8 their resiliency but we also want to have an
9 opportunity to make sure they're doing well from
10 the physical side as well, make sure that they get
11 linked up with the regional care coordinator
12 through the Defense and Veterans Brains Injury
13 Center and that they are ensured that follow on
14 care when they get back to the home station. So
15 on the training piece of it, we did issue a policy
16 memo requiring that all clinical medics get
17 training on the concussion management guidelines
18 in the deployed setting and that will be part of
19 their training requirement on their orders in the
20 future but as far as getting it implemented now,
21 it was issued by a policy memo. For the providers
22 at the home station, we issued over 1,500

1 traumatic brain injury packet guides that were put
2 together as an effort between the Defense and
3 Veterans Brain Injury Center and the Defense
4 Centers of Excellence so over 1,500 of those went
5 out to
6 providers across the Air Force Medical Service. They also have a new product, the traumatic brain injury and
7 [inaudible] disorders took kit. A similar little
8 pocketbook like this that goes over specific
9 treatment recommendations including medication
10 guidance if someone has traumatic brain injury and
11 sleep disturbance or headache or PTSD, so trying
12 to make sure that we're providing the best medical
13 care when there's not just isolated traumatic
14 brain injury but other things going on as well and
15 we'll, likewise, be trying to distribute those
16 across the AFMS as another tool for providers.
17 Information on traumatic brain injury has been
18 implemented in squadron and wing commander
19 courses. There's a new section on TBI in the
20 leadership guide. It's also in self-aid buddy care
21 which all airmen are required to complete. And
22 the Centers of Excellence for Multimedia has put

1 together a fabulous site on traumatic brain injury
2 of all spectrums of traumatic brain injury, A to
3 Z. As far as specific Air Force clinics, we do
4 have a TBI clinic in Balad. There's other TBI
5 clinics in the AOR that are headed up by the Army
6 and by the Navy. There's two joint programs in
7 CONUS at Elmendorf Richardson and also at San
8 Antonio. The program at Balad is staffed by an
9 Air Force psychologist and a tech. They can
10 provide initial evaluation education and they also
11 have laptops available to do A&M testing, as indicated, post injury. An estimated more than 75 percent of the
12 patients that are seen are Army rather than
13 airmen. At Elmendorf, this is a multidisciplinary
14 TBI clinic that was started up in March of 2009.
15 Offers a variety of services, including support
16 groups for children and spouses and service
17 members. They offer a low-stress listing of this
18 environment, they offer stress management, sleep
19 hygiene, etc. Some more of a full-service TBI
20 clinic. I'll mention here, when we're talking
21 about Elmendorf, addressing the cognitive rehab
22 piece of it, Lieutenant Colonial Dickey was

1 correct in sort of distinguishing that between
2 cognitive behavioral therapy. Certainly the hot
3 topic right now is cognitive rehabilitation for
4 persistent cognitive symptoms from mild traumatic
5 brain injury. I'm not a TRICARE expert and I'm
6 not going to pretend to be but I'll try to address
7 a little bit of how that question's being answered
8 with regard to covered services. So TRICARE
9 coverage has to be medically and psychologically
10 necessary and is based on the current acceptable
11 medical practice in the general population so
12 there are a few initiatives under foot to try to
13 determine if cognitive rehabilitation is a valid
14 practice for recovery from cognitive symptoms from
15 persistent symptoms of mild traumatic brain
16 injury. So the Defense and Veterans Brain Injury
17 Center has a study on cognitive rehab beginning in
18 March of this year and Elmendorf is one of 13
19 sites participating in the cognitive
20 rehabilitation pilot project looking at best
21 practices for cognitive rehab. One of the
22 problems with cog rehab is that it's not one size

1 fits all. There's lots of different methods and
2 modalities out there. Some just do computerized
3 cog rehab where there's no provider input. Some
4 of it's face-to-face. Some of it's group. So we
5 really need to know what works. Does it all work
6 and anything is fine or are specific measures got
7 to be more effective than others and those are the
8 ones we want to make sure our service members are
9 getting. The Department of Defense has also asked
10 the Institute of Medicine to take a look at this
11 issue and provide a comprehensive review and
12 report of cognitive rehabilitation therapy.
13 MS. DAILEY: Can I get the military folks to reassemble please.
14 GENERAL STONE: I wonder if before we
15 start with the next phase we could talk about
16 process for a just a minute, and if that would be
17 acceptable. We spent the last two days listening
18 to the Services provide us fairly comprehensive
19 presentations. As I sit and take my notes I
20 wonder what I'm going to say to this except in
21 their report based on these reports, these
22 presentations. I really believe that the

1 committee may be better served by asking for
2 reports based on questions we have all jotted down
3 in advance, reading those, have the subject matter
4 experts arrive from the Services or from whatever
5 organization, and then allow us to have an honest
6 dialog. We have seen a number of people in the
7 last two days that we have tried to engage, they
8 didn't have answers, this is not any sort of
9 attack on the really hard work that has been done,
10 but what I'm wondering is, what do I have on our
11 list that we can now take back to the Congress, as
12 well as to the Secretary of Defense to say we've
13 really looked at these pieces of this delivery
14 system, here's where we're concerned, here's where
15 we think we're doing well. Now, I will stand down
16 if you all think that I'm completely off base in
17 this, but I do not believe that it is effective
18 for us
19 to sit and listen to power point presentations for two days. If we need to do that, then we have to put into
20 the time for us to really deliberate in an
21 effective manner where the real issues that we
22 have identified have come from. So anyway, if I'm

1 off base, please, I will stand down.
2 DR. PHILLIPS: No. I agree. I think our
3 staff, Denise and the crews, have done an
4 absolutely fabulous job. Just to get us all to
5 sit here through two sessions and present these
6 interesting briefs is a marvelous accomplishment.
7 But again, I am not sure and I agree with Rich,
8 that we are maximizing our time and effort. We do
9 need to be briefed to a point, but I think we need
10 to begin being briefed on the questions that we
11 want answered as you organize. And we also need
12 time to discuss among ourselves for this. It would
13 be nice to come away from each session or each
14 half-day session or each day session with two or
15 three bullet points that we want to either
16 reexamine or consider as recommendations or to
17 expand upon.
18 GENERAL GREEN: Well, okay this is the
19 same discussion Denise and I had before we came
20 into this meeting and so, I also share your
21 concern about us having enough time to deliberate
22 and actually, there is a little bit of 'Storming

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1 and Norming' to get to where we really
2 think the issues are. And so, I think that we can set up those times. That's not the question. The harder part
3 is if we don't have the background information
4 before we go out on site visits, if folks don't
5 understand the differences between the Services'
6 approaches it's going to make it very difficult to
7 basically go out and get the site visits done.
8 So, I guess I would look at the presentations that
9 have been given thus far as orientation in large
10 part. We're trying to get to a common level of
11 understanding so that when we all start talking,
12 because we all come from different backgrounds and
13 expertise, that we are now talking about things
14 from at least a common level of understanding.
15 So, from my perspective I think we still need to
16 listen obviously and hear the Navy and Marine
17 versions of same. We may want to we're going to
18 hear probably the same iterations from what I'm
19 seeing on the TBI and the PTS, and so we may want
20 to there is a particular effort going on in
21 theater right now by the Marine Corp. that I think
22 would be worthwhile for this group to hear. But,

1 we may want to limit some of things we are having
2 them present to us if we are seeing this is
3 repetitive because of DoD guidance being uniformly
4 implemented. But, I think we need to understand
5 how each service is actually approaching, I'll say
6 Warrior Transition Units, or followup of Wounded
7 Warriors, because when we go out on a site visit if you're expecting to see everything in a very organized
8 and highly command structured way, the way that
9 the Army does it, when you go visit the Air Force
10 you will sorely disappointed. And if you expect
11 to see, I'll use the Air Force, if you expect to
12 see a decentralized approach where everything is
13 done within the units, when you go and visit the
14 Army you will be disappointed as well. So, I
15 think we have to understand at least the basics
16 between the Services. The other piece that I have
17 not seen on the agenda, and that some would argue
18 is outside of this, but since this is about
19 basically recovering our wounded warriors and
20 seamless transition, it would be very interesting
21 to hear what the VA is actually receiving, because
22 part of this that we are hearing is how they put

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1 their programs together, and what we really want
2 to hear is, what are the warts, what are the
3 things you haven't been able to solve. And so if
4 we don't get that from the people who are
5 presenting then we probably need to look at the
6 people who are receiving.
7 DR. GUICE: And that was the point I was
8 going to make. I think what we've had for the
9 last two days is a terrific orientation for our
10 site visits. I think we can take what we are
11 going to do now with the focus group
12 protocols and better hone into very specific questions as opposed to the more general ones that were put in here
13 initially. Instead of saying, do you have a
14 recovery, we have a whole host of people asking,
15 "Do you have a recovery care coordinator?" "Do
16 you know what that person does?" "Do you have a
17 Wounded Warrior Case Manager?" "An AFW2 person?"
18 "Do you know what that person does?" "When do
19 they come in and help you?" "When do they leave?"
20 I think there is a lot more of concreteness that
21 we can put our site visits, which will then, I
22 think, start to uncover areas of problems that

1 then we probably have the obligation to go back
2 and say, "we found these things, are you aware of
3 them and what is your plant to mitigate them?" So,
4 that if they already have a solution set in place
5 than a recommendation may not be worthwhile, but
6 if they haven't and they haven't thought about it
7 then we are picking up on something they haven't
8 heard yet. That's why I think we can add value to
9 the process as well.
10 GENERAL GREEN: The other big advantage we
11 have of listening to some of these presentations
12 is that we are finding out what their measuring
13 and what they are not. And when you think about
14 us, we are a 5-year Task Force. So, there may be
15 things that we want to say we expect to see, okay,
16 no necessarily this year but next
17 year in terms of data that should be collected. Case management is a good situation in point. We know if you
18 can do the same things with nonmedical case
19 managers, as family liaisons or as recovering care
20 coordinators and don't need to have the high price
21 case management if there is duplication then
22 perhaps we need to either say show us that you're

1 making a difference or why are you making this
2 investment? But again, I don't know that that is
3 true, I just know that now I'm going to be
4 questioning how are you assessing, and what are we
5 going to do? And when we go out if the folks don't
6 know the clinical case managers that tells you
7 something again. Okay, so again if you have got a
8 group of people that too focused on training and
9 not necessarily getting this to the next step,
10 which is actually something that makes a
11 difference in the lives of the Wounded Warriors
12 and their families then we have bureaucracy
13 problem. MS. CROCKETT-JONES: Yeah, I
14 think I'd like us to think about it this way.
15 These meetings, yeah power point presentations are
16 painful, we just all know it. But this is about
17 process. I think that we can all take comfort in
18 the fact that we won't have to be so in-depth on
19 any process after this year probably, because we
20 will have direction. That is the advantage of
21 over-time, our work over-time. But I think that
22 this painful process

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1 portion might be important, first of all, to focus us on implementation and the practical aspects when we go to
2 ask the questions, but also, it's no good if we
3 want to try to jump into what we are thinking or
4 might be issues if we find out that we have to
5 backtrack because that's already been addressed.
6 So, this is painful, but I'm sort of thinking, I
7 really hate to admit it, but I really think it
8 might be necessary, but I do think we can maybe
9 get a little more assertive in moving along some
10 of these presentations when we are getting into
11 the weeds.
12 GENERAL GREEN: The only other thing that
13 I would tell is that by receiving these in a
14 central form when you go on yourfrom a very
15 pragmatic standpoint on any of the site visits if
16 they want to brief you on the Army Program you
17 should say, "No" okay, "We've been briefed on the
18 Army Program we now want to talk about". And so,
19 I think that this is also giving you a baseline
20 that will make the site visits much more timely,
21 because we do have limited time on the site
22 visits, if you don't have the background so that

1 you can say we have already been briefed on this
2 it's time to move on and we need you to work with
3 us on X, Y, or Z. So, you understand. I think
4 there is some pragmatic reasons to do it in terms
5 of a central forum that is painful as it may be.
6 GENERAL HORST: Chuck, I'll kind of harken
7 back
8 to the site that you and I had yesterday. We've had the opportunity to look at the processes by the Services, and
9 clearly the Army is different than the Air Force
10 based on caseload. I think having a good solid
11 understanding of the processes is good, but really
12 what we are after is the outcome of the processes.
13 That's the value added, I believe, that we bring
14 back to the Secretary of Defense, is measuring the
15 outcomes and the progress we have made as a
16 function of those processes. And so, I think we
17 ought to focus on, okay, we understand the Army
18 process we have seen this now tell us how well
19 it's working. So, I think we ought to focus on
20 outcome based findings rather than evaluation of
21 the process of whether or not it is working okay.
22 GENERAL GREEN: I don't disagree. By the

1 way, the questions that went to all these people
2 were about, "Tell us how it works", and they were
3 all having troubles giving us that data, which
4 tells you something by itself.
5 GENERAL STONE: And sir, that is exactly
6 my point. Each of them, I mean, I really think as
7 hard a time as we gave our researchers last time,
8 I think that they really developed firm questions
9 that demanded outcome reports. And what we got in
10 the words of a friend of mine, 'was pablum' from
11 both groups. When you
12 discuss evidence based medicine that means you have assessed some sort of probability of success and there is
13 data associated with that. I am extraordinarily
14 impressed with the quality of the people sitting
15 around this table. You guys just get it and you
16 skill sets come from very diverse areas, but you
17 get it, and I think the strength of the
18 interchange is where the value is. I can read,
19 and each of us can read any one of these
20 presentations and then hammer the issues of where
21 is the data that responded to our questions and if
22 you're not prepared when would you like to come

1 back and give it to us? We are all being very
2 courteous, but it's also taking an extraordinary
3 amount of this committee's time to prepare. Now,
4 if not, than we need to come offline in public
5 forum, Denise I understand, but we need to come
6 offline like we are doing now and really discuss
7 have we captured what we need to? For instances,
8 for me the comprehensive transition plan was a key
9 point for General Williams, but in the Air Force
10 plan it doesn't seem to play as much of a report.
11 Can we capture the data that says whether that has
12 value or not. How do we assess that data? And
13 those are the sort of things we have to get to in
14 order to get an affective report to the Secretary.
15 DR. GUICE: I think a lot of obviously what
16 we are
17 missing was the impact factor, the effectiveness of what people are doing and how they measure their outcomes.
18 And even if that is just the observation and
19 recommendation then you need to have these things;
20 otherwise, none of us are going to be able to
21 figure it out. And if that is a recommendation of
22 this to tell the Secretary of Defense you got a

1 little wobbliness here in outcomes and effective
2 measures and what we expect is we expect to have
3 those measures in place and in two years time we
4 will ask you, once again what are those outcome
5 and what is the impact and effectiveness. So, you
6 know, forewarned we will ask again so you better
7 have them place sooner than later, but some of
8 these things aresome of the programs are new, I
9 mean, most of these things are 07 and forward.
10 Not a lot of them have a lot of track record
11 ground. A lot of it is an evolutionary process
12 because you are trying to kind of fit needs and
13 get your IT system stood up and get your people
14 hired and get your processes in order, so in some
15 respects it may besome of these programs may not
16 be to that level of maturity to actually grapple
17 with that. I think that's probably what we heard
18 today is, "Oh we know we sort of need to do that,
19 but we've been so busy trying to implement a
20 program that we really haven't had time to figure
21 that out" and then for instances, for the case
22 management for

1 recovery coordination how do you know that those programs had an impact given that they rely on a lot of other
2 programs to actually do other things. So, some of
3 this is pretty hard to get too, but that does not
4 meant we shouldn't try it.
5 GENERAL HORST: I think the illuminating
6 point is capturing Best Practices. Clearly the
7 Army's challenges are different based on the
8 caseload and how long we have been doing it in the
9 Army. And so, Army has got a bunch of things in
10 place as a function of lots of experience doing
11 it. I think that the Air Force in looking at Best
12 Practices has recognized a comprehensive
13 transition plan as something that is out there
14 that the Air Force can leverage as well, and so, I
15 think we have to recognize the dichotomies between
16 the Services and I think we can make the same
17 argument about the Marines as well, but there is
18 goodness out there moving forward.
19 GENERAL GREEN: I heard from two different
20 members. I mean we needed to have this
21 discussion.
22 DR. PHILLIPS: I was just going to say, I just

1 want to suggest, and this is just a suggestion,
2 and let me preface it by saying, this is a very
3 visible Task Force. I would venture to say that if
4 there was not other things going on in the world
5 right now we would have TV cameras in the room,
6 perhaps. And the reason I mention this is
7 because there are outside folks that have been very critical of the whole process. There have been some
8 folks that have come before us that have opinions,
9 and I'm just wondering, and this is just a
10 suggestion, shouldn't we be at some point talking
11 to these people? I don't want to make a media
12 circus out of this, but I'm just wondering if we
13 should not be in some format engaging the critical
14 people from the outside that can actually do this
15 system a lot more harm if we don't engage them and
16 let them know that we are diligent, we are
17 working, answer their questions or let them ask us
18 questions. Again, just a suggestion, it's a whole
19 different category and I don't know if that's in
20 our mandate. To me it's an M & M conference for
21 the nonphysicians morbidity and mortality where
22 you discuss everything. It's a public forum, but,

she's laughing, and I'll be quiet.

LT. COLONEL KEANE: Sir, I don't know if we can make it a public thing until we have made our findings to the SECDEF. And maybe that's one of the recommendations that a course of action would be to make aengage those people, those organizations that we would want to engage. But we couldn't, I don't think we can really do that before we present our findings annually or each year.

GENERAL GREEN: Yes Sean, all of our discussions are going to be public and so anybody who wants to come to this can actually listen. We can actually--we can go out and invite people to come. Obviously as you have seen at the start of every second day we had open forums for people to come in, so we can also invite those folks or others that we feel have been ardent criticizers of the program to come in and speak with us. Again, before we jump towards that I say we should probably have a pretty good understanding of what DoD's intent is, but eventually, although, the report itself it is up

1 to the SECDEF to release all the discussion that
2 lead to the report will actually be an open forum.
3 DR. PHILLIPS: You know I bring it up
4 specifically. I don't know who this fellow Karl
5 Prine is, but he has written a lot of negative
6 things about the project, to the point where
7 General Shoemaker had replied and there's
8 controversy over that. Now, I don't whether that
9 is within our jurisdiction or whether we want to
10 consider that, but since it is in the public arena
11 and since both sides seem to be banging heads.
12 I'm just saying as an information source for us.
13 Not to try and convince them not to say the things
14 that he has been saying or convince them to say
15 something differently, but for us to at least get
16 that point of view. And where did he get his
17 information? I guess from interviewing people and
18 observations.
GENERAL HORST: I agree with Doctor Phillips. I think it
19 would be helpful to keep his perspective but I
20 don't believe we have an obligation to respond
21 him. I really think that in this case, General
22 Shoemaker has got the challenge to do that, to

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1 make the response. I think his perspective as a
2 critic is valuable to us and could add to our
3 inventory of questions or assessments that we need
4 to make because he's made some pretty strong
5 allegations and so
6 GENERAL GREEN: And do we follow up and confirm or
7 deny those allegations without responding formally
8 back to him without confirming or denying. I mean
9 just listening is not a bad thing. The other
10 question is when. Do you do it before we have any
11 knowledge or do you do it before we go out, do we
12 do it after we have a couple of trips under our
13 belt and have some people who actually have seen
14 and so right now we're an interested audience;
15 we're not a credible audience yet. MS. CROCKETT-
16 JONES: If we're considering it, can we consider
17 if someone has any familiarity with what his
18 criticisms are, could we ask him to present just
19 give us his information in a written form in
20 response to either one or two pertinent questions
21 tasked to do. I don't know I mean, I'm not
22 familiar with what he said in his

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1 criticism.
GENERAL HORST: I think all we need to do is read these
2 three articles that he's written and that will
3 pretty well define his criticism and I think you
4 could sort of read between the lines and figure
5 out what he's talking about. It's a combination
6 of hearsay, mythology and distortion.
7 GENERAL GREEN: Caution, caution. My warning
8 lights are going off in terms of judgments
9 (inaudible) documents.
10 GENERAL HORST: I've read all three of them, sir.
11 MS. DAILEY: Yes. We did a string where his
12 article was (inaudible) back to. We can
13 regenerate it in a different format and send it
14 out as an attachment or something. I have one
15 copy here.
16 GENERAL STONE: Denise, could I ask you to just
17 wait for a week because my boss is actually giving
18 a direct one-on-one interview with him the end of
19 this week. We've been working this week for
20 talking points and I'm sure he'll be a follow-up
21 article and maybe we can just complete the series.
22 GENERAL HORST: May the Army Surgeon General will

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1 do our work for us regarding talking to Mr. Prine.

2 There's actually more than three.

3 MR. REHBEIN: There's more like the number is

4 actually six or seven, I believe, but several of

5 them get into

6 subjects that this task force doesn't has no business. It's not within our purview to address but I just wanted

7 to be sure that for a complete understanding,

8 there are more than three articles. I received

9 through another source well, there was a set of

10 articles on a Sunday and another set on a Monday.

11 DOCTOR GUICE: I would just request that before we

12 were talking about one reporter and there are

13 others out there through Blanch's or through

14 newspaper articles or journal articles that have

15 been critical as well and I would think that we

16 would want our research team to kind of do an

17 environmental scan for us and find a grouping of

18 those and see if there are any patters that start

19 to emerge, not just focusing on individual's

20 perspective, but really looking across and seeing

21 if it's just one individual's perspective or if

22 there starts to be a repetitive scene to some of

1 the topics and I think we'd be better served if we
2 did an environmental scan and included more than
3 just one.
4 GENERAL GREEN: So Denise, do we have the ability
5 to get an environmental scan?
6 MS. DAILEY: Yes, sir, we do.
7 GENERAL GREEN: I think that would be helpful.
8 Also would you want that focused toward the area
9 of the site visits? Are you prepared to work the
10 local climate,
11 rumors or whatever may be as you arrive there to go where you actually read up on what's happening in this area
12 whether positive or negative, factual or
13 unfactual, but are we read up on what's happening
14 in this area as we arrive?
15 DOCTOR TURNER: I would agree with that. If
16 there's any local Intel you can give us before we
17 go like, you know, is it really true you're doing
18 this or you know, and maybe before like a group
19 goes to San Antonio obviously, if there's
20 something out there in the environmental scan
21 about Sam coming, you could you know let the group
22 know before we go and we can talk about it before

1 we engage to see if it's worthwhile.

2 GENERAL GREEN: Even to know who who the most

3 vocal advocates or detractors are in that area

4 DOCTOR TURNER: On both sides.

5 GENERAL GREEN: Right, so that when you go in

6 you're not blindsided. Let me ask one other

7 question. So do we believe that we need to give

8 the Navy and Marine backgrounds so am I getting a

9 thumbs up on continuing the

10 [a few thumbs up; no thumbs down] okay. So then

11 the

12 follow on is so how should we divide our time

13 because everyone's kind of looking at the same

14 thing in terms of how do we get discussion time

15 and so should we divide our time in some type of

16 percentage early on, is because of

17 the visits do we need to finish off these things and then think more about how we're going to do this. My intent

18 was that after each trip that we would expect the

19 groups that went on that trip to kind of share

20 impressions in terms of what's happened here. Now

21 some of that can be done electronically in terms

22 of looking at whatever kind of data we collect but

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1 the other question is, are there things that we
2 need to talk about in open group so people are
3 kind of hearing perceptions and those kinds of
4 things? So I thought that the troops would
5 actually stimulate a lot of the discussion. Am I
6 way off base in terms of where we're going?
7 GENERAL STONE: Sir, no. We're answering two
8 different questions. The trips run the risk --
9 first of all will confirm or deny the validity of
10 the reports that we've seen. Number two, they run
11 the risk of antidotal, you know whoever's the
12 loudest voice and we all see that in our chains of
13 command as you know whoever's sort of in there in
14 the room. I think more importantly I guess what
15 I'd like to see in the presentations from the next
16 services that present to us is show us your bottom
17 line, the answers, the questions that we've posed
18 for you because we've spent a lot of time putting
19 those together.
20 If you would like to build us a slide deck that is
21 back
22 up to those questions, but let's make sure that we emerge
from those presentations answering the questions that

1 have been posed. It is not appropriate for those
2 briefers to arrive saying well, I really don't
3 know the answers to the questions you've submitted
4 in advance. I will submit that at some future
5 date, okay, because then we're going to weed it
6 anyways which is what I was proposing in the
7 beginning but you know I think that that will
8 allow us then to focus our discussion and
9 interchange with those briefers in a more
10 effective manner than I think we've done in the
11 first two services.
12 DOCTOR TURNER: I would agree with General Stone.
13 First point is we need to engage them and make
14 them answer our questions and having them come on
15 message because I've got a feeling that a lot of
16 these people were kind of on message just like you
17 do in a press briefing, right. I felt this was
18 more on message instead of back and forth
19 answering questions as General Stone says. Number
20 two, in addressing Doctor Green's post visit
21 structure, I think there does need to be a
22 crosstalk because there will be actually lessons

1 learned from just the mechanics of the visit that
2 we can pass on to the next group. Like well this
3 worked well in the sessions, this worked not so
4 good, you know whatever you do, don't do this you
5 know
6 kinds of things so I think even just some mechanical group crosstalk when we come back and I think -- what
7 does everyone else think about that? I'd be
8 interested to hear.
9 DOCTOR PHILLIPS: No, I agree. I mean I would
10 like just to ask each group to tell me where are
11 you, where do you want to be, and what resources
12 do you need to get there? You know tell us where
13 your gaps are. You know you're doing this every
14 single day. What do you need to get from point A
15 to point B?
16 GENERAL STONE: You know going to that subject,
17 both of the services the briefed us have kept an
18 entire portion of the organization for post
19 retirement advocacy. Well, what's happening that
20 we need advocacy and what does the VA, and this
21 goes back, sir, to your previous discussion, you
22 know what is not happening at the VA that we feel

1 we need the advocacy?

2 MASTER SARGEANT MACKENZIE: Also on the other side

3 I would agree, however, I caution that we try to

4 spend that time discussing those trips at the

5 beginning of the day because our conversations

6 tend to go very fluid with the briefers and

7 information that's provided and exposure to items

8 that perhaps that we would block out a chunk at

9 the beginning of the day to say that okay let's

10 review field experience over the last couple of

11 days, to focus on that

12 and then get into those briefings. I think if we try to put it in other areas of our days we may find that it

13 gets cut out or ineffective communication on that.

14 MS. DAILEY: So you like to do it early in the

15 day?

16 MASTER SERGEANT MACKENZIE: Roger. That's my

17 recommendation.

18 MS. DAILEY: I do [inaudible] is next -- will be

19 next month's agenda, March's agenda, but it looks

20 very much like this agenda so it's in Tab P but

21 I'll need to compress it over a lot more than you

22 even saw today's briefings compressed because I,

1 too, want to put in coast installation visit
2 reviews.
3 UNKNOWN SPEAKER: Do you have a guess?
4 DOCTOR GUICE: I would make the request, in order
5 to expedite some of this and I think this is part
6 of the problem is that we get at the briefings no
7 later than the Friday before the next meeting so
8 that we can review them, read them, we have that
9 truncated, answer the questions and you know the
10 bottom line up front and then as many backup
11 slices they want to provide us, we can have the
12 time then to kind of sift through it, read it and
13 then they can go take five minutes to give us the
14 highlights of their program, just the highlights,
15 and then go into a question/answer where we just
16 ask what we think we need to get out of the
17 briefers in order to give
18 us a better lay down of information.
MS. DAILEY: I got most of these Friday night. I got all
19 of them except the Air Force's non-case management
20 [inaudible]. I can't email them to you guys. I
21 mean there were seven, eight, ten, twelve megabyte
22 briefings so to send them to you I've got to send

1 them via FedEx.
2 GENERAL GREEN: Well, I can't put them on our
3 website so we - is there a way that you could send
4 us a link to a portal?
5 MS. DAILEY: Yeah, we can load them up into the
6 website, yeah.
7 GENERAL GREEN: Well, I mean just so we can go and
8 view them.
9 MS. DAILEY: Okay, yeah, yeah. I can load them up
10 on the website. And they've had this. The Air
11 Force and the Navy and the Marine Corps have had
12 this agenda, this March agenda, since the 15th of
13 -- well, like the 30th of January so they've had
14 almost a full two months and some of them were
15 back here getting Intel on what you all are going
16 to look at but they still saw everyone go through
17 you know Army program 101 and Air Force program
18 101 so I think they left here but [inaudible] will
19 be back, too. So I need [inaudible] them of that
20 idea.
21 GENERAL HORST: Well, I think Doctor Guice's
22 recommendation of an executive summary. We read

1 faster

2 than they can talk so we can get most of that and then give us an executive summary, here are the points that we

3 would like you, the task force, to take away and

4 then we go to questions and answers.

5 MS. DAILEY: Okay. That's good info. You still

6 want them to attempt to give you the information

7 that we're asking for on effectiveness and

8 measures of performance and accountability. We'd

9 still like them to go at that information for you,

10 right?

11 GENERAL HORST: Yeah, I think so, and then

12 basically we'll drive them to the slide we want to

13 discuss if that's where we're going to go with

14 this. So they tell us in five minutes what they

15 think is really important for us to know and then

16 we basically drive them back to their slide deck

17 and ask questions based on what we feel we need to

18 understand. I think that will work. That will

19 get us back on time, too, because a lot of the

20 discussion is just weighting as they get to things

21 and reality is we kind of know where we're going

22 to go with this. I have to ask one other question

1 and that is is there any other kind of structure?
2 I mean right now the way this is structured is
3 over the trips and over the research plan, etc,
4 but is there another structure in terms of -- you
5 know we laid out some things this morning
6 that we may want to be looking into or talking about in terms of the DIVBIK and diagnostic criteria, you know
7 what we know, but are there other venues in terms
8 of in terms of -- I mean we've got a lot of
9 expertise in this room. Are there some things we
10 feel are not going to be brought up by the
11 services, not necessarily by critics of the
12 services and DoD, and things that we know
13 internally that we need to have time to discuss
14 and bring in expertise on whether on the trips or
15 into this forum? Because I mean if you think about
16 it I mean I'll use some themes that have kind of
17 come out of this. So Mack, you've been pretty
18 good at pointing out things that are available to
19 people who separate and go into a different system
20 versus things that are available to people who
21 stay on active duty, okay. We've heard a lot
22 about family issues and longevity of whether or

1 not people -- you know what is recovery and so
2 what should be expected and should we bring in any
3 experts to talk about what should be expected in
4 some of these cases? You know it's kind of the
5 Kubler-Ross approach in terms of the different
6 stages of rehabilitation and what should be
7 expected. But, again, I'm just saying are there
8 some areas that you're not sure we're going to get
9 covered based on what you've seen thus far from
10 last session and this session that you want to
11 make certain we bring
12 forward? Things like job placement is something that obviously is very -- vocational training in terms of the
13 military other than cross training is very slim
14 from what we've seen in both the two presenters
15 thus far.
16 MASTER SERGEANT MACKENZIE: One of the things that
17 I saw was exactly that, sir. Was you tell me how
18 many people you're retaining or how many people
19 you're retiring but you're not telling me what are
20 you doing for them when you do that? You know
21 what is this retraining? You know for instance
22 with the Colonial today was you know we don't have

1 anybody like that and I walked right up to you and
2 said well you need to go follow up on this guy
3 right here because yes, you do. Which is why I
4 highlighted the Air Force in saying how old is
5 your system? Let's the lead up with that. But
6 the other problem I have is just in the standard
7 you know upward brief, execution-type brief. You
8 come right out and say here's what you wanted me
9 to provide, I don't have it. Here's what I'm
10 doing to work on it but I don't have this
11 information. You know, I think there's a lot of
12 time spent in descriptors and beating around the
13 bush instead of coming right out and saying you
14 asked for this, I don't have this information but
15 this is what we're doing to work on it, next
16 topic. You know something a little more fluid in
17 their response to us and giving us the ability to
18 respond to them and
19 question some of their processes because they don't have the results we're asking for you know and that kind of
20 stuff and some of the little more -- let's get
21 effective here. You know it's not personal. I
22 just need this information and we need to talk

1 about it, let's get it out there.
2 GENERAL GREEN: Yeah, I think we get closer to
3 that with what's been suggested in terms of a
4 format. I guess I was trying to go a step
5 further. I mean right now we're bringing in the
6 service reps that run these programs so are there
7 some people that we want to bring in? I mean hey
8 we could talk with the Vice Chiefs about what
9 their expectations are. I'm sure we'd get an ear
10 full, okay, or we can talk with personnel
11 communities if we're going to talk jobs to see
12 about how do they look at retraining or you know
13 how do they make decisions on retraining or on --
14 you know pick the subject. I'm just saying that
15 are some things that right now are not necessarily
16 in our scope because we're focused on the existing
17 programs and so the question is are there things
18 that we should be looking at based on the
19 expertise here that may not be looked at right now
20 by DoD?
21 GENERAL STONE: Number one, I think that the
22 library that we continue to build would be served

1 very well if a brief XM would be included in the
2 release of those things, you
3 know, whether it's GAO or DAIG. If you could give us a little brief XM so that we can decide sort of how deep we
4 need to dive into that piece of information but
5 you know our final report will be informed by that
6 data link as we use it to help direct our
7 approach. Number two, I think the Department of
8 Labor would be very effective at taking a look at
9 some of the work that's going on from a post
10 service employment relationship and some of the
11 things. Number three, I think the Department of
12 Veteran's Affairs, I realize you sit here, but I
13 think we really need to understand sort of their
14 view of our systems as we encompass and wrap this.
15 We heard a hundred times the last two days, the
16 warm handoff. Well, you know what the heck is
17 that and is it as warm from the receiving end as
18 people perceive it to be on the giving end? So
19 I'd like to think that I'm giving a warm handoff
20 to my children. At times they have different
21 opinions.
22 DOCTOR TURNER: I think like as we all learned in

1 medical school, as staff officers, work
2 transferred is work accomplished. But something
3 else also and, again General Green brought it up,
4 this is a five-year program and I was wondering if
5 there's some ways we need to do we need a report
6 on everything every year or is there some things
7 we need to frame over the five-year, well, we're
8 going to look at jobs every two years or because
9 you know there
10 won't be much change or how best to frame the things we look at most efficiently, what things do we look at every
11 year, what things do we frame in the longer
12 standpoint and again, I'm just throwing this out
13 to think about is we might can best use our time
14 on some things now to get started and then some
15 things maybe over the longer haul.
16 DOCTOR GUICE: I believe Denise, you had checked
17 with the Office of General Counsel and their
18 interpretation of the statute is that we must
19 report on everything that's in the statute every
20 year. That means that you don't have to go very
21 deep on some things and then you can go deeper on
22 some other things or that we can you know start to

1 figure out our layering of information, if you
2 will. You know my interpretation of what we're
3 going to accomplish this year because of the time
4 is you know we'll be about an inch deep all the
5 way across and maybe two inches in some areas
6 where we've been able to dig a little bit more but
7 then certainly the next year, we've got to be four
8 inches and then set some things up. For instance,
9 if we don't -- if we start to recognize that
10 nobody has outcome measures, nobody can tell us
11 whether their programs are effective, then you
12 know, again, the recommendation could be you got
13 to have these things in place and two years from
14 now we're going to come back and ask again.
15 DOCTOR TURNER: I think that's exactly right. I
16 think
17 like the first year, obviously, will be generally across
the board but we might say okay, we're -- you know we're
18 identifying this, this year we're going to talk
19 about everything but we're going to kind of
20 feature outcome measures this year so be ready.
21 This year we're featuring outcome measures or one
22 year we're going to feature -- we're going to

1 report and everything, but we're going to feature
2 jobs or we're going to feature disability or
3 something. So just maybe there needs to be an
4 emphasis items for the years.
5 MR. REHBEIN: Couple of thoughts on the
6 employment, on the jobs issue particularly. You
7 know we hear from the services about what they're
8 doing to prepare the people but I don't -- finding
9 out how well prepared they actually were is
10 unknown at the moment. I'm wondering if we can
11 identify some folks that operate voc rehab
12 programs that maybe would have some expertise as
13 to how well their folks were prepared or I, and
14 this is only a name, I'm not advocating anything
15 here, the gentlemen from Able Forces rather than
16 promoting their program, get their feedback as to
17 what they saw of the folks that came out of the
18 military. Were they as well prepared as the
19 services are trying to make them?
20 DOCTOR GUICE: I know there are a couple of things
21 and I
22 ask Suzanne. I believe that there is an ongoing study
that we should be able to get results with the voc rehab

1 program at VA.
2 DOCTOR LEDERER: Correct. I don't know when the
3 results are going to be available but certainly
4 ICF will be more than happy to read them as soon
5 as possible.
6 DOCTOR GUICE: And to the other thing. I would
7 wonder if the right population to ask or the right
8 target audience would be employers instead of
9 someone who does voc rehab training and you might
10 think that people who go through one program
11 wouldn't necessarily access another but certainly
12 the employers, at the end of the day, are going to
13 be able to tell you you guys are doing a wonderful
14 job or not so much. MS. CROCKETT-JONES: Would
15 that be information that the Department of Labor
16 might have if might we say that that -- well, if
17 we ask them to speak to us, could we ask them if
18 they have that information?
19 MR. DRACH: Well, I just retired from the
20 Department of Labor. There's a lot going on in
21 the area of employment.
22 Able Forces, for example, and there's a lot of

1 organizations out there that are trying to do the
2 right thing, but I think there's also an image
3 that a lot of them have, particularly for the
4 severely disabled, wounded, ill and injured, that
5 they can't get out of the
6 house. They need home-bound employment. A lot of these organizations, they're looking for money to provide
7 training, to provide you know substances to
8 themselves so that they can provide the training.
9 I probably shouldn't say this because I have a
10 little bit of a bias here. I've been doing this
11 for 42 years. I have never met a disabled veteran
12 from my generation or subsequent, including this
13 generation, who said I am so disabled, help me
14 find a job that I don't have to leave the house.
15 Never once, never once in 42 years and I've seen
16 from this generation of veterans that, and we've
17 heard this before, what's the first thing they say
18 when they wake up at the hospital? When can I go
19 back to my unit? You know, this is a "can't do"
20 generation. You know it's a want to do
21 generation. They don't want to go out there, they
22 don't want to work in competitive employment; they

1 want to go out there on their own. The problem
2 that I've seen over the years is the match. How do
3 we match the skill sets of the returning service
4 members to the skill sets that the employers are
5 looking for? There's not an employer in this
6 country that's not looking to hire veterans,
7 particularly wounded warriors. We give you a
8 wounded warrior with a college degree and
9 particularly with a security or a TS, I can get
10 him a job tomorrow at $80,000 a year. Not a
11 problem. Not a problem.
12 Employers are looking for them. You've got some of the
younger service members that are coming back that
13 basically infantry, MLS, they've got good skills
14 but they don't realize what those skills. You
15 know you get somebody (inaudible) may have been a
16 squad leader in Iraq or Afghanistan, leadership
17 skills that are sometimes very difficult for a 21,
18 22 year old to translate into the language that
19 these civilian employers are looking for. There's
20 also no centralized data base at the present time.
21 The Army just recently announced just about two
22 weeks ago a new portal that (inaudible) working

1 with a group called direct employers and there's
2 about 700 employers who have agreed to work with
3 this centralized database through the Army
4 Reserves so you have the demand side. You have all
5 these employers saying, this is what I'm looking
6 for. Now where is the supply side. Okay, as far
7 as the Department of Labor goes, the supply side
8 is through the Career One Stop. The Career One
9 Stop used to be called the Job Service. It's had
10 different iterations, different names over the 40
11 years, 50 years. It's commonly called the
12 unemployment office because that's where you go
13 when you're unemployed and you sign up for your
14 unemployment insurance benefits. This generation
15 does not use the Career One Stops. Employers for
16 the most part do not use the Career One Stops
17 except
18 those that are required to list their jobs as federal contractors. They list their jobs but I think you'd be
19 hard pressed to show that there is a system in
20 place that is meeting the demands of the employer
21 or the demands of service members. How do we
22 match those skills? We've heard for years and

1 years but it's not in this generation and we hear
2 a lot from employers, I don't understand these
3 resumes. Look at all the acronyms we saw the last
4 day and a half. Somebody that coming out of the
5 service, General when you do your resume, done
6 intentionally or unintentionally, you're going to
7 have a lot of military acronyms. Employers don't
8 understand what those acronyms are so we need to
9 try to get these transition service members to
10 understand this is (inaudible) language. I don't
11 think it's enough to try to educate the employers
12 on what the military they don't want to know.
13 They have a job they need to fill. They don't want
14 to sifting through all this information. You know
15 a lot of military service members with good
16 credentials are always in demand. They don't even
17 need a resume. They're being hired right out of
18 the system. They've don't need a resume. You've
19 got some programs that are going on right now with
20 Sysco, transition training academy. Sysco
21 Systems, the wounded warrior project and
22 Department of Labor are working with wounded and

1 injured at Balboa and

2 they just started a BAMC and I think they're at Eisenhower. Basically what they're doing is they're

3 training the wounded and injured while they're

4 still on active duty in Sysco Systems

5 acknowledging what's happening and I don't have

6 any critical data but I can probably get some,

7 what is happening, what we're seeing is that some

8 of these individuals they're getting out and

9 they're going to workforces. They're going to

10 work for Norfolk. They're going to work for

11 General Dynamic. They're going to work in IT type

12 jobs. Some of the ones that want to stay in, they

13 now have the IT training and they can change their

14 MOS so if they were infantry and now they've

15 become a Sysco Systems person, the command base

16 they hold, this is great. We'll give you a new

17 MOS.

18 We'll transfer you from infantry to (inaudible)

19 so

20 there's a lot of that kind of stuff going on. In

21 terms of studies, I can't put my finger on any

22 recent studies. There's been some studies on them

1 we've talked a little bit this morning about the
2 compensation. Can just did big study not too long
3 ago (inaudible) compensation system, it's like
4 four volumes and each volume is about this big. I
5 mean we could spend the rest of the five years
6 just reading all the reports that have s come out
7 on some of this stuff so it's a very, very
8 frustrating system when it comes to the employment
9 but how can we
10 prepare the transition service members for jobs that available today and tomorrow and when they're going to
11 get out. I don't think it's necessarily unique to
12 service members; it's what's going on in the
13 country today. We have a relatively high
14 unemployment of people who are trained or skilled
15 in certain areas but they don't match the jobs
16 that are out there. Sure, there's employers
17 higher every day, federal government is hiring
18 every day even if it's a freeze. They may not be
19 hiring new positions but they're back flowing the
20 vacant positions. Now do we get those matches?
21 How do we get those people trained.
22 GENERAL GREEN: You bring up another interesting

1 point. I mean, we've heard from all these
2 different folks, but all the services have
3 transition assistance programs and all of them
4 when you attend a transition program, all of them
5 tell you that you probably should do it about a
6 year in advance of separation and so one of the
7 questions that would be interesting is are we
8 doing any transition assistance program training.
9 Mack, did you get anything that way?
10 MASTER SARGEANT MACKENZIE: No, sir, but anyway,
11 are the I was going to ask that question on that
12 point too is we haven't asked the services and
13 what's their effectiveness and what's their
14 outcome in job placement for these
15 wounded warriors.
16 DOCTOR HORST: It's because we just focused on a process; we didn't focus on outcomes.
17 MASTER SARGEANT MACKENZIE: Right.
18 DOCTOR GUICE: And it's also very hard to get
19 because once individuals leave the military, they
20 become civilians and you can't get that
21 information unless you go directly to the
22 individual and the art of finding somebody after

1 they leave the military, it's catch as catch can
2 because every thing changes and they change
3 frequently so it is a bit of a problem. The group
4 and maybe its something for us to think about, the
5 federal agency that knows where everybody is
6 employed is the IRS but getting that information
7 is problematic.
8 MASTER SARGEANT MACKENZIE: But that's one of
9 those things you want to look at. If we're going
10 to advise the DoD, let's say there are people who
11 get adequate or appropriate employment prior to
12 departing the service, they're going out of the
13 service going straight into a job, whether that
14 through agency such as semblance of freedom, VA
15 voc rehab. In 2009 when I actually got to see a
16 VA person because I was no longer getting that, oh
17 you're active duty; we can't talk to you, and it
18 was, oh by the way, if you're getting out, this
19 whole process we can start this a year in advance
20 and they went after my
21 memorandum of disability rating and all these processes and we can start working this stuff through the voc rehab
22 versus GI bill through the process so although the

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1 system isn't perfect and there's a lot of missing
2 information, if we're making a recommendation for
3 how we do this better, we have to know the good
4 solid information as well as where the giant holes
5 are and if we're go into the Air Force and they
6 go, okay well we only know of 25 percent of our
7 departed warriors that actually got employed as
8 they were walking out the door. That's not saying
9 that I'm doing a good job but its like okay we've
10 got a 75 percent gap here, we're not really paying
11 attention to this or we don't have a way to track
12 this. How do we recommend that back to Congress?
13 MS. DAILEY: The jobs and unemployment and efforts
14 to re-employ was a requirement for this briefing
15 and the measures of success for those programs was
16 a requirement for the last two days and they got
17 short shift. The Army's briefer dropped out and
18 couldn't brief it but the briefing is in your
19 books and the Air Force slid through it. I think
20 their program is a lot more robust and there's a
21 subject matter expert somewhere in the A1 staff
22 who could talk to it a little more vigorously but

1 they have decided to devote one slide to it so the
2 re-employment efforts of the services got a short
3 shift
4 on this and unless we can find a way to compress the next effort, it seems it might get a short shift on the next
5 Marine Corps and Navy efforts also, and the real
6 question is, knowing that these programs are out
7 there just like you said Sergeant MacKenzie, is
8 how successful they are and do you want to
9 resource them more or would you make a
10 recommendation to resource them more or do you
11 want to make recommendations to shift it to DOL or
12 do you create some other resource to address
13 unemployment for our wounded warriors but every
14 one of the services have a program. How effective
15 it is, whether it's really employing people, is
16 the unknown.
17 MR. DRACH: Just following up on that, the
18 Department of Labor does one part of the
19 transition assistance program and that's the
20 employment workshops so they see about 160,000
21 separated service members a year that come to
22 these workshops. The employment instructor comes

1 into a room and there's 25 to 30 transitioning
2 service members generally in civilian clothes. No
3 idea who they are. No idea what their name is,
4 what their rank is, what their marital status is.
5 He only knows that he sees these 25 people out
6 there which in and of itself isn't necessarily
7 bad, there are some changes going to be made to
8 that, but right now that's the way it's been for
9 the last 20 years.
10 So the Department of Labor encourages you as you
11 transition, when you get out of the service, we want you to know that there's been boots on the ground back home
12 where you live, that the local veterans employment
13 representative or disabled veterans program
14 specialist I think it was on one of the slides
15 yesterday of these resources we want you to go
16 see that person. That's the person on the ground
17 that's going to help you get employment. Okay,
18 now 10 percent, 20 percent, 30 percent may do
19 that. We have the Department of Labor has no
20 idea how many go and register with that Career One
21 Stop so unless they know who goes to the Career
22 One Stop, there's no way to track them so they

1 don't know at the end of the day or at the end of
2 the year how many transition service members went
3 to the job service and of those how many actually
4 got placed. I think in part that's why General
5 Thurgood talked to this initiative with the Army
6 Reserves because he was saying where do my people
7 go? A lot of them are already job attached when
8 they activated. Not all of them. I think there
9 was a common mis-perception that the guard and
10 reserve were people that were already employed;
11 not necessarily true but those that were employed
12 and got activated, they have re-employment rights.
13 Okay, so the Department of Labor can track if you
14 file a complaint or an SGR might be able to track
15 but I think General Thurgood was thinking I
16 don't know what's happened to my Army Reserve members. I don't know what happened when they go back home because
17 the Department of Labor can't tell me whether
18 they're employed. Well the Department of Labor
19 can tell if they have a social and they can check
20 against IRS records or Social Security records
21 whether or not somebody is employment and they can
22 say for how long and so forth, but where the

1 frustration comes is if they don't register with
2 the system, how do I find out if my troops have a
3 job.
4 MR. REHBEIN: As far as preparation for work, just
5 about two years ago the Department of Home Land
6 Security made a commitment to do a better job
7 about hiring veterans into their positions. I
8 think they fulfilled it. They've done a very
9 active (inaudible) job fairs that I'm familiar
10 with. There may be that there's a source of data
11 there as to how well prepared people are when they
12 come to apply for a job and how many they've
13 hired, you know, what their experience is.
14 DOCTOR GUICE: There is a requirement for all
15 federal agencies to report the number of veterans
16 hired and it's a I think an OPM document. I just
17 saw it last week so we can get that and make sure
18 that everybody sees it. It doesn't answer the
19 question about whether they were prepared; it just
20 shows their annual percentage of the employees
21 compared to the private sector. It hires by agency
22 though.

1 MS. DAILY: I've gotten the picture that you all
2 want to do the employment peaks and I'm ready and
3 resourced to do the research and the investigative
4 process with it. Do you know where you want to go
5 with that? I mean, we can lay as much information
6 as we have out. What do you want to do with it?
7 DOCTOR GUICE: I think it fits under the enabling a
better future which is the, that particular group and it
8 seems to me what might be more interesting instead
9 of since the vocational rehab employment piece was
10 sort of missing from these two, it's maybe better
11 to have it so that we've got all the services and
12 the voc rehab and then maybe if someone from DOL,
13 it's more of a power presentation so that we can
14 just clear you right up across the spectrum and
15 answer some of those questions about, okay this is
16 why you guys are doing; is this what you're seeing
17 or what are you seeing that they need to know and
18 have a more of a give and take among all the
19 players so that we get a better picture with sort
20 of one group as opposed to kind of having to loop
21 it
22 together.DR. GUICE: From each of our meetings.

1 MR. DRACH: I'd like that and the Department of
2 Labor should be part of that panel.
3 UNKNOWN SPEAKER: One of the things that I saw
4 was..
5 MS. DAILEY: That's easy. That's easy. I mean
6 that's-that's not a problem. And any other kind
7 of leg work for research to robust out this area
8 for you, we can do. What type of recommendation
9 would you make: To fund it more on the D. D. 214
10 side; to robust up the programs on the D. D. 214
11 side?
12 GENERAL STONE: The first piece, Denise is the data
13 gathering of what percentage of people are employed. If they come out with a hundred percent disability, you
14 know, how are we doing with that group? I dropped
15 the puck at a hockey game on Saturday night with a
16 transected spinal cord soldier who gave me an
17 earful about the fact that he got everything he
18 could possibly have except one thing. He says
19 I've been sitting at home for two years. And he
20 said I can't get anybody to pay attention to me to
21 employ me and he said I've got some really good
22 skills. And you know, I think the first thing to

1 do is just try and do the data gather. And if you
2 get the data gather then you can inform the
3 process to decide where we need to go with this.
4 And where have we dropped the ball or are we doing
5 pretty well how we should?
6 MR. DRACH: You know, I don't, I don't dispute,
7 that suggestion. I think it's a good suggestion.
8 I don't think that the VA has that data of
9 somebody that's specifically a hundred percent
10 rating. Say for example, paraplegia; it's an
11 automatic hundred percent if you're paralyzed.
12 You know, that's a statutory uh, uh, rating.
13 Paralyzed veterans of America years ago did a
14 survey of its members. I don't know if they've
15 done anything fairly recently or not and we might
16 want to reach out to them. Their membership,
17 which is not every paralyzed veteran in America
18 but a fairly substantial membership,
19 ninety percent were unemployed. Ninety percent were unemployed. A lot of them had given up employment, given
20 up looking for employment because back at the time
21 that study was done, you didn't have the
22 environment that you have today under ADA, where

1 buildings have to be accessible, so forth and so
2 on. But the PVA about three years ago started
3 their own voc-rehab and employment program.
4 That's been relatively successful. They're in
5 four sites: Richmond, Palo Alto, Minneapolis, and
6 I think they just opened one up in Brook. So it
7 might be instructive to get some information from,
8 from Paralyzed Veterans of America with what
9 they've done. They also, it gets very complicated
10 when you start asking VA, and this is not a
11 negative, for percentages or numbers of people
12 that are employed that have a hundred percent
13 disability. I know that they do, uh, I think
14 it's, I don't know in four or five years, they do
15 some sort of a study and I think their most recent
16 one either is due very soon and there might be
17 some good employment data in that. Um...
18 DR. GUICE: I gave Denise a study that was
19 completed in '08 regarding employment, a fairly
20 nice study, but it was sort of pre-recession, so
21 you know, you'll have to take it with that, with
22 that lens, but we, we do have that information and

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1 then I think with the uh, potentially

2 maybe getting some information from ICF regarding their new study with voc-rehab would help a little bit. But

3 getting the employment data after someone becomes

4 a civilian is tricky.

5 DR. PHILLIPS: Would the veterans' organization

6 have some that information?

7 MR. REHBEIN: Not a great deal. DR. PHILLIPS: No.

8 MR. REHBEIN: We attempt, and I can only speak for

9 one of them, we attempt to facilitate the process

10 of people finding jobs by running job fairs and we

11 attempt to collect some data from the vendor's

12 afterwards, but it's very fragmentary. It's

13 certainly- it's certainly not anything that I

14 would base a lot of recommendations on.

15 DR. PHILLIPS: Could we ask them to do a study? I

16 mean that might not be a difficult thing to do.

17 Are you employed? Yes or no and why aren't you?

18 Are you retired or, I-I don't know. Maybe, maybe

19 something like that could be --

20 GENERAL STONE: You know, Steve, this may be right

21 in front of us. In that both of the services that

22 have briefed us have organizations that reach out

1 and the Air Force has, you know, seven hundred
2 airmen that they've retired and they have
3 organizations that reach out. They have to have
4 some visibility of that of where those,
5 those airmen are. The eight thousand that Colonel Gadson has responsibility for, how are they-how are you doing
6 with it? Are you tracking it? And, if there is no
7 data, that may be an answer. That may be an
8 answer. We need some real data on how this
9 population is doing.
10 MR. REHBEIN: I frankly wonder sometimes why the
11 services don't run their own job fairs. We had
12 one in Louisville, Kentucky some years ago where
13 we had busloads of people from Knox and Campbell.
14 People that were about to ETS looking for
15 positions and here was a, and here was a place
16 they could contact a whole group of vendors.
17 MS. DAILEY: Well, but they do. In fact, the
18 Army's got one going on right now, today and
19 tomorrow. So, I mean that is on going. They are
20 engaged, they are actively engaged in job and
21 reemployment and finding jobs for the population.
22 MR. REHBEIN: If we could, if we could at least

1 get some of that kind of that data what the
2 services are doing as far as job fairs and
3 employment opportunities, that would be helpful.
4 MS. DAILEY: Well, again they will, that, that was
5 teed up for today for both services and um, that
6 ran out of time or they made other choices on what
7 they wanted to emphasize.
8 MR. REHBEIN: And that's, that is what I was
9 going to
10 bring up. So all these people have these tracking programs. You know, they are tracking these guys. Army,
11 AW2, AFW2, Navy Safe Harbor, all these people that
12 are tracking people beyond their military life
13 would know directly, is my guy employed or is he
14 not employed and is he satisfactorily employed?
15 Or did he choose not to be employed; that
16 information is out there. We just, or they
17 haven't the availability to collect that
18 information through the systems. The question is,
19 are they doing all of that and do they have a
20 sense of responsibility to do that. The other
21 thing too, is I saw today in a, in a unique
22 opportunity within the Air Force portion with the

1 personnel of the A-1 briefing, one of the things I
2 did not ask and it-it's, I wish I had, was of
3 those returned to duty that they were tracking on
4 those slides, were they returned to duty in their
5 original specialty code -- their original job
6 code? Were they returned to a different job code
7 and if so were they retrained? And what steps are
8 they taking to do that when they go to retain
9 airmen? And we had the personnel person right
10 here and I blew it. But, you know, that's one of
11 those questions too that we've also made through
12 optimizing ability, a requirement that we want to
13 find out is-is are we, as a, are the services
14 making the effort to keep these guys by either
15 retraining or are they only looking
16 at can they go back their original job and did the rest of them get MED boarded out? Um, did...
17 GENERAL GREEN: Well, that's a fairly
18 straightforward question. And we could ask all
19 the services, so I mean for data calls like that,
20 I think we just have to frame the question and
21 then send it over and get the percent retrained of
22 those retained. I mean, you know, to kind of let

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1 us know. I mean, I think it falls into the same
2 thing as having a job fair or doing some of the
3 other issues. So, the, the...
4 MR. DRACH: On March 11th, the Department of
5 Labor, the Bureau of Labor Statistics will be
6 issuing a report that's an annual supplement. It
7 used to be every two years, and then last year was
8 the first year of a consecutive year. It's going
9 to be done every year, now.
10 It's done in August. It's a supplement to the um,
11 to
12 the current population survey that's done by the
13 Bureau of the Census. And uh, it drills down much
14 more deeply and it's more accurate than the
15 monthly data. It doesn't, it gives you a lot of
16 information on the percentages, numbers in the
17 labor force, numbers out of the labor force. It
18 drills down to periods of service. Now the one
19 thing when you look at this, you have to remember,
20 when they say era, they mean era. So the era
21 would be 9-11 through today. Not just in theater,
22 it

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1 would be all veterans who served during a certain period of time. There have been people that have misinterpreted
2 that and said oh these are OIF/OEF veterans.
3 Well, yes. OIF/OEF veterans are included in this
4 population, but it's not, there's no break out of
5 those who have actually served in theater. It
6 will tell you the percentage and it's based on,
7 you know, on, on a sample, but it will tell you
8 the percentage of unemployed disabled veterans. It
9 will give a, a number of unemployed, uh, veterans,
10 of disabled veterans who are unemployed and the
11 number of disabled veterans that are out of the
12 labor force. Out of the labor force could be
13 because they are retired; it could be because
14 they've given up; could be because they're too
15 disabled to work, uh, you know, any number of
16 factors come into play. It can be broken down by
17 sex, by um, by um, uh, um, minority ethnic status,
18 Hispanics, there's a lot of good data there. Uh,
19 there's- I believe there is also in the
20 supplement, data on industry, industry data. So,
21 you can look at what percent of veterans who are
22 working are working in manufacturing, whether

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1 we're, how many are working in the area of sales,
2 how many are in retail. Again it doesn't get
3 very, very specific but, it gives you something.
4 It gives you a snapshot in pie. So when that
5 comes out, I'll be getting the link, I'm on their
6 distribution list. And the link
7 is about a four or five hundred page report with nothing, almost nothing but data. There are some narratives. But
8 I can send the link to Denise and she can get it
9 out to everybody and then we can get somebody from
10 the Bureau of Labor Statistics to come in, if you
11 want to discuss how the data is collected, how the
12 data were used, so, you know, all that stuff.
13 MS. SABOTA: I also recommend, you've talked
14 about the services coming in, but uh, the
15 Department of Defense and the under secretary for
16 personnel readiness, one of his strategic goals is
17 employment of wounded warriors and the Wounded
18 Warrior Task, uh, the Wounded Warrior Care and
19 Transition Policy office is actually has some
20 initiatives for employment and education. So it
21 might be something that you would want to listen
22 to that brief. They've got statistics on what

1 they see as the unemployment rate for that-that
2 work group. So, that might be another avenue for
3 you to look at.
4 DR. GUICE: What I'm, what I'm sort of craving
5 right now is more information and I'd-what I'd
6 like to do is: ask our research team. We've talked
7 a lot of about things that we each know that are
8 available that provide a little snapshot of
9 information, but since this seems to be an area
10 that we're interested in looking at, I'd like the
11 research team to look at the DOL supplement, the
12 Census Data, the VA study that I provided to Denise about information from the voc-rehab study that's on going as
13 well as the one that was done several years ago;
14 the C. N. A. study that was done after Dole-
15 Shalala looking at disability compensation, which
16 does have some very good employment information in
17 it; and then perhaps an environmental scan about
18 what the employment challenges that we continue to
19 hear about. And to provide to us an issue brief
20 blowing up that information so that we can look at
21 it in terms of, you know, what are those big
22 problems, where do we have missing information,

1 you know, what can we definitively start to drill
2 down? It will save us time, uh, having to do it.
3 I- we certainly probably won't have it by the next
4 time we meet, but maybe the time after to know
5 it's coming. And then when we have a group to
6 come in, if we do have the services and the
7 Department of Labor and the Office of Wounded
8 Warrior Care and Transition, as well as whoever
9 else we feel like having up there, we could use
10 that issue ring to better inform us about
11 targeting questions for that group. Does that
12 sound reasonable?
13 GENERAL STONE: [Nods yes].
14 GENERAL GREEN: We have some visits that are
15 going to start here within probably the next two
16 weeks and probably when we get through a little
17 bit of the uh,
18 follow on repeat, so Denise back over to you. And let's get this moving again.
19 MS. DAILEY: Can I get you all to go to tab N?
20 Can we start at tab N? First thing, I'm-I'd just
21 like to do is just familiarize ourselves with this
22 focus group protocol. And so, very quickly in tab

1 N, the first thing you see there is it says focus
2 group protocols. The first one we're looking at
3 here is service member protocol and the second one
4 we look at are family member protocols. Then I
5 want to just, kind of create some situational
6 awareness on what a focus group protocols will
7 look like when you get out there. The very first
8 items that you've got are introductory
9 information. We're going to talk about, you know,
10 introductory information. You're going to talk a
11 little bit about, you know, introducing yourself
12 and the wounded warrior or the recovery warrior
13 task force. We provide that information to you,
14 so you don't have to kind of pull it out of your
15 hat. It's there for you to use as a queue. And
16 then, and then, you talked a little bit about how
17 you're going to do the focus groups, what are some
18 of the ground rules. And then Susanne is going to
19 take you through this. So I'd like you to go to
20 page three now. So, at the bottom of the page
21 three, ladies and gentlemen, is something that
22 you're in the format and now a sequence

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1 that you're very familiar with over these last two days. Our first set of questions for a service member is his
2 medical case management. So with, again, what did
3 we lead with in most of these briefings? Well at
4 least this morning we led with medical case
5 management. So, that's one of the first sets of
6 questions you're going to be talking to service
7 members about. Any concerns about that? Is that
8 where you want to be?
9 DOCTOR GUICE: My concern about it is asking
10 someone who your medical case manager is. I'm not
11 sure what kind of an answer we would expect. To
12 me, it's more about who helps you with your
13 medical problems and then seeing that they're
14 pulling out of this what their resources are, that
15 they really understand them. We heard today too
16 that services do things differently and the
17 structures are going to be different and so the
18 responses should be different. But I, but I'm a
19 little worried in going into a room and saying
20 well, you know, who are your medical case managers
21 and having people really understand what we're
22 trying to get from them. It's, they may, may or

1 not, may or may not know that Mary is my medical
2 case manager and for what aspects of my medical
3 care.
4 MS. DAILEY: Okay. And we do cover a little bit
5 of that at the bottom of page three. We are
6 asking them things like, you know, the medical
7 case manager's part of your
8 recovery team along with the commander, the recovery care coordinator or the federal recovery care coordinator and
9 we're asking you to a take a little bit along the
10 lines of the medical case managers typically a
11 registered nurse. Maybe that would get them
12 there.
13 GENERAL GREEN: I think that my personal
14 impression in looking through this for the first
15 time is that you need a prelude to this. Okay?
16 The prelude to before you go on to the medical
17 care medical care case management would be to ask
18 them who is the person most instrumental to your
19 progress in this transition process. So let them
20 specify whether it's medical or non-medical. I
21 think that would be very helpful to us. And then
22 when they say that, the following question is, is

1 it how have they best assisted you? Is it about,
2 you know, easy appointment schedules or because is
3 it because they make things go faster. I mean,
4 the question is why do they consider them
5 valuable, and if we understand a little bit from
6 the casualty or the family for that matter as to
7 who they consider the most valuable and why, then
8 as we get into the more specific questions, we'll
9 find out more I think.
10 MS. DAILEY: Okay. All right.
11 GENERAL GREEN: I would also say since we're
12 talking about it, is we need to ask some outcome
13 questions. So
14 what is the outcome that they value? I mean, is it speed? Is it better information? Is it reception. I
15 mean, something that they value so we're looking
16 at it through their eyes as we start this.
17 MS. DAILEY: Okay. So what kinds of support, so
18 we're not any where in the ballpark with these
19 protocols, am I not there at all?
20 GENERAL GREEN: I think you're in the ballpark.
21 I'm just saying that before you jump to a single
22 we're going to go medical care than non-medical

1 case management, it would be nice to hear up front
2 whose the most valuable person in the chain for
3 giving you information or for assisting you in
4 this process.
5 MS. DAILEY: Okay.
6 GENERAL GREEN: Let them tell us. We heard from
7 the Air Force that the RCC is the most valuable
8 person. What if we find out that that's not the
9 most valuable person? Okay. In other words,
10 what's the mismatch between patient experience
11 and it's really a simple thing by, if before
12 you're number one the on medical care case
13 management, you ask --
14 MS. DAILEY: Okay. Okay. So those of you going
15 out, you kind of, does that lead you into your
16 discussion a little better for those of who asking
17 these questions, does that -- are we getting there
18 for you?
19 MS. CROCKETT-JONES: I think there's something that we might want to do even before that. I think it might be
20 instructive to ask if they are, who they would
21 describe as part of their team because -- not just
22 who's important, because I think if we need to

1 know we've got all these triad of care and this,
2 you know, these -- this is the team and this is on
3 the team, but if that service member feels well I
4 go see my docs, if they have no connection to
5 various members of the teams, that's significant.
6 That's a gap that we need to know before we can
7 even -- it's no sense in asking who's the most
8 important that won't give us all the data we need,
9 as far as their perspective if they don't even
10 know about some of the people. We don't know if
11 someone is unimportant if they're not even making
12 a connection. Do you see what I'm saying? So I
13 think first thing we need to do is get an idea of
14 how much service members feel they know and are
15 empowered in their own care and knowing the team
16 was there to help them. That I think would be the
17 first step to say do you know who's your team and
18 how comfortable are you in what you know is
19 available to you from that team and then whose the
20 most important member of that team to your care in
21 your experience?
22 MS. DAILEY: Okay. All right. And Suzanne, you

1 there? No.

2 GENERAL HORST: I think even before the question Suzanne posed is another question that has to be asked. General
3 Williams told us the number one thing that's

4 important to him was the comprehensive recovery

5 plan, comprehensive transition plan. WTC

6 commanders says this is my number one priority, so

7 if the WTUs are not talking in terms of

8 comprehensive recovery plan, comprehensive

9 transition plan, then we're kind of out there a

10 ship without a rudder. There's, he articulated

11 structure. He gave us three pillars. Here's my

12 number one priority and so I think we've got to

13 set the stage by saying the warrior transition

14 commander's number one priority is your recovery

15 plan and your transition plan. And then who are

16 those people in the process that help you with

17 that, but if our wounded warriors and their

18 families are not talking in terms of recovery plan

19 and transition plan, we have a huge disconnect

20 from what the headquarter says and what, where the

21 rubber meets the road. MS. CROCKETT-JONES: Let

22 me just modify that to say we don't want to put

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1 them on the spot. Let's just ask them if they
2 know if they have a comprehensive recovery plan.
3 DR. GUICE: I'm not even sure I would do that
4 because you're sort of leading the witness. I
5 think what you want to do is start with, what have
6 you needed in your recovery and how have you
7 articulated those needs and who
8 helps you accomplish them and if they don't mention independently well I've got this great thing now, the
9 comprehensive transition plan and boy it really
10 coordinates everything, then I think we have a
11 problem. If they don't bring it up, I'm not sure
12 we should, again lead, because somebody's going to
13 say, oh yeah, we're supposed to tell you that we
14 have those.
15 GENERAL GREEN: Can I -- MS. CROCKETT-JONES: I
16 have a question about that, though. I know that
17 there are going to be several people who, unless
18 there are going to be people who can't necessarily
19 form the phraseology, even if they have sat down
20 every week and discussed a comprehensive recovery
21 plan with their primary care manager they might
22 not if you don't necessarily use the right words,

1 they still might not be able to say oh yeah,
2 that's right I have a plan. That's what we talk
3 about every week. They might never get, there's
4 a, we might have ask it more, start with a broad
5 then maybe say what about a plan. We might have
6 to prompt a little in order to have people be
7 clear about what they're really experiencing.
8 GENERAL STONE: You know, Suzanne, those of us that
9 go out in the field as unicorns, it's hard to get
10 people to talk to us. We work a long time to get
11 people to talk to us honestly. You have a 90-
12 minute session with 45 separate
13 questions with ten people in the room all of which are nervous and I don't care how you try to diffuse them, I
14 think you take this is the key words that you're
15 looking for and you throw the word out and in some
16 manner allow them to come back and talk to us or
17 you're going to end up, I don't know how you get
18 through this with the introductory phase of this
19 and to be courteous and try to diffuse their
20 nervousness and get through 45 questions in a 90-
21 minute process to get anything out of it.
22 GENERAL GREEN: I think that you can shape this.

1 Okay. And the way I think you can shape it is
2 you've got your warm up and introductory questions
3 with the 1-2-3 kind of where are you in your
4 process? And then I think you can as part of the,
5 after you do your little bit of discussion, you
6 can ask more questions. And so you can ask whose
7 a part of your team and helping you get through
8 the recovery process? If they don't mention the
9 clinical care person or they don't mention that,
10 then why would you go through these other
11 questions? Whose most valuable to you as you face
12 this? Okay. I don't know, they may mention a
13 family member; you just don't know which way
14 they're going to go. What is it about this
15 individual or team that makes them valuable?
16 Okay. And now, and then do you feel you have an
17 active part in your recovery plan? Okay. And
18 now, you know that they know
19 they have a recovery plan or not. I mean, you mean, and so now you can decide based on the questions you get what
20 else are you going to ask.
21 GENERAL STONE: Sir, you have.
22 GENERAL GREEN: OMG! I do think we can shape it

1 and then based on the responses, you can go to
2 where it makes sense.
3 DR. PHILLIPS: And I'd also ask that you not get
4 into something that you know someone else is
5 getting. Just to say you can ask those questions.
6 GENERAL GREEN: I would just do that at the end
7 after you've gone through whatever else you're
8 going to ask and so, I think you can shape this
9 with like seven questions.
10 You know, so you kind of lead in, and then you ask
11 four
12 very broad questions and see what the issue is and
13 and then you know if you're going to be able to
14 get down to the specifics or if you're not going
15 to be able to get down to the specifics. MS.
16 CROCKETT-JONES: Exactly. So you need to start
17 broad and then that point is --
18 GENERAL GREEN: Yes.
19 MS. DAILEY: We do have several topics here,
20 basically in which you have medical case
21 management; you have non-medical case management;
22 they're in the DES system. You have DES so that's

1 three; and then we touch a little
2 bit on legal support so that's four. Then we talked about vocational training, transition training, that's
3 five, and then six is their service for TBI and
4 PTSD and then you wrap up. So there's really six
5 topics there that we've provided you some robust
6 questions. Once you're in the topic, you can
7 probe them with or you can elicit information from
8 them with.
9 DR. TURNER: I would agree that we're going to
10 stick to some kind of structure if we're going to
11 have any consistency between the visits. And
12 unless some giant turd floats to the top of the
13 punch bowl, I would stick with the structure there
14 somehow.
15 MS. DAILEY: Suzanne, Dr. Lederer, would like to
16 add something.
17 DR. LEDERER: Hi folks. Originally we hoped that
18 you would not only add your perspective as you
19 already have done and I appreciate your thoughts
20 on how to ease into that line of questioning, but
21 in addition, we really were hoping that you would
22 cut down the length of this protocol. It is,

1 General Stone, far too long. It is not doable
2 with the 90 minutes. It's going to cause great
3 frustration for you and the participants. So
4 personally I think we need to either eliminate
5 some of these topics from the protocol or delve
6 into each one at a pretty superficial level.
7 DR. TURNER: I would say maybe something as prioritizing them. Hit the first, put your best foot forward or the
8 ones that are most important to you. So if we can
9 may be prioritize some of these questions and make
10 sure we get those out of the way before we dance
11 into something else. MS. CROCKETT-JONES: Can I
12 make a suggestion? If we have the topics, if we
13 have the questions to go speak to a group and to
14 get them to give us that information, then what's,
15 some of these aren't even going to be applicable.
16 We might have a group where no one is receiving
17 TBI or
18 PTSD or where no one is currently in the DES,
19 okay? So we'll be able to eliminate those. It's
20 kind of hard to see it in this format, but if we
21 had almost like it in the form of topic cards, we
22 would know that those are the things we want to at

1 least introduce and open the floor to get
2 discussion on and only use the in-depth questions
3 if that's pertinent to the group we are
4 addressing, so that we can be flexible. Still
5 cover all the topics, but still have them in front
6 of us, but each group would be able to give us
7 what they actually have to give us, rather than
8 asking them questions that is not relevant to them
9 or for which they have no, no data to give us.
10 DR. LEDERER: You know, I like your idea, but based
11 on my experience apart from the DES question
12 where, where there
13 are many inflations that simply have not rolled out IDES yet, so we won't have to address that with them. Apart
14 from that topic, what you'll discover is that
15 there's will always be somebody in your group who
16 can speak to each and every topic. They're not
17 going to answer us a block, so there will be
18 somebody who has had experience first-hand or
19 second-hand with the TBI and PTSD services and
20 with every topic there.
21 MS. DAILEY: But I am concerned that if we do go
22 out and ask, even if there's no one is in the

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1 group, Congress wants us to touch base with the
2 topics in the field. MS. CROCKETT-JONES: That's
3 based on, no response from the room.
4 MS. DAILEY: Yes, we would move on for sure.
5 Again, as Suzanne said this is kind of a
6 recommendation on topics of service members and
7 Congress has a distinct interest on getting
8 feedback from, from the field. That's really why
9 we included these in here, because again we can
10 gather data. Congress validates this data by the
11 fact that we've asked about it. The service member
12 protocol again we've got five topics there. Now
13 the family member protocol is much smaller. If
14 you'd continue on, the last page is the eighth
15 page and then it starts at page one. And then
16 there's some introductory information. But for a
17 family member, we're
18 go straight to, and that's on page three, we're going
straight to support for family caregivers. And then we
19 would ask about the recovery care coordinator. So
20 that's sort of like topic two unless it hasn't
21 already come up. And then for family members,
22 topic three is what's your chain of command doing

1 for you.
2 MR. DRACH: Can we go back to the caregiver for
3 just a moment. Without having a chance to look at
4 the subject, you know this is our controversy the
5 last couple of weeks, about the VA's lack of
6 expeditious action on implementing the new
7 caregiver Bill and I know Secretary Sinseski
8 called up the bill and some other things. I think
9 that if we talked to caregivers, we going to find
10 some levels of frustration on a lot of issues that
11 may not be covered here. I'm not sure what I'm
12 going to say here, or where I'm going with this,
13 but I'm just saying if you get a group of
14 caregivers in the room together, be prepared.
15 MS. DAILEY: You know, I think without asking them
16 what have you needed, as part of the questions.
17 You know it's one thing tell them what they'd
18 rather have, but (inaudible) focus on what did you
19 need, what did you think you needed, did you get
20 it, who helped you get it, what other kinds of
21 support were you offered along the way and what
22 we're trying to do is match up what we hear

1 as DoD service policy versus what's actually being implemented in the field and what people actually get at
2 the end of the day. So you know, in many ways
3 what we're trying to do is get that outcome
4 information from policy that we've heard about
5 today, but reality hits the road when you ask
6 these people what did you need during the process
7 starting from the very beginning and how you
8 walked through the process with your service
9 member. Who was instrumental in helping you to
10 get that, whether it was NMA orders or something
11 else and then what other support services were you
12 offered that you didn't necessarily ask for but
13 you found as important as you know, you would have
14 ask them if you got that far on your list.
15 MS. DAILEY: And I'm going to challenge you on all
16 this, alright. Which is those services have been
17 out there for a while there. It's like asking our
18 services members and our family members to tell us
19 what we already know. I'm want to go beyond that
20 question. Don't tell me you've got a recovery
21 care coordinator. I know you have one. You're
22 supposed to have one. You wouldn't be in this

1 group if you didn't have one. You know Congress'
2 requirement of us is are they efficiently
3 delivering these services to you.
4 DR. TURNER: To follow up on that very thing. On
5 the
6 participants when we walk into the room, how much where they have been prepped on what we're going to ask.
7 MS. DAILEY: I do not send the protocols out ahead
8 of time.
9 DR. TURNER: They will be cold. This will be cold.
10 MS. DAILEY: Correct. You all agreed to do some
11 introductory material. You're going to explain
12 what the recovery task force is and you're talking
13 about your congressional mandate. MS. CROCKETT-
14 JONES: I want to make a suggestion to anyone who
15 is talking to family members. That they might
16 want to actually start with the question of what
17 that family member thought their wounded, ill or
18 injured family member, service member, did not
19 get, because I can tell you, I can tell you, I do
20 not know one spouse who is asked the question what
21 did you need, would give you an answer of anything
22 at all. It's really, I cannot, I could only have

1 told you only what I think I needed five years
2 later maybe is when I started realizing what I
3 could have needed then. And when people ask me
4 when I was at home doing round the clock in bed
5 traumatic care that I had to be taught how to do
6 at Walter Reed, when people asked me what I
7 needed, I told them ever single time, absolutely
8 nothing; we're fine. So and I'm not unique.
9 What this is, this is going to be a really
10 difficult I think family members have to be coached into sort of pushed into the idea of saying you actually might
11 need something. Now some won't, but I'm saying
12 there's going to be a lot of spouses, this is
13 common, this is a common discussion amongst
14 spouses.
15 DR. GUICE: Then should we break it down to
16 things more specifically that did you get the
17 training to help you individual in his
18 rehabilitation. Break it down into further
19 specific questions were you told how to transfer
20 your guy in and out of bed. Did somebody come to
21 teach you that. MS. CROCKETT-JONES: Yes, we
22 might need to, you know, get them to that point

1 through some more specific questions, but if you,
2 I don't think you'll get productive answers with
3 what did you need and did you get it. I think
4 that if you start by asking what their soldier
5 didn't get, you will find out that there what
6 they will tell you is what they wanted, what they
7 didn't have to help. I don't know how to explain
8 this, this is, this is a clear issue. And I have
9 trouble enunciating. Like I said, if you had asked
10 me what I needed, I would had have no clue what to
11 tell you. But if you'd asked me what my husband
12 needed, I would tell you from the perspective of
13 being his caregiver which would have been
14 obviously what I really needed support with and
15 help
16 with. But it's just really, you know, there's a cultural thing here that I think we are totally going to miss some
17 good information if we don't, if we don't just
18 keep that really in mind. Like I said, it's not
19 going to be true of everyone, but I think it's a
20 big enough chunk.
21 GENERAL GREEN: You started off by saying that
22 maybe their starting question would be what

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1 services do you feel your service member has not
2 received that others received. MS. CROCKETT-
3 JONES: Or what care or services did your service
4 member not get that you would have think he
5 needed.
6 GENERAL GREEN: Okay. If I understand you right,
7 not a comparison of what anybody else was getting,
8 but just a listing of what you, what they needed
9 that was not provided or available. So what
10 services do you feel your service member did not
11 receive that he or she needed. MS. CROCKETT-
12 JONES: Yes.
13 GENERAL GREEN: And maybe a following question is
14 what skills do you wish you had to be of more help
15 to your service member. Okay. MS. CROCKETT-
16 JONES: Yes.
17 GENERAL GREEN: Alright. MS. CROCKETT-JONES:
18 But I think you have to ask it in that order.
19 GENERAL GREEN: Okay. That's what I'm trying to do. I think if we I think that what I'm hearing is if we can
20 start with relatively general questions and then
21 take some of these things and put them on a
22 separate sheet and based on what you get, you can

1 then go to the page and pick the question that you
2 think is really the most pertinent because as I
3 look at these, we can go through and eliminate
4 some of them as applicable with one case and not
5 applicable with the next and so you may be better
6 off, since there's going to be a group there, that
7 when you pick up on something they go to the page,
8 essentially saying, I really need to ask this
9 person this question. I mean I look at some of the
10 legal and DES. And I'll be surprised for somebody
11 who's been at this for a couple of years, I would
12 be able to answer these things. I mean some of
13 these things that I look at and go, don't know if
14 I could answer those things today and so then
15 having them for a more experienced person who has
16 been in the process, is very reasonably. I mean I
17 look at the vocational support and some of the
18 questions and they get very in detail, and so I
19 guess again it would be one of the things I pull
20 out of the hat a little bit. But if we could
21 delete or eliminate or we can make it so these are
22 or we can simplify, but I think the really key

1 case here is to find out how sophisticated your
2 audience is.
3 MS. CROCKETT-JONES: Yes.
MS. DAILEY: There's an opportunity in the introduction
4 when you go around and you say, as part of the
5 introduction, who are you, and how comfortable are
6 you talking about your experience? What is your
7 experience? How long or how far along in the
8 process is your, are you or are you as a family
9 member? And so, you will be able to assess there.
10 I just want to caution everyone that I have
11 concern about the way we structured this is that
12 was that I do think it's important we come back to
13 Congress and we can say we talked to service and
14 family members about these topics. This is the
15 feedback they gave us about these topics. So when
16 you're saying what services do you need? I
17 realize that our family members will have a whole
18 list and we can capture that, but if we don't get
19 anything on that list that Congress wants to find
20 out information on, then we really haven't really
21 gotten, doing what Congress asked of us.
22 MASTER SERGEANT MACKENZIE: And that's one of the

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1 things is if I do completely agree of that set-
2 up, is having the honor of being the objective fly
3 on the wall in many cases, you do find that. I
4 can walk into a room, a spouse hasn't eating; she
5 hasn't gone to the bathroom; she hasn't taken a
6 shower; she hasn't put on make-up, she hasn't done
7 anything, she is so incredibly grateful at
8 the bedside of her loved one. You could walk into the door, and go hey do you need anything, and they'll look
9 you right in the eye and a smile and say I don't
10 need a doggone thing. You go at them a second
11 time and go, do you think that too much is being
12 asked of you to take care of your loved one.
13 Things we see notoriously is that, hey, the wife's
14 willing to do this, the wife's willing to do that,
15 and the nurses kind of back off and go hey I'm
16 going to let you do this, I'm going to let you do
17 that under the pseudo umbrella of training, but
18 it's like hey I can, I've got more cases, this
19 will make it a little more easier to focus on
20 these other guys. And you ask the wife if they're
21 overworked or if they over-utilized, or are they
22 doubting the things that they have no training in

1 whatsoever and they will absolutely one hundred
2 percent tell you no. So you do have to frame that
3 and it's not about family. I've had a mom who
4 could only deal with the situations by being a
5 hostess. You know, the same mom that calls me at
6 two o'clock in the morning, because she's watching
7 her son sleeping and she's thought about a million
8 of questions to ask me. Wonder if I'm actually on
9 the other end of the phone. But when you go to the
10 room, she's serving coffee, she's bring water, do
11 you want donuts, do you want snacks, like
12 everything is incredibly okay and her world is
13 falling
14 apart. So with that, those frameworks of those questions will help us to decide when and how many of these
15 questions in this guideline that we're being given
16 do we need to ask to meet the intent of touching
17 on that topic.
18 GENERAL GREEN: And Denise, don't misunderstand
19 I'm not saying that we're not going to the
20 question in the more specific categories. It's
21 just that as you talk with someone, I think that
22 you will get an understanding how specific you can

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1 get. So I'll use the example of a service member.
2 If the services member says that the most valuable
3 to you as you recover and it's a family member.
4 Okay then the follow on question is there anyone
5 within the warrior transition unit that's of
6 benefit.
7 MS. DAILEY: Yes.
8 GENERAL GREEN: And if the answer is no, then
9 there's probably not a good reason to ask them
10 about the medical case manager or the you know the
11 non-medical case manager. You've already gotten
12 your answers. MS. DAILEY:. Okay. On this one, we
13 don't want to probe in the areas that make service
14 members uncomfortable or they just, you know --
15 GENERAL GREEN: And if they've been there for a
16 while, set-up with how long length of time you've
17 been in this, they can't tell you the name of
18 someone working with
19 them, that tells us something.
MS. DAILEY: And agreed. If you find a relatively robust
20 in their experience levels, then I would ask that
21 you discuss these areas in some detail because
22 Congress does want to know how effective their

1 medical case manager is, how effective is their
2 non-medical case manager, information sources,
3 They're eager for you to bring that information
4 back to them directly from the field.
5 GENERAL GREEN: And I think that will flow fairly
6 naturally because then we can go to, they tell us
7 it's the nurse that's working with them that's the
8 most valuable. Now you can go to the medical case
9 management essentially and ask you know, some of
10 the specific questions if that's what we need to
11 have. If they say that it's the nurse and then go
12 on to say theirs always omni is present and always
13 there to answer my questions et cetera, I probably
14 don't need to what extent does your medical case
15 manager meet your needs. Since we've already got
16 that.
17 MS. DAILEY: Right, right.
18 GENERAL GREEN: And if they don't, if they go to
19 the month medical case manager, the family liaison
20 then I can go to the non-medical case manager and
21 look at it and say, well do I want to follow up
22 with a question or not.

1 MS. DAILEY: Right.
GENERAL GREEN: In essence, I think we can use what
2 you've given us and we can go through it if there
3 are questions we want to add or subtract. I just
4 am wary of subtracting because you're going to
5 find specific instances where that question may be
6 very useful as long as you know how to get there.
7 So you go from the general to the specific and
8 hopefully we get the specific thing that you want.
9 And if not, we at least got the general Gepstalt
10 as to whether the programs are working and so
11 using what Suzanne has suggested, you know, what
12 services do you feel your service member receive
13 that he or she did not receive that he or she
14 needed. What skills due wish you had to be of
15 more help to your service member and who is the
16 most valuable to you as your spouse recovers.
17 Suddenly that sets up all the other topic areas
18 that you kind of put in there and so it let's you
19 go to more specific information if you want to.
20 That's my two cents. I'm a good family doc, but
21 I'm not all that experienced in recovery medicine
22 and rehabilitation.

1 MASTER SERGEANT MACKENZIE: That's one of the
2 things that I agree with, sir. This is not over
3 on the docket. This is giving a lot of research
4 to use on the fly while I'm right there in the
5 room. Have I met the intent by
6 covering the topics? You know, did my general question answer several of those topics right off the bat and I
7 don't need to go there. Our research team go
8 okay, we can accept the fact that those topics
9 have been answered and we're honing in on where
10 you didn't get answers and then it gives you the
11 ability to pull it out. I think back to my
12 recovery, I learned more as I went through ONEAL.
13 But I guarantee you can ask my mom and my wife and
14 neither one of them thought anything was wrong
15 with me being out patient the day after surgery
16 still receiving medical attention ever two hours
17 in an T. L. F. Environment. At the time you were
18 to ask them that, they would say nothing was wrong
19 with that. My mom was just happy to be able to
20 cook me dinner and wasn't sitting in a silly
21 chair. And all those kind of stuff. It wasn't
22 too much longer that was that really the right

1 thing to do. You still had up coming surgeries
2 and blah blah blah. But at the time, those were
3 things that, no thought whatsoever. Now that's
4 all changed because what was exam for them was the
5 return to normalcy.
6 GENERAL GREEN: But they wanted the return to
7 normalcy.
8 MASTER SERGEANT MACKENZIE: Right. MS. CROCKETT-
9 JONES: I think my, actually the one thing I'm
10 concerned about and imagining is working with the
11 focus group is for those who have done it before,
12 when we
13 ask our initial questions, are we going to try and round rob in the room individually. Are we going to throw out
14 a question and those who wish to come to
15 participate with the answer come forward. Or are
16 we going to be more direct from eliciting
17 information from individuals and see what the tone
18 of the room is.
19 MS. DAILEY: Yes. Now I would like to bring
20 Suzanne up now. She's going to go through an
21 orientation on focus group work and focus group
22 meeting and answer that very type of question.

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Okay? Good. WHEREUPON, deposition was concluded at 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 23 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