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U.S. DEPARTMENT OF DEFENSE

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DEPARTMENT OF DEFENSE TASK FORCE
ON THE CARE, MANAGEMENT AND TRANSITION
OF RECOVERING WOUNDED, ILL AND INJURED
MEMBERS OF THE ARMED FORCES
(the Task Force)

5

Wednesday March 30, 2011

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U.S. Department of Defense

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Gaylord National Resort and Convention

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Center

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201 Waterford Street

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National Harbor, Maryland 20745

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APPEARANCES:

12

Non-DoD Task Force Members Present:

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Dr. Karen S. Guice, M.D., M.P.P., Non-DoD

14

Co-Chair

Mr. Justin Constantine

15

Mr. David K. Rehbein

16

Ms. Suzanne Crockett-Jones

Jesse Brown, National Library of

17

Medicine

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DoD Task Force Members Present:

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Lt. General Charles B. Green, M.D. Chairman

Major General Karl R. Horst

20

Master Sergeant Christian S. MacKenzie

Commander Timothy A. Coakley, M.D.

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Lt. Col. Sean P. Keane

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Staff Present: Denise F. Dailey, PMP,

1 Executive Director Larry Nisenoff, MBA,
2 PMP, Director of
3 Operations James B. Wood, Records Manager Lokia
4 Brockenberry Philip Karash Stephen Lu
5 Bella Gonzales DeQuetta Tyree Phillip
6 Karash Heather Moore John Booton

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

9 MS. DAILEY: Ladies and gentlemen, can
10 I call the room to order please? Good
11 morning everyone. I'd like to welcome
12 you to the task force meeting for
13 recovering wounded warriors. We are
14 in our third meeting of the year. In
15 our opening time period today will be
16 discussing in our most recent
17 insulation visits. I'd like to make a
18 couple of introductions: ladies and
19 gentlemen, I'd like to introduce Mr.
20 Jesse Brown. He is sitting in today
21 for Dr. Stephen Phillips. So he is
22 our special guest. And Dr. Guice and

1 General Green, I'm going to turn it
2 over to you all.

3 LT. GENERAL GREEN: Well, first let me
4 say good morning, okay? Thank you for
5 joining us.

6 MR. BROWN: It's a privilege. Glad to
7 have you.

8 LT. GENERAL GREEN: I think we're
9 going to start off this morning. I'm
10 looking to see if I have something I'm
11 supposed to formally say here on the
12 script. It looks like I - it looks
13 like I'm okay here. We are going to
14 start off this morning, basically
15 talking about some of the trips and so
16 really just impressions I think from
17 some of the folks that were able to go
18 on these early trips. No particular
19 format and nothing that has come back
20 to us in terms of size. I was able to
21 look at the recorded session and see
22 some of that input from the various

1 people that we've talked to. But I
2 think today, rather than talking to
3 specific inputs what we're looking for
4 you is just impressions; things that
5 you saw, things that obviously were
6 working and things where you think
7 there may have been some areas that we
8 should look at a little bit further.
9 Unfortunately, because of events
10 across the world, I haven't been able
11 to make one of the trips, so really
12 this is an opportunity for me to hear
13 from everybody else, kind of, what
14 your impressions are. And Karen, I
15 don't know if you have anything you
16 want to add to that.

17 DR. GUICE: No, thank you.

18 LT. GENERAL GREEN: Okay, so we were
19 talking in smaller groups about some
20 of the initial impressions. And so,
21 I'm going to put Suzanne on the spot
22 and ask her to start us off.

1 MS. CROCKETT-JONES: I was - I wasn't
2 sure what to expect with the
3 installation visit. And I - I have to
4 say it was good to hear information
5 that was very present and in the
6 moment. I think the installation
7 visits are going to give us a much
8 better idea of what's work - what's
9 really best practice. And we did see
10 several things that were very, very
11 good. I - also, one thing I did come
12 away with was in - in talking to the
13 SVAC folks at Benning, there was -
14 there is - they're doing the right
15 thing with personnel. Their personnel
16 are really proactive. Good for the
17 job and they are in great
18 communication for a lot of different
19 services they're providing. And it -
20 it made me want to look at
21 communication in other - among other
22 tiers of care. Among medical folks,

1 and cadre folks, and non-medical case
2 folks, to get an idea of just - if
3 increased communication might be
4 something that would alleviate some of
5 the things we're seeing that are -
6 that are of concern.

7 DR. GUICE: Actually, I would like you
8 to elaborate a little bit more on the
9 family assistant centers cause I think
10 that those of us that went to Fort
11 Campbell, there was a definite sense
12 that wasn't as well utilized as they
13 would like it to be. They have a
14 lovely facility, they have people who
15 have a variety of programs, but
16 somehow it seemed like it - they - it
17 needed to be better interdigitated
18 with the battalion there. They're
19 really trying to work on that and I
20 think when they move to their new
21 campus they may have some unique
22 synergies. But it felt like there was

1 a need to do something a little bit
2 more there and a little bit better
3 integrated at Fort Campbell. So, I
4 think that if there are other
5 installations that are somehow using
6 that resource and doing it quite well,
7 then you know, that is something that
8 we can point to - to say, if we do
9 have a -- what seems to be a best
10 practice in a certain area.

11 MS. CROCKETT-JONES: One might just be
12 location. I don't know if that's a
13 factor, but because they're creating
14 sort of a closed campus feel -- a very
15 pedestrian area where the services are
16 almost around the quad and I think
17 though they're moving to new
18 facilities, they're going to maintain
19 that same sense of pedestrian village
20 that kept soldiers, sort of, visually
21 aware of what was available to them.
22 It seemed like a very good idea. And

1 that might - I don't know where, how
2 those services are provided at Fort
3 Campbell if that's part of the issue.
4 DR. GUICE: Well, it - it, I think
5 that's part of it too. They are
6 moving to a new wounded warrior
7 campus, for lack of a better term,
8 which - which actually is closer to
9 the hospital than their current
10 location. And so I think some of those
11 things hopefully if you put them in
12 proximity, it will kind of have a
13 little bit better synergy, but I think
14 that was - feel free for the other
15 people who were at Campbell to make
16 comments if you - if you observed
17 something different.
18 LT. GENERAL GREEN: Can I ask, just
19 out of curiosity, one of the questions
20 that I had after listening to the
21 programs was whose in and who's out?
22 So, when you get to the programs,

1 looking at the wounded versus the ill
2 and injured, or I shouldn't say versus
3 but wounded, ill and injured, is there
4 any differences in terms of the way
5 that you've seen at various activities
6 support? Once they're in the WTUs are
7 they pretty much all treated in the
8 same manner and have the same
9 services? That's the impression I got
10 from the reading the testimony, but
11 I'm curious.

12 MASTER SERGEANT MACKENZIE: Yes, I - I
13 did find that. That once they were -
14 they were in and accepted into the
15 WTU, or WTB, that that's exactly how
16 it went; was it was you know, pulling
17 all those resources together; those
18 folks that had access to all those
19 resources. One of the big family
20 things that we found -- or that I
21 noticed at Fort Campbell was, you know
22 the only difference you had was in the

1 caregivers. You know, the complexity
2 of family members being there to
3 assist their loved ones that were not
4 on orders, it was a - it was a
5 challenging part where they were not
6 getting - getting to some of the
7 services because of simple things like
8 just getting in the gate were - were a
9 major challenge. We tend to look at
10 the bigger facilities where the
11 injuries are more catastrophic and we
12 had folks on orders, whether they need
13 brother, sister, cousin, whatever.
14 And I think - I think some of that
15 focus is lost as we get out to these
16 individual bases where although the
17 question may not qualify if you're non
18 medical attendant orders the presence
19 of family is essential in their
20 recovery and yet, there was nothing
21 set up in place to deal with that.
22 DR. GUICE: And when we were at

1 Campbell we made an intentional effort
2 to divide things after we spent our
3 time into two categories. And we
4 looked at things that we thought were
5 potentially policy implementation,
6 bigger, probably systemic issues
7 versus things that we thought that the
8 battalion could affect change
9 immediately. So we - we sort of
10 divided our observations into those
11 things. We had an out briefing to the
12 command there and kind of told them
13 what we've seen and then gave them
14 some very specific things that we
15 thought you could fix these three
16 problems, or four problems tomorrow if
17 you so chose. So we tried to do those
18 as well so that we had that too.
19 Because I think we're going to get
20 that. We're going to hear things that
21 we think that can be addressed quickly
22 and don't really need a task force to

1 tell them to go do something. Over
2 there we're going to see things that
3 are - start to be systemic issues
4 either because of the way they were
5 implemented, or because there's a
6 barrier, or because there is a - a
7 problem that is a consistent one
8 across the services because of a law
9 or a policy. But that's what we try
10 to do.

11 A couple of things that we saw at
12 Campbell that were - were very
13 interesting and it would be nice to
14 hear if it's replicable. At Campbell
15 it - from all of the focus groups it,
16 all of the wounded warriors identified
17 the nurse case manager within the
18 triad as the person who they went to
19 with for reliable. They were - they
20 said they were available, affable and
21 able and proactive. So, you know,
22 very strong words, but they really

1 appreciated the work that the nurse
2 case managers were doing and they
3 thought that that was a key - key to
4 their support. The other thing that
5 we found that was a good thing was the
6 - the legal support that is provided
7 through the - the attorney who was
8 there to assist in the - with the
9 legal issues; particularly with the
10 MEB PEB; that was something that
11 people thought was a - a very good and
12 worthwhile thing. We had a little bit
13 of a problem in that she couldn't -
14 wasn't able to provide us with data in
15 terms of outcomes and - and you know,
16 how she measures success. So we - we
17 asked for a little bit more
18 information about that.
19 And then the other thing that we found
20 that was pretty interesting was that
21 they are doing some - a real focus on
22 rehabilitation and intensive, kind of

1 sports therapy rehabilitation. We
2 attended an event there where they had
3 everyone divided up. They had
4 different activities. We went to a
5 bowling event where there were a lot
6 of wounded warriors there
7 participating in just a weekly bowling
8 activity. And they've made a
9 conscious effort that you know, people
10 need to be out rehabilitating and that
11 there are various ways of doing that.
12 In fact, one of the things they do is
13 they sort of assign this sport
14 activity as part of their work. It is
15 part of a work effort on their part.
16 And they're expected to attend. It
17 was a - it was very nice. It was well
18 attended and I think by all our
19 observations, it looks to me like a -
20 a good thing that they're trying to
21 accomplish there. You know, Fort
22 Campbell is fairly unique in that when

1 we talk about wounded, ill and
2 injured, you know, in our minds we
3 focus on Walter Reed and - and
4 National Naval and sort of the
5 catastrophic, but there's a whole
6 spectrum and Fort Campbell has sort of
7 a lower acuity, but - and really what
8 they said were a lot of behavioral
9 health issues that they have to work
10 on there. So, part of this is to
11 address some of those issues.

12 MR. REHBEIN: I think maybe one of the
13 other things from Benning -- and I
14 wanted to go to the other end of the
15 spectrum a little bit. I know that
16 General Horst -- I kind of wish he was
17 here, made some of his own visits and
18 specifically talked about whether you
19 call it a comprehensive recovery plan
20 or the comprehensive treatment plan,
21 and was struck by the difference
22 between the way it's discussed in the

1 briefings we got here and the way it's
2 actually being implemented on the
3 ground. That there is - I believe that
4 he talked to some nurse case managers
5 that said, "We don't think this is
6 being used the way it was intended".
7 So there - there seems to be - there
8 seems to be something of a breakdown
9 as that moves - as that process moves
10 down the chain to where it's actually
11 being implemented.
12 The other thing we heard at Benning
13 was that there are definite problems
14 in the open door policy in moving up
15 the chain of command. The folks --
16 the wounded warriors - and they
17 weren't all wounded warriors. We had
18 a - in the focus groups we had an even
19 blend of wounded and injured. I don't
20 know that we had anybody that fell
21 into the yellow category, but they
22 were - they were blended together.

1 There didn't seem to be any
2 difference, but they were all - they
3 all seemed to be expressing the same
4 problem with access to their squad
5 leader and the open door policy was
6 kind of a name only policy. That was
7 two things that came out of there.
8 The one thing I was very glad to see
9 was the rate of satisfaction with the
10 integrated disability evaluation
11 system. That seems to be coming
12 together very well. The people - the
13 people who had been through it or were
14 beginning to go through it seem to
15 have a - a high expectation that it
16 was going to work for them. And based
17 on my experience in the past, that's
18 considerably different than what we've
19 seen out of the old legacy system. So
20 that was a real - that was very
21 encouraging.
22 LT. GENERAL GREEN: How is the CRB,

1 CTP, whichever, how was it actually
2 being used? Can you give us an idea
3 of the difference?

4 MR. REHBEIN: It seemed to be being
5 used by however the individual wanted
6 to use it. There didn't seem to be a
7 real - there were problems discussed
8 about people that are really
9 progressing through the system to get
10 better and people who are using the
11 system to stay there. And the CTP was
12 a tool that could be used in either -
13 by either individual. In one place -
14 in one place the comment was made that
15 the CTBU, CTP was being used to raise
16 red flags in areas where the
17 individual didn't think the treatment
18 was adequate. Now, whether the
19 treatment was actually not adequate or
20 not I don't know whether it was the
21 perception of the individual, but it
22 was providing, in some cases, a way to

1 put pressure on the nurse case
2 managers because it was complaints
3 going down - going down into the
4 record and obviously it's - it's,
5 obviously the whole triad sees that as
6 a comprehensive recovery plan. So it
7 wasn't always - didn't always seem to
8 be used as a tool to regain health.
9 DR. GUICE: One of the things that we
10 heard at Campbell that we did not
11 actually see a comprehensive
12 transition plan, but we did hear that
13 their only access is when they're on
14 base. So if - in Fort Campbell
15 because they have some people in the
16 barracks and some people at home, you
17 know off base at home, if - if they're
18 not on base they can't access their
19 comprehensive transition plan. So a
20 lot of people said they would like to
21 be able to review, look at it, work on
22 it, when they're not on base and we

1 did bring that up to the commander
2 that would probably be something they
3 could work on and figure out a way to
4 do that. But we didn't hear that
5 particular -

6 MR. REHBEIN: That was something -
7 that was something also admitting -

8 DR. GUICE: Yes. We didn't hear that
9 particular thing of the, I guess you would almost
10 call that a misuse of the intent of the
11 comprehensive transition plan. We didn't hear
12 that.

13 MS. CROCKETT-JONES: They have
14 actually even
15 modified it. Wasn't that one of the things that
16 we heard was that they had actually even modified
17 the format, or had modified some of the questions
18 or limited what they used? I can't remember now
19 exactly how they put it. But they - they wondered
20 if even there was - if there was a disparity in
21 scope from what the intended is to whether it's
22 being used. Because there were two different

1 kinds of recovery plans talked about -- two
2 different formats. So, it -- it definitely is
3 something that needs to be examined for a standard
4 and for standard usage as well.

5 LT. GENERAL GREEN: When you say two
6 different kinds of recovery plans did they give
7 you any specifics where is one medical and one non
8 medical?

9 MS. CROCKETT-JONES: Someone - the -
10 when
11 they were discussing it, one -- at least twice
12 someone said, "do you mean the six point recovery
13 plan? Or do you mean and they gave it a different
14 name". And it gave me the impression they were
15 using two different formats.

16 MR. REHBEIN: It was almost like they
17 were - yes you're right. Now I'm
18 beginning to remember some of that.
19 It was almost like there was a
20 stripped down version and I don't - I
21 don't know what - I don't know what
22 went in to the full version, what went

1 into the stripped down version, but
2 they referred to it like there was a
3 -- I don't want to say minimal. But
4 some things had been considered to be
5 less important and pushed off to the
6 side.

7 LT. GENERAL GREEN: Was that a way of
8 not putting things into the
9 overarching plan that would be
10 visible?

11 MS. CROCKETT-JONES: I have - we had
12 no way to measure that. And we did
13 not - we did not see either of those
14 like formats. And there seems to be a
15 lot of trouble with access to the
16 format. Even when it's made available
17 over the internet, it's not actually
18 often available.

19 LT. GENERAL GREEN: And so, is it just
20 the question of CAT card? Or is it so
21 readers, or is it something else into
22 where they're not, not a web based

1 program?

2 DR. GUICE: At Campbell it was CAT
3 Card. So if you're off base, it's not
4 web enabled and you can't access it.

5 MR. REHBEIN: But there was all - I
6 think, I think beyond the ability to
7 access it through the computer system,
8 at least in the focus group,
9 particularly the enlisted focus group
10 that we had, I'm not sure that they
11 really understood what they're part of
12 the comprehensive recovery plan was.
13 I'm not sure that they understood that
14 they really had a role to play in
15 making entries and -

16 MASTER SERGEANT MACKENZIE: One of the
17 things we found uniquely getting to
18 see two different facilities,
19 different ends of the spectrum; both
20 BAMC and Fort Campbell, one of the
21 things that we found was number one:
22 access. You know the - the - the

1 ability for the program itself and for
2 AKO "the bottleneck", limited people's
3 involvement. So you add to that
4 frustration the TBI or PTSD case, they
5 tend to not good timing. They don't
6 see it as a useful tool because it's
7 hard to access. You look at a
8 facility like BAMC where they have a
9 place for these guys to go while
10 they're on base doing their stuff
11 because they have a computer room
12 where these guys can type it in and
13 the facility has the responsibility to
14 provide effective equipment. They
15 tend to use it more. However, those
16 who are there for long term treatment
17 find it to be a waste of time because
18 the CTP doesn't take into account
19 questions that no longer need to be
20 asked. There's no trimming of, you
21 know, this person doesn't have an
22 issue with this stuff anymore. Why

1 does he have to continue to answer the
2 question? So it almost becomes a -
3 over the long term becomes just a
4 point and click and I mean seriously
5 I've got to fill this out again? You
6 know, I've already answered this
7 question 30 times. What's - how's my
8 answer going to change on the 31st
9 time or the 40th time? The - so I do
10 finally - we did find that people get
11 bored with it because it doesn't seem
12 like it doing anything because it's
13 the same stuff over and over again.
14 There may be one or two good questions
15 in there but it just becomes - it
16 just, it doesn't tailor itself towards
17 the individual. I mean, if you have a
18 program that can start as the
19 broad spectrum but then it must tailor
20 itself to the individual to actually
21 make it actually their CTP and that's
22 something we found to be a negative on

1 the CTP. But most importantly, every
2 time we've asked for a sample of the
3 CTP we've never been presented it at
4 any facility or the main Army brief.
5 And I find that to be a continuing
6 question for the task force and
7 continuously not answered and not
8 presented. So, that might be
9 something we have to pick up and say
10 we now have to get this in order for
11 us to evaluate correctly.

12 DR. GUICE: Colonel Keane --. Would
13 you talk about the differences in when
14 you were at camp you all did the focus
15 groups with the service members and
16 there was a distinct difference in
17 what the groups valued with the CTP
18 and how they thought it was working
19 for them or not. Can we talk about
20 that a little bit?

21 LIEUTENANT COLONEL KEANE: I'd like to
22 talk about San Antonio if I could

1 ma'am. In the Officer Focus Group it
2 was unanimous that they felt they
3 weren't being read. This weekly
4 requirement of putting in - making
5 their entries and the officers would
6 spend some time writing paragraphs and
7 they would address things in there, I
8 don't have any specifics I wrote down,
9 that their level of care wasn't being
10 met or they would like someone to
11 focus on this area. And putting that
12 same thing in for weeks on end and a
13 couple of officers just stopped doing
14 it.

15 I have some general comments regarding
16 - I went to San Antonio and Fort
17 Campbell and of the three focus groups
18 I participated in were all very well
19 received. They all came up to us
20 after - I shouldn't say all, but many
21 of them came up to us after - they
22 would come up and thank us for being

1 able to speak and to let us know of
2 their happiness and the ability to get
3 what's on, you know, to get what's off
4 the - you know, get what's on your
5 mind out in the open. And also, in
6 San Antonio and Fort Campbell it
7 seemed the best practice set. They
8 were very happy with the Nurse Case
9 Management; those that seemed to be
10 able to go to Case management.
11 And, so your opening comment regarding
12 the care, I just want to put some
13 comments regarding Wolford Hall.
14 There seems to be several challenges
15 there as far as manning, funding, and
16 organization. Not necessarily that
17 could do that or Commander Coakley.
18 But the briefings lack of slides an
19 overall sense of laissez-faire when we
20 went there. And they do at Wolford
21 Hall have the - a definite distinction
22 between the Air Force wounded, that's

1 one category and then the ill and
2 injured is another category.

3 MASTER SERGEANT MACKENZIE: I'll wait
4 until we get back to the Wolford Hall
5 community. We gain pretty big focus
6 items on that. One of the things, I
7 forgot about this, that we found in
8 the focus groups at Fort Campbell was
9 some of the folks actually put stuff
10 into their CTP to get attention to see
11 how affectively it was being read and
12 found that people weren't responding
13 to some pretty big items they put in
14 there. However at BAMC we found that
15 pretty much people felt that it was
16 being read that it was just mundane.
17 So kind of an interesting way to go
18 about it, but it's reached a point
19 where people are now, in some cases I
20 think, toying with it to see if
21 anybody's paying attention to them.
22 So, and I think that may be to either

1 lack of access or -- I mean lack of
2 effective access, or just that it's
3 become mundane. You know, because it
4 doesn't tailor to the individual
5 person.

6 DR. GUICE: It also sounds like it -
7 it, we really need to understand if
8 it's an effective tool or not because
9 if what I'm hearing in kind of a
10 collective, not a little snapshot of a
11 few places is it may - well congress
12 mandated it, it may not have been an
13 effective solution to a problem. And
14 maybe we have to relook at whether or
15 not it's met the intent of was
16 designed and if it's not and if it's
17 because of design or - or the way it
18 was implemented, or whether it's just
19 even an effective tool at all. I
20 think that's probably something that
21 would be good for us to grapple with.

22 MS. CROCKETT-JONES: I think we're

1 also going to have to find out if it's
2 being used. If it's not really being
3 used consistently we can't really
4 assess it's effectiveness as a tool,
5 so a standard sort of has to be
6 examined to see if - if every place is
7 using it differently and if some are
8 modifying it - we have - we won't be
9 able to assess it's effectiveness
10 until - unless one particular usage of
11 it is effective. So maybe we need to
12 tailor some questions in the
13 installations that we visit from this
14 point on to see if we can find out
15 whose getting the most from it and
16 seeing if there's a commonality there.

17 So we need to maybe get a little more
18 specific with it at the next visits.

19 I can also say Benning had staffing
20 and sometimes even just space issues
21 they're approaching the behavioral
22 health concerns with a clinic that the

1 people who are targeted at high risk
2 for behavioral health issues get free
3 use of the - you know, get full use of
4 the clinic in a walk in basis. And
5 they - but they spend a lot of their
6 time doing assessments to get - find
7 out who who in their population is
8 high risk. But they are limited by
9 space and funding for Manning
10 Clinic, so even though they allow
11 walk-ins, walk-ins sometimes will have
12 to wait, or take a long time to be
13 seen. So the intention seems to be -
14 to have quick reaction for high risk
15 behavioral health issues. But they're
16 not being able to meet that due to
17 both lack of space and lack of
18 manning. And I don't know if that
19 kind of separate clinic was - that
20 kind of targeted clinic availability
21 was at Fort Campbell, was there
22 something similar?

1 DR. GUICE: Do you want to?

2 MR. REHBEIN: This was called "The
3 Battle Mine Clinic" if that
4 nomenclature helps.

5 DR. GUICE: They had at Campbell - I
6 think one of the ways they have
7 approached the high risk and something
8 that actually we did hear from all of
9 our groups was formation. And the
10 frequency of formation, the
11 requirement of formation at 6:30 a.m.
12 and the difficulties that presented
13 for some of the families who live off
14 base and having to get them down
15 there, particularly if they don't have
16 the pass to get them onto the base.
17 So, you know, that - they were using
18 that kind of as a tool to maintain
19 that visibility and management of -
20 they have a clinic that didn't seem to
21 be an issue where people had a need to
22 go see the doc or see somebody in

1 clinic was quite available and did not
2 seem to be a problem.

3 MASTER SERGEANT MACKENZIE: One of the
4 things I'll say right out from getting
5 to see these visits, the communication
6 that was read to us by the WTC is not
7 effective. The annual meeting to talk
8 about those practices apparently is
9 they're not. Because one of the
10 things I've found is that the the
11 things that are happening on these
12 different installations are not being
13 communicated either down the chain or
14 up the chain. The fact that you can
15 go to different facilities and see
16 different things happening tells me
17 that nobody's communicating. And some
18 of the - you know and when I say that
19 the formation was one of the examples.
20 The - the formation deal of doing
21 formations twice a day, five days a
22 week in an attempt to manage their

1 medium and high risk patients without
2 actually focusing on their medium and
3 high risk patients. And then you go
4 to BAMC to whom very much like Walter
5 Reed because I worked it there I'm
6 going to do an assessment, was they
7 focus. They did put people personally
8 responsible. There's an
9 accountability of those medium and
10 high risk patients. And that - that
11 kind of communication didn't happen
12 because when we brought that up to the
13 WTB at Fort Campbell they just kind of
14 looked at us and went, really? You
15 know the guy asked us how well the
16 facility did. So, you know that -
17 that's a systemic problem that these
18 best practices and these challenges I
19 don't think are being communicated at
20 all. We went to Fort Campbell and
21 although they, you know, are trying to
22 take care of their cadre and are

1 trying to make the right things
2 happen, some of the first ordinance
3 are getting definitely involved with
4 selective - selecting their people.
5 There was no recognition,
6 acknowledgement or anything else for
7 the cadre. However you go to BAMC and
8 they have a robust recognition
9 program. They knew who their best
10 company was in any particular quarter.
11 They focused on their star performers
12 and who was the best of the best. If
13 it's - there's less disparity between
14 companies as far as who was good and
15 who was bad because they were, the WTC
16 at BAMC was looking out for these
17 guys. Not because the WTC told them
18 to, but because they felt it was the
19 right thing to do. But yet, it
20 doesn't seem to be getting around
21 because when you ask the same
22 questions on both sides you get that

1 blind sector. So I think that you
2 know that - that communication and
3 that - that storage of best practices
4 in how to make this whole program
5 better is something that we definitely
6 need to look at in the report as
7 something that they need to focus on.
8 So -
9 DR. GUICE: I think it's also
10 important for us to remember that you
11 know we've been to three places --
12 we've been to three places. While
13 we're just in the beginning of our
14 fact finding, information gathering in
15 it, I think what we're doing is we're
16 setting up, are these things going to
17 be consistent? Where do we start to
18 see disparities, changes, and where we
19 start to see consistent problems or
20 consistent best practices? So this is
21 just the beginning of - of what we're
22 doing and I would remind everybody

1 that you know keeping a list of are
2 these things consistent; do I find the
3 same thing over and over and over
4 again is really what we need to be
5 focusing on. So I think that this is
6 a very good discussion is to kind of
7 start to identify those things. Are -
8 is - is the way the CTP being
9 implemented consistent across? Is the
10 way the - the - the cadres are
11 recognized and is that a best
12 practice? Is that consistent across?
13 And if not then we can sort through
14 it. But I - I think you know it's
15 premature to come to any kind of
16 conclusion about what's working and
17 what's not working based on what we -
18 the snapshot that we've seen.
19 That said, I would - we had a distinct
20 feeling that we probably needed to tee
21 up our - our request just maybe a
22 little bit differently, particularly

1 at Campbell. I think people are
2 struggling with the question about
3 when we ask them well, what's the
4 outcome? What's the so what? You
5 know, that's - that's - these
6 programs are new enough and they're still kind of
7 grappling with, do we even have the
8 right formula yet? And I think that we
9 need to be very specific about asking
10 you know what - how do you - how do
11 you show the value of what you're
12 doing? And pushing on that a little
13 bit because it's - it's still kind of
14 a new, it seems to be a new thing and
15 we weren't really getting a lot of
16 hard data to show why they think it
17 works and in what ways they think it
18 works. You know, capturing the things
19 at Fort Benning, for instance, with
20 this - the focus on rehabilitation and
21 sports, I mean that looks to be a
22 really good thing, but they hadn't yet

1 thought about how to collect data to
2 actually show that it's a really good
3 thing. And to show that it does make
4 a difference and it does matter and
5 that people who go through that
6 program are better prepared to take
7 the next step, whatever that next step
8 may be. So I think pushing on that a
9 little bit is something that we need
10 to do.

11 LT. GENERAL GREEN: Yes. The other
12 reason for sharing is we don't get to
13 go to all the different sites. So, I
14 mean, we're kind of fortunate right
15 now that we've got some comparison
16 between two Army sites. But again, we
17 haven't crossed services yet. And
18 feel free to talk. I didn't mean --
19 when I mentioned in the Warrior
20 Transition Units to exclude Wolford
21 Hall or any other services that's been
22 visited.

1 So, one question before we leave this,
2 does anybody have any idea, to get a
3 sense of length of time that people
4 are spending in these units? In other
5 words, can you give me any idea of
6 what was the longest person that had
7 been there - the person that had been
8 there for the longest?

9 MR. REHBEIN: Go ahead.

10 MASTER SERGEANT MACKENZIE: We had -
11 we had one patient at Fort Campbell
12 that had been in the system for five
13 years. So yes; it was - that was
14 interesting to see. The -

15 DR. COAKLEY: Most of the patients,
16 the members that were in these units,
17 they had the length of time that they
18 actually spent was varied. But I
19 think from my experience at both Fort
20 Campbell and at San Antonio, it
21 averaged anywhere from like six
22 months. And then there was a couple

1 there they had been there two years.
2 It really depended on the severity of
3 their injury. For instance, Master
4 Sergeant Mackenzie was speaking to one
5 of particular patient endured some
6 severe trauma and then was starting to
7 make more and more gains on their
8 overall outcome and so - but again
9 that just depends on the injury, and
10 where, you know, the aftercare whether
11 they wanted to come back in a co-ed or
12 whether they were going to be
13 medically retired.

14 MR. REHBEIN: One of the things that
15 we actually learned from General Horst
16 at Benning: there is concern in the
17 Army about the length of time people
18 are in the WTU's. And evidently,
19 there is beginning a process now where
20 each individual case, a person that's
21 been in the WTU over a year, each
22 individual case like that will have to

1 be briefed up the chain of command to
2 the - and in this case the briefing
3 will be - have to be given to the
4 Major General Brown; the maneuver
5 center commander. Benning - Benning
6 has 98 of those.

7 MS. CROCKETT-JONES: Only if they have
8 not entered an MEB process.

9 MR. REHBEIN: Right. Yes, I'm sorry.
10 I'm sorry. There is that - there is
11 that qualification; if they have not
12 yet entered the MEB process. That's
13 something of a concern to me because
14 those are going to be briefed to a lot
15 of individuals around the country and
16 there was - I don't remember any talk
17 of what standards would be used in the
18 evaluation of those cases. As they -
19 as they were being briefed, but 98
20 individual cases being briefed to a
21 General Officer is going to take up a
22 lot of his time whether there will be

1 a full briefing or a slim down

2 version, that's another - that's

3 another point of concern.

4 LT. GENERAL GREEN: any sense talking

5 to the patients? I mean, the question

6 is so if you've got, I'll just use the

7 numbers that you just gave, if there's

8 98 that are not yet in the MEB process

9 and yet are over a year, is there any

10 sense from the patients whether they

11 feel that's because of their rehab and

12 their requirements or if they wish the

13 system would be moving. I mean,

14 there's this delicate balance between

15 what the patients, you know, expect.

16 And so I'm trying to understand where

17 we are in that, their expectation.

18 MS. CROCKETT-JONES: Of - of the

19 patients that we spoke to, all who

20 were over a year were already in MEB

21 process. So we did not speak to any

22 of those individuals. My impression

1 is that there's a pretty wide
2 variation among circumstances in those
3 individuals.

4 MASTER SERGEANT MACKENZIE: I think we
5 did - we did see in some cases it
6 depended upon the individual.

7 I - I think you - it's a very delicate
8 thing to say;

9 however sometimes it's about those who
10 want to recover and get back and get
11 on with their lives as fast as
12 possible. Sometimes I see the system
13 is taking too long. Some that are
14 working at a slower pace don't find
15 any problem with how long the system
16 takes at all. So, it's a hard
17 question to answer because it's - it's
18 - the answer you're going to get is
19 going to be personality driven and
20 motivation driven. And - and that's
21 that's a tough thing to deal with.
22 But one of the things in the three

1 psych visits and the four or five
2 folks here that attended, one of the
3 things I did find was of great value
4 was talking to the family members and
5 the service members of those family
6 members. That makes it being able to
7 see that the response in the
8 difference I think is very good.
9 I think one of the things that we
10 noticed at Wolford
11 Hall though as we planned these out to
12 do them back to back. I want to be
13 cautious. You know, caution is kind
14 of forced on us because I worry
15 sometimes that she may not listen
16 effectively enough if you've already
17 heard the problem. You may already
18 have thoughts in your head on those
19 kinds of things.
20 And at Wolford Hall we did the family
21 member focus group and then turned
22 that right around to the service

1 members that were there and the family
2 members rolled right back into the
3 room and we did another focus group
4 with them. And I don't think we did
5 that, but it was kind of one of those
6 things that was kind of in my mind
7 that, you know, if you do more psych
8 visits that's very, very important. I
9 just caution that we don't either have
10 the same numbers doing the focus group
11 back to back in sense, or that we look
12 at doing a separation. Fort Campbell
13 it was - one day it was the family
14 members and the next day it was the
15 wounded, the wounded, ill and injured
16 that they were taking care of. And I
17 just - I saw that as a difference
18 there because we did have the same
19 folks in the - that's where - and
20 that's where both of those focus
21 groups. So, that's an input there.
22 DR. GUICE: I wanted to answer that

1 because I actually wrote it down.
2 Good thing to have a pen and a piece
3 of paper when you ask a question. At
4 Fort Campbell the average length of
5 stay in the WTB there was nine months.
6 Now there are outliners. As we
7 indicated that
8 one individual because of the - and he
9 actually went to Fort Campbell because
10 his family support was there. And so
11 there was a real reason for him to
12 come so he and he's had a long
13 trajectory but fortunately, he's
14 actually back at his military, doing a
15 military job. I'm not sure it's the
16 same one that he had started out with,
17 but he's committed. He definitely
18 wants to stay in the military and is
19 doing everything he can to try to do
20 that. And it looks like he might well
21 be successful. So, I think that's -
22 that's good that their average length

1 of stay was nine months.

2 The one thing that we found at Fort

3 Campbell that I think was pretty

4 unique and it would be interesting to

5 see if it was their approach to a

6 trial. You know, once the medical team

7 has said okay, we think this

8 individual is ready to go back to

9 return to duty, they do have that

10 course there on site where they run

11 them through a simulation of - of

12 going back to combat either - and they

13 have various scenarios depending on

14 the MOS of the individual whose going

15 to try to return to duty. And they -

16 it's - it's very intense. It mimics a

17 battle scenario; either it's the

18 combat medics trying to recover

19 someone from a down helicopter, and

20 they have various types of things.

21 But they - they run them through that

22 and they find that even of those that

1 they medical community says we think -
2 we think these individuals are ready
3 to go back to duty. There is a subset
4 that following that course are not.
5 And I think that has been a very
6 interesting approach to really
7 defining who is significantly
8 recovered to reengage into a combat
9 situation. You guys want to - who
10 were at Campbell, do you want to
11 comment on that? We did see a - there
12 was a nice video that we saw of that
13 and they explained it quite well. But
14 I don't remember the exact number and
15 I was looking for my notes about who
16 sort of can't complete that course.
17 But it looked like a really
18 interesting way to do sort of proof of
19 the pudding kind of - kind of concept.
20 DR. COAKLEY: The number that comes to
21 my mind is - I think it was right
22 around percentage - they said it very

1 quickly. I think it was around 18
2 percent, 18 to 20 percent and they
3 attributed that to the hyper realistic
4 scenarios they were trying to place on
5 the individuals to see what their
6 skill level would be in an extremely
7 stressful combat situation. Their --
8 I think their training modalities that
9 they were using were quite effective
10 and it did help them ferret out those
11 individuals that probably would not be
12 as effective down range and that was
13 the whole purpose in doing it is to -
14 it's one thing for we medical
15 providers to say, yes, they're fully
16 primed. They're ready to go. I think
17 medically we've reached the end where
18 we can help them. I think they can do
19 their job. It's another thing when
20 they can go into a situation like that
21 and actually have to perform basic
22 skills. This wasn't an advanced

1 combat course. It was basic skills
2 and they still did that read of
3 failure. So, I think that was, I
4 didn't see that anywhere at - in San
5 Antonio, but I think that was related
6 to the fact that they have a higher
7 acuity, I'd like to stay here a little
8 - significantly longer due to their
9 injuries and disability, but I - I saw
10 that it was best practice for sure
11 because that's one thing as a combat
12 line officer, I want to know if this
13 individual can do their job. I really
14 did think that was an excellent way of
15 going about doing it.

16 MR. REHBEIN: I don't remember,
17 Suzanne you can help me. I don't
18 remember any - any talk of anything
19 like that at Benning.

20 MS. CROCKETT-JONES: No, there's
21 nothing like that but we were dealing
22 with a reserve unit which has a lot of

1 very specialized policy issues. They
2 had some - some very specific things
3 that they were struggling with and in
4 manning and staffing and orders that
5 have to do with the way reserves work.

6 And I suspect that something like
7 that would also be - the - these
8 reserve soldiers go back to a pretty
9 dispersed number of places and I'm not
10 sure who would be, who they would wind
11 up getting that kind of a course from.

12 There's also some time constraints on
13 orders for reserves. You know, their
14 only - their orders only extend a
15 certain amount of time and where that
16 would fit into that limitation I'm not
17 sure. I have - I do have a question
18 for the folks from - who went to Fort
19 Campbell.

20 There seems to be, one of the areas we
21 were tasked with was looking at the
22 effectiveness of non medical case

1 management. There seems to be a wide
2 variation in who is a non medical case
3 manager and what their role is. I
4 haven't seen much definition or
5 consistency of concept. And I'm
6 wondering who at Fort Campbell, who
7 were the non medical case managers?
8 At Fort Benning it was - that was a
9 function of the cadre; which is why
10 the open door policy came up as a
11 question. Soldiers, wounded, ill, and
12 injured should have fairly decent
13 access to their non medical case
14 managers. And what role do they have
15 in - I think this is an area we need
16 to hammer out as far as what our
17 standards, so we know what we're
18 looking at.

19 MASTER SERGEANT MACKENZIE: We found
20 that the -- you know that the cadre
21 definitely was not pre head lead as
22 far as the non medical case

1 management. However the difference
2 was a very, very effective use of the
3 open door policy. The majority of
4 those folks have a good communication
5 with their cadre, with some of those
6 resources. There's a few that found,
7 I mean, there's really minor of those
8 that were found to be a challenge. But
9 the majority at Fort Campbell was very
10 happy with their cadre and they knew
11 what was going on so -

12 DR. GUICE: We did seem to start to
13 see some particular comment on the
14 family focus group. They were all
15 obviously not in the same squad leader
16 formation, but a couple of them said
17 that their squad leaders had really
18 taken a proactive way in involving the
19 family and starting to bring them in.
20 And talking about the comprehensive
21 transition plan and talking about the
22 transition and they thought, you know,

1 this is really great. And then there
2 were a whole side here who were - said
3 they do what? So, you know, even
4 within you start to see even within
5 that structure that their differences
6 or they're trying different things.
7 They're trying different ways to kind
8 of approach problems and identifying
9 them work something out. So, but
10 there was a real effort in - in one of
11 the squad leader teams to start to
12 involve the family and that was very
13 appreciated.

14 MS. CROCKETT-JONES: I think one of
15 the things we might want to see is if
16 the folks who are functioning as non
17 medical case managers know that they
18 are functioning as non medical case
19 managers. I - I got an impression
20 that may not - I mean I didn't have
21 the opportunity to confirm it. But
22 that - that maybe there were some who

1 did not know that that was part of
2 their defining roll. And that's why
3 I'm wondering if we can find out how
4 they are defining that job and if it
5 has a list of responsibilities and
6 requirements and if - if folks who are
7 not from, say a social work
8 background, because I know at least
9 some warrior transition units have
10 separate social workers to provide non
11 medical case management, but if cadre
12 are, are they trained to do that job
13 and are they clear of what that job
14 is?

15 MASTER SERGEANT MACKENZIE: I think
16 that so far with what we've seen, some
17 of the terms that we're using or that,
18 that congress and DOD is using doesn't
19 apply. When you start to explain the
20 definitions of these things to people,
21 that's when they start to catch on.
22 And they go, okay yeah, that's that

1 person, that's this person, that's
2 that person, but this terminology
3 we're using, we're trying to get
4 answer to go with how familiar the non
5 medical case management. Everybody
6 cross war book and their like what?
7 DR. COAKLEY: Yes.
8 MASTER SERGEANT MACKENZIE: But as
9 soon as you explain it then they
10 understand. So, I - I think that the
11 search for a value to that statement
12 where we're starting, I'm starting to
13 see that nobody's addressing that as
14 you've said. It's not being addressed
15 as that. It's not being coordinated as
16 that, so we're really going to find
17 that most people aren't going to know
18 what that means.
19 DR. GUICE: Well we've been puzzling
20 through this a little bit in a
21 different venue, but I can tell you
22 that just the terminology, medical

1 case manager is used differently and
2 changes depending on which group
3 you've talked to. Sometimes it's a
4 clinical case manager. Sometimes in
5 the statute it's a medical care case
6 manager. Sometimes it's a medical
7 case meant - it - it - the
8 terminology, but when you actually
9 look at the definition and as long we
10 know that we've got a consistent
11 definition and that all these terms
12 mean that, then I think it's de-
13 conflicted a little bit, but it's -
14 it's the - what are we understand that
15 a non clinical case manager is to do
16 and what are they then once you
17 define it, then what are those clear
18 roles and responsibilities, and then
19 how do you make sure that people are
20 carrying them out and implementing
21 them the way that it was intended.
22 LT. GENERAL GREEN: Can I ask, were

1 any of the case managers, whichever,
2 whether non medical or medical, was
3 did anyone have data on any type of -
4 any categories of injuries? So as we
5 talk about the wounded warriors that
6 were there, is there anyone who's
7 looking at all these broad categories.

8 So, for ill and injured cancer
9 therapy patients, versus amputation
10 patients, versus mental health
11 patients without - to and seeing if
12 there's collecting any data on average
13 time that they're on the system or to
14 try to get to give you any idea of
15 what they think or what their
16 expectations should be in terms of
17 transit through the processing. Is
18 anybody sharing that in any of the
19 sites that are looking at it?

20 MASTER SERGEANT MACKENZIE: I think
21 that my impression of what I saw at
22 BAMC, they had a robust organization

1 to try to manage, you know, nurse case
2 management team as to severity and how
3 many cases each one had and really
4 trying to make sure the system will
5 not perfectly CNS somebody with you
6 know 20, you know, high level cases
7 and somebody else at low level cases,
8 but we didn't ask that question
9 specifically. But I think the
10 resources may be out there, we just
11 didn't ask for it.

12 DR. GUICE: I think the answer is no.
13 LT. GENERAL GREEN: Particularly, the
14 reason I asked the question is,
15 particularly as - if they're going to
16 start looking at time in the system,
17 we really without any data to tell us,
18 you know, what is the usual time or
19 what's the best time or what's the
20 worst time, it's tough to come up with
21 anything to say, and - and
22 unfortunately as it gets outside the

1 medical range, because the docs will
2 probably have some idea of what they
3 think that should be. But the data
4 would be very helpful, particularly if
5 you're going to have non medical
6 personnel starting to say this is the
7 time. You know, so -
8 MS. CROCKETT-JONES: I don't think
9 this is happening and I know it's case
10 management level; maybe just in the
11 aspect of making - of worrying about
12 load for each, the individual
13 managers. However, the - the next
14 tier of management did seem to have a
15 grasp of that data. I didn't - we did
16 not ask for it. But in at least one
17 of the discussions to where the team
18 on the medical side of - of the
19 program were talking about - they had
20 definite awareness of - of the range
21 of kind of care that they, that their
22 soldiers represented. So they -- I

1 think they have that data. I don't
2 know whether their collecting it
3 specifically for that purpose. That
4 did not come up.

5 LT. GENERAL GREEN: And, if you have
6 an idea of where we can request that
7 data, I think that it would be very
8 helpful. But I really do think that
9 even without setting, you know, any
10 specific time table, if it helps an
11 expectation management if up front you
12 can say based on your injuries we are
13 expecting this to happen. At the
14 front of the trauma system we use an
15 injury severity score. And, so it
16 basically helps us know, you know, in
17 terms of looking at survival and how
18 closely we have to watch someone. But
19 a lot of this data that I would think
20 we would have after you know years of
21 working some of these issues would be
22 very helpful. So now when you see

1 someone new to the system and say,
2 this is the average amount of time
3 that it takes that we see for people
4 to get to this level of function
5 within, within a single amputation for
6 instance --I'll keep it simple;
7 probably harder when you talk to PTS
8 or especially TBI. But, for some of
9 the things that we're dealing with I
10 would think that there were kind of
11 expectations in terms of what the time
12 table would be. And so, then the
13 question gets more towards, so, how
14 many people do you have that are at
15 the far end of the time table versus
16 the - the people who are kind of
17 meeting what we think are the norms
18 for process time - to process through
19 the system.

20 DR. GUICE: I - I think you're -
21 you're exactly right. My - my guess
22 is in having worked with some of these

1 data, certainly not just trying to
2 identify individuals using proxies for
3 injury severity, or disease severity
4 and trying to - to align them with
5 services. We - we collect a lot of
6 data. We don't correlate it very well
7 and with our data systems are such
8 that, you know we have the design for
9 our specific need as opposed to a
10 specific projection and to - to
11 identify things. I wonder if this is
12 something that the population health
13 data base might be able to at least
14 start to help identify. It had to be
15 cross walked with probably another one
16 on the terms of, you know, those that
17 are in the MEB/PEB process and those
18 that are in the - in the sort of the
19 identified wounded warrior categories
20 regardless of the service, but you
21 know, to kind of cross walk it across
22 those two to start lining up the - you

1 know, here are the disease entities,
2 injury constellations and then the
3 time spent in various components so
4 that you can then start to build those
5 trajectories. But I don't - I think
6 the data is probably there. I'm not
7 sure that going to one source we'll be
8 able to - I think it's going to have
9 to be pulled from a variety of
10 sources.

11 MR. REHBEIN: I think it might be
12 interesting to ask the Army how they -
13 how they came up with that one year
14 deadline. I mean they're - I'm
15 assuming that there must be some
16 justification behind their decision to
17 do this 12 months without having MEB
18 as opposed to ten or 14. I would - at
19 least I would hope there would be, but
20 there may be some available
21 information there if we ask the
22 question.

1 LT. GENERAL GREEN: Well the other
2 question is what's included in that
3 timeframe? So, for instance, the
4 thing that you were talking about at
5 Campbell I think it was where they
6 were doing the realistic training --
7 the simulated combat training so
8 that's actually now something that's
9 gone a little beyond - a little
10 further beyond what you think of the
11 normal medical time to do this because
12 you're actually starting to work on
13 some retraining issues. And so how
14 much retraining are you going to put
15 into the time frame? And so as you
16 make those decisions for one year, for
17 instance, if there's retraining
18 involved in that, well that may be a
19 very short time. Okay, but I don't -
20 I don't have any sense of it right now
21 and that's why I'm asking the question
22 if anybody gave us a sense of that

1 because these folks have now been
2 working with wounded warriors for at
3 least three years in some of these
4 sites and some longer than that. And
5 so I'm just wondering if they have any
6 idea of you know how do they work
7 expectation management for the
8 patient? I mean, it would just be
9 helpful in making personally, but if
10 you know, I was coming into something
11 that was kind of an unknown, what are
12 the expectations? How do you drive
13 yourself to try to meet a certain
14 expectation, whether realistic or not,
15 it gives you a self issued for.

16 MASTER SERGEANT MACKENZIE: Walter
17 Reed may be those may be a good place
18 to ask that. One thing I saw were
19 working there was the experience there
20 those medical professionals, where
21 they got that idea from I don't know,
22 but they had an idea in their head to

1 actually explain to these folks and
2 say, the average you know, single blow
3 to the amputee think about. Here's
4 your time frame. Here's what to
5 expect on a rough scale. It seemed to
6 be more experience based by working on
7 the number of patients not because
8 they could pull out the data and go,
9 this is the fact - these are the
10 facts. So, I think they are looking
11 at it to give the wounded, ill and
12 injured a generalized ball park
13 timeline. But I don't know where they
14 get that information from.

15 LT. GENERAL GREEN: We'll see it. I
16 mean, it may be that this is a
17 different avenue that we want to
18 pursue, but again, not so if Walter
19 Reed is the right place to ask about
20 amputations that would be good. But,
21 you know we even said courses of
22 therapy for TBI or for PTS and so you

1 wonder, so how do they set the six
2 weeks of therapy for PTS? Or whatever
3 the course of therapy may be. What is
4 the expectation management that goes
5 into this and I don't know who we
6 could go and talk to, but there's
7 probably whether, on the VA side or on
8 the DOD side, it may be something that
9 we could pursue and also kind of gain
10 an understanding as we talk with
11 people on these visits. What's that
12 to help you with your expectations?
13 So that you kind of understand what's
14 happening. I mean, if - if I was I've
15 got a daughter in OCS right now.
16 Okay? And so she has a - now a
17 sprained ankle and is on medical hold
18 and is getting to experience OCS a lot
19 longer time and so, yeah, you guys
20 understand. And so the problem is
21 that, you know, if you're being
22 mustered you know, several times a day

1 or several times a week, and there's
2 no end in sight, it becomes somewhat
3 demoralizing. And so, how do you work
4 with the expectation management?
5 MR. REHBEIN: Talking about time
6 periods and I think this is a good
7 time to come back to something that
8 Suzanne alluded to our - our visit to
9 Benning was somewhat specialized. We
10 saw wounded and injured folks, but we
11 saw all Army Reservists. We didn't
12 see any active duty and they face some
13 special challenges in the orders
14 area. MR. REHBEIN: Activated for a
15 certain period of time. As they come
16 to that period of time and we were
17 told of one young man that was back in
18 the barracks packing his bags because
19 his orders ran out that day, and
20 tomorrow he would no longer be able to
21 be on post. Whether his treatment had
22 ended or not, his orders were running

1 out, and that seemed to be something
2 that a number of them had either
3 experienced personally or knew of
4 other folks in that area. So, that
5 was a real concern to them that was -
6 I think -placing some additional
7 stress on a number of them even if
8 they weren't personally affected.
9 Somebody in their squad was.
10 The other part of the Army Reserve
11 National Guard issue was in the cadre
12 because one a reservist or a guardsmen
13 is activated, they come to the cadre,
14 it's for a year - a year from the time
15 they leave home 'til the time they get
16 back, and of course training time
17 comes out of that, leave time comes
18 out of that. So, that really
19 contributed to the manning problems in
20 the - in the WTUs. Someone was
21 officially in the WTU as a cadre
22 member for a year, but effectively

1 only there about ten months.

2 MS. CROCKETT-JONES: So their turnover
3 rate, just when cadre were getting
4 experienced with the process and what
5 their role was, their turnover rate
6 was very high, making it hard for them
7 to emphasize quality of staff or give
8 time for further training of staff
9 because it was all being pulled out
10 of. So, that is a specific reserve
11 issue.

12 LT. GENERAL GREEN: So, are all the
13 cadre reservists that were basically
14 being taken care of reservists.

15 MS. CROCKETT-JONES: They couldn't
16 staff with enough reservists. They
17 had coordinated with units on post at
18 Benning to provide some staff from
19 regular Army, but that was - seemed to
20 be a bit of an ad hoc at need. Those
21 were folks that were expecting to go
22 back to that unit at Fort Benning with

1 a fair - they weren't anymore long
2 term was my impression than the
3 reserve.

4 MR. REHBEIN: This was a mixed WTU
5 with active duty army reserve, army
6 National Guard folks. They didn't give
7 us any details on how they - on how
8 they assigned people to platoons or
9 how they assigned cadre to squads, but
10 I got the impression that there was
11 not necessarily a discrimination that
12 this squad is all reservists, this
13 squad is all active duty, because I
14 know they didn't do that with enlisted
15 and officers. Those are mixed squads.
16 So, I doubt very much they made that -
17 they made that distinction as they
18 assigned - as they assigned soldiers
19 into the squads.

20 LT. GENERAL GREEN: So, with somebody
21 who is - orders had run out,
22 supposedly leaving the base where the

1 therapy is not complete, where was the
2 non-medical case manager in that? I
3 think they would have authority over
4 the orders.

5 MR. REHBEIN: The orders all seem to
6 come out of reserve headquarters.

7 MS. CROCKETT-JONES: No, they don't
8 have authority over the orders. Those
9 orders have to come from headquarters.

10 MR. REHBEIN: I can only imagine - I
11 can only imagine someone going through
12 PTS therapy knowing that the orders
13 were about to run out and the therapy
14 is about to end, and --

15 MS. CROCKETT-JONES: Or, even cancer
16 treatment.

17 MR. REHBEIN: Or, diabetes disorder.

18 MS. CROCKETT-JONES: I mean, or even
19 something as -- as extended and as critical as
20 cancer treatment. If you've, you know, going to
21 an unknown facility back home, are you going to be
22 able to pick up where they left off? I mean, this

1 seemed like a really critical issue for people in
2 any kind of requirement of routine care. You
3 know, they could because they were - because they
4 were reserve, they're going back to maybe a
5 civilian provider, and would there be any
6 consistency of care continuity?

7 LT. GENERAL GREEN: So, what was the
8 cognizance of the medical treatment folks of the
9 one year time frame? Were they trying to do
10 everything within the one year time frame? Is that
11 what was going on?

12 MR. REHBEIN: No, I think they were -
13 I think they were doing the medical
14 treatment as the individual required
15 medical treatment. It was just the
16 orders complication was outside of
17 everyone's control. I don't think
18 they were trying to compress treatment
19 to necessarily account for that - it
20 just seems to be an added complication
21 for the reservists even more than the
22 National Guard. No one seemed to have

1 a good handle on to be able to
2 control.

3 LT. GENERAL GREEN: I know that within
4 our service it has to do - the orders
5 have to do many times with line of
6 duty determinations, and so they tend
7 to cut the orders for a year, but if
8 they're in the middle of therapy,
9 that's why I asked about the non -
10 somebody should be providing feedback
11 up the chain so the orders would be
12 renewed.

13 It may be something we want to
14 basically find out how each of the
15 services is determining who gets to
16 stay on continuation orders.

17 MS. CROCKETT-JONES: They were trying
18 to provide a - the chain to the
19 headquarters for changes. They were
20 being - they were not unaware or
21 unresponsive to this issue. There was
22 a sense that in - that Wounded, Ill

1 and Injured did not have a priority in
2 having orders complications addressed
3 that when it was a matter of combat
4 readiness or line unit strength, those
5 orders do get processed fairly
6 quickly, but that there was a low
7 priority to address glitches like this
8 for Wounded, Ill and Injured.

9 It was not at the WTU level that there
10 was a lack of concern or proactive
11 addressing of this.

12 MR. REHBEIN: I believe WTU, both the
13 medical and the non-medical people
14 were doing everything they could.

15 It's just that the people in control
16 were not there, far away.

17 LT. GENERAL GREEN: It sounds like
18 we're back to an expectation of time
19 management in terms of how long they
20 think it should take for these things
21 to be resolved, and then when things
22 are resolved within that time frame,

1 what's the exception of policy. But,
2 again back to how is this all
3 determined is an interesting question.
4 So, I'm sure each of the services have
5 issues with this. So, it's going to --
6 MR. CONSTANTINE: It sounds unusual to
7 me because it's my understanding
8 there's DOD instructions saying if
9 you're activated as a reservist for a
10 period of more than a month and you're
11 injured, if you want to stay on orders
12 until you're fit for duty or mentally
13 ill, that's there.
14 I could be wrong on that, and I'm sure
15 people can here probably say it. As a
16 reservist, I was mobilized. I was
17 injured. When my year mobilization
18 orders were coming up, I said, "I want
19 to go on with my life. I'm a
20 reservist. I want to go back to that
21 stuff," and it was a big shock.
22 I had a conference call with Bethesda,

1 in the room was a Navy commander who I
2 called over my situation and others,
3 and a senior marine officer there who
4 was a liaison but also there was three
5 other people on my conference call,
6 documenting and verifying the fact
7 that I wanted to not come on orders
8 until I was completely finished. I
9 wanted to understand what I was
10 getting into by leaving active duty.
11 So, to hear that situation is
12 (inaudible) anomaly its definitely
13 different than what I went through,
14 and I believe it's contravention to
15 DOD instruction on that.
16 So, it's a big deal or it was a
17 mistake, but I hope it's not going on
18 in other places.
19 MASTER SERGEANT MACKENZIE: We've got
20 to have a lot of - a little more time
21 for the army than we did anything
22 else, but I want to get back to San

1 Antonio in a little bit. Ms. Dailey,
2 the task force tried to set up a visit
3 there at Wolford Hall, and found out
4 very little involvement by Wolford
5 Hall this day.
6 Our day was scheduled based on what
7 information was given back to us.
8 When we arrived there that day, they
9 didn't have anything prepared for us
10 -- for me, but yet had a lot of people
11 who wanted to tell us things that
12 weren't actually understanding, that
13 seemed to be, "We didn't know," or "We
14 thought we were going to have an
15 opportunity here."
16 And, some very critical key pieces
17 that they were trying to squeeze in
18 there that nobody told us (inaudible).
19 For instance, the Air Force AFW2
20 program.
21 Those guys were eager. They heard we
22 were coming, and this was boots on the

1 ground. This was the centralized
2 location where the experience and the
3 interaction happens, and they were
4 noticeably upset that they didn't have
5 an opportunity to brief us, but yet it
6 was never fed back to us that anybody
7 wanted to talk to us from AFW2 until
8 we arrived.

9 As we've done in some of the other
10 situations, we always get feedback as
11 to what our visit was, and the - no
12 one in Wolford Hall had any kind of
13 feedback for us whatsoever. We tried
14 to set up an outbreak deal, and no one
15 wanted to talk to us.

16 We had a few interesting things
17 brought up (inaudible). So, we did
18 have somebody to talk to that we were
19 able to pull somebody in and say, "Hey
20 you need to take a look at this," but
21 all in all, there was very little
22 involvement.

1 The one particular area that we had
2 requested information on briefed on,
3 the person showed up with a packet of
4 slides or of notes, typed out notes on
5 pieces of paper, but they didn't have
6 any copies for the task force and
7 didn't have anything prepared. It was
8 a real shocker to us that that was -
9 that's the way it was approached.
10 And, I think it's something that
11 requires a further look to see what's
12 going on. On a different note --
13 LT. GENERAL GREEN: Can I ask?
14 MASTER SERGEANT MACKENZIE: Yes.
15 LT. GENERAL GREEN: What was requested
16 because we don't have a warrior transition unit,
17 per se? So, the Wounded Warrior program - was this
18 AFPC who was wanting to talk? There's also a
19 continuity management for the reservists that
20 deals with the orders and some of the things that
21 were going on (inaudible) that's in San Antonio. I
22 don't know what was requested in terms of the

1 visit.

2 So, when we visited the Air Force
3 site, were
4 we visiting with the personnel system who attracts
5 the Air Force W2 or with the continuity cell
6 that's at AFMOA because Wolford Hall is per se a
7 treatment facility, but doesn't necessarily unless
8 there's a patient up at BAMC who's in the Intrepid
9 Center or something, they track with that, but
10 there's no such - there's not a Warrior Transition
11 Unit that's equivalent, per se.

12 So, I'm trying to understand what was
13 requested when you went to visit with the Air
14 Force programs so we know where we target our
15 effort.

16 MASTER SERGEANT MACKENZIE: Yes, we
17 did. We actually looked at the IDES
18 system, the medical and non-medical
19 case management. We looked at the RCC
20 program that was on the list, and of
21 course we had the focus groups that
22 was going on, but that was all the

1 feedback that was given back to the
2 task force. The total questions that
3 were asked, I'd have to refer you to
4 Ms. Dailey on because that was the
5 information that we were there to see,
6 and that's all that was back to us.
7 MS. DAILEY: First item we targeted
8 was the IDES system. We didn't get a
9 briefing in. We didn't have a request
10 for briefing in February in IDS, and
11 we were going to San Antonio and
12 that's the home of the DES PEB System.
13 They briefed us. They came in and
14 briefed
15 us.
16 The information we got from them was
17 very
18 helpful for the big Air Force PEB and
19 DES program. We also had in there the
20 hospital PEB MEB director, which
21 provided us good information.
22 The other piece we looked at and

1 wanted to look at was the RCC non-
2 medical case management piece. They
3 were there, and we were unaware and I
4 did not solicit AFW2 because Captain
5 Demmons briefed us - Colonel Demmons
6 briefed us in February. They were
7 there, and they were eager to brief
8 us, and that was a little bit of a
9 surprise.

10 We also had the Patient Squadron
11 Commander there, and there is a
12 Patient Squadron there, and the
13 information they provided us was
14 informative, and not something we had
15 visibility of before. So, that was a
16 little bit of a surprise. It was a
17 free flowing conversation with a lot
18 of back and forth, not a more
19 structured type presentations.

20 So, they did answer our questions, and
21 - but it was not a more structured
22 type of presentation.

1 LT. GENERAL GREEN: No, you went to
2 the right places because they have
3 PCO, the Wounded Warrior and IDES.
4 So, it sounds like you went to the
5 right places. The continuity cell for
6 the reservists is actually at AFMOA,
7 so they - yeah.
8 Then, the patient squadron is a good
9 place to go and look, but yeah, it's
10 just - yeah, if you're looking for the
11 WTU type of approach, it doesn't exist
12 in the Air Force.
13 MASTER SERGEANT MACKENZIE: That's the
14 thing. We weren't looking for that
15 type of approach. It was
16 just one of those you try to get
17 feedback out of these people, and it
18 was just - we were - they were very
19 eager to talk to us, but just very
20 unprepared I would say, and those
21 additional folks that were coming in
22 trying to provide us with information

1 that weren't on the schedule was one
2 of those things was if we had known
3 about it before, we could have
4 scheduled that. So, the requests, the
5 R5 (inaudible) application did not
6 kick back with these other agencies to
7 come talk to us.
8 So, but I did find that the difference
9 - you look at the army - the two that
10 I went to plus the briefing was non-
11 medical case managers, squad leaders.
12 We went to visit with the Air Force,
13 and it was more the RCC - very robust
14 RCC involvement there, and that was
15 their big player. Found a little
16 units, some of the disparities as the
17 organizations (inaudible) the Air
18 Force folks at the same time, who owns
19 what program. The Air Force folks and
20 the families are very excited over the
21 Warrior and Family Support Center at
22 BAMC. Once they broke the ice that it

1 wasn't an Army facility, what we did
2 find is as that joint base combines,
3 some of the stuff that's provided with
4 the Army uniquely is now going under a
5 different support agency, so some
6 people are wondering is this the same.
7 Is it still going to be the same, and
8 it's very hard to judge?
9 It is one of those grey areas in that
10 realm, but the - I lost my train of
11 thought. I'm going to give it to
12 somebody else for a second.

13 LT. GENERAL GREEN: Let me just ask,
14 Mack. So, for instance the people that
15 wanted to talk to you that you felt
16 didn't have any opportunity, were they
17 folks that were running the programs
18 at AFPC? In other words, what would
19 be like cadre? Are they Air Force
20 Wounded Warrior Programs, or are they
21 patients in the patient squadron? In
22 other words, are there problems that

1 you think we didn't give the patients
2 a chance to talk with the task force
3 while they were there?

4 MASTER SERGEANT MACKENZIE: Absolutely
5 not. There was plenty of time in the
6 focus groups. We had a broad mix of
7 individuals either in the patient
8 squadron or over at BAMC because of
9 the nature of their injuries. We had
10 had a good level there. It was those
11 cadre that the AFW2 brought the guy
12 (inaudible) three people who worked in
13 the program.

14 So, those who wanted to provide us
15 some input were very robust in that.
16 Having the patient squadron come in
17 the one location that really has a
18 long-running patient squadron dealing
19 with a broad spectrum, he was at times
20 kind of our escort back, but it was,
21 you know, it was interesting to see
22 the - having that many people to

1 manage on top of another squadron,
2 that it's not a separate focus. The
3 commander has an entire squadron to
4 run. Oh, and by the way, here's I
5 think at the time he said he had
6 between, it was close to 50, almost 60
7 medical folks, personnel in the
8 medical treatment from ill and injured
9 to wounded folks that he also had to
10 manage separately without any
11 additional staffing. So, I found that
12 to be a point of interest into that.
13 LT. GENERAL GREEN: When you started
14 your discussion, the other thing I got
15 a sense of was you felt there was some
16 disorganization. So, that's why I
17 kind of was trying to figure out. You
18 started with Wolford Hall, but most of
19 the interactions are actually with
20 AFPC because that's where most of
21 these programs are overseen because of
22 the central nature of them. So, I was

1 trying to get a sense - so the patient
2 squadron thing is a good takeaway and
3 important to me that the patients got
4 a chance to talk to the task force.
5 So, hopefully that happened.
6 Then, the other part of the
7 disorganization between the people you
8 talked to and the people who wanted to
9 talk to you. That's why I asked who
10 we asked to speak with. So, I'm not
11 sure I still have a sense. Do you
12 think that the program needed some -
13 that there was a lack of coordination
14 between the various components? Is
15 that what I'm hearing from your
16 comments?
17 MASTER SERGEANT MACKENZIE: Yes, sir.
18 It is (inaudible) the location we went
19 to see. I don't want to point the
20 finger directly at Wolford Hall in the
21 fact that it was these different
22 agencies, but as these different

1 components are somewhat separated
2 because of the fact there's no
3 organized command, because of just the
4 numbers. Although these programs are
5 working very well, I don't know that
6 there's one (inaudible) button to push
7 to go, "We want information on all
8 these areas," and then they can go out
9 and task across the command society,
10 "We want all you guys to come in and
11 brief and put together a briefing
12 because the task force wants to know
13 X, Y and Z."
14 I guess that's where the
15 disorganization. I don't know if
16 there was any set place to say, "This
17 is what we want to see," and then they
18 task that out. I don't know if I'm
19 explaining myself correctly. It just
20 seemed to be very - it seemed to be
21 disorganized, and I think what may
22 have - may make it more of a challenge

1 was seeing the commands at the other
2 facilities. We wanted to know what we
3 saw because of the - you get that
4 impression that they wanted to see if
5 we saw anything that they could fix,
6 and right off the bat was, we don't
7 want an out-brief.

8 I think that may have set me off a
9 little bit because doing what I do for
10 a living, as well as doing this task
11 force, we all care very deeply about
12 these folks, and if we see something
13 that can be fixed in a rapid fashion,
14 we ought to be able to address that,
15 and given that opportunity, it was
16 just for me, it was - I was very
17 surprised by that response.

18 DR. COAKLEY: Well, just to tag along
19 on what the Master Sergeant was
20 saying, I didn't know personally that
21 AFPC was - had the major oversight per
22 se of the wounded warriors. The thing

1 was is that when we were talking to
2 the staff at the installation, they
3 were more of the mind of exactly that.
4 It would seem to be or perceive to be
5 a disconnect between, "Well, what do
6 you want to hear from us that you can
7 not, that's not already being provided
8 by them."
9 They didn't go into a lot of detail
10 about staffing issues, and it's just -
11 not again what Master said, we were
12 just expecting some sort of uniform
13 feedback from them especially being
14 the boots on the ground component of
15 it.
16 Specifically, we talked about the IDES
17 and they seemed to have some severe
18 staffing challenges as well. The
19 (inaudible) were at a one to 86 ratio,
20 and that's what their TDRs as on
21 their books, and even at that they
22 were at 146. They had an all paper

1 system. They went through a lot of
2 their specific challenges, but again,
3 they always defer it back up to who
4 was supposed to have the oversight,
5 the command and control. I think
6 that's my major takeaway from that
7 system there was that there didn't
8 seem to be a central oversight or
9 command and control on the boots on
10 the ground level like there is at the
11 other Warrior Transition Units. So,
12 there was a lot of confusion as to
13 what we were supposed to be briefed
14 with the questions, but we did get a
15 lot of good information from the
16 visit.

17 But, I think that was it. It wasn't
18 as structured as to what we were used
19 to.

20 LT. GENERAL GREEN: So, is it
21 something that the Air Force because
22 they don't have a central oversight,

1 or at least that hasn't been
2 identified, is that something that led
3 to, you think, that adversely affected
4 the Wounded Warriors? It sounds like,
5 you know, if you're talking about
6 manpower problems and things not being
7 filled, and then the question is does
8 that actually move all the way into
9 patient care issues. I say patient,
10 but really people in the process from
11 your perspective, from what you've
12 heard.

13 DR. COAKLEY: Well, my perspective is
14 yes, and the reason I say that is
15 because if you - just like every
16 single individual that did provide us
17 with information, it was, "These are
18 our specific constraints, and here's
19 what the oversight, the AFPC for
20 instance, what they're not giving us
21 or what they're not supporting us in."
22 Then we can actually - because of

1 that, and again what Master Sergeant
2 said, we had the squadron commander
3 who was in charge of 490 plus
4 personnel, and then as a side, I hate
5 to say collateral duty, but as a
6 secondary duty, he was in charge of
7 the patients -- the wounded warriors
8 there which is roughly 50 people, and
9 they all have significant challenges,
10 too. There was a lot of the families
11 in the feedback I received there, some
12 serious illnesses and so forth.
13 It just didn't seem like there was
14 enough coordination of effort on any
15 level, and with the different agencies
16 that we did get information from, the
17 agencies that -- I hate to say
18 desperately, but very much wanted to
19 talk to us about some of their
20 challenges like the Air Force W2, and
21 then the patients themselves. It just
22 didn't seem like there was any direct

1 line of communication, and they had
2 some very challenging points that they
3 were making, and that was my takeaway
4 from it, to elaborate on what Master
5 Sergeant MacKenzie was saying.

6 LT. GENERAL GREEN: Is that also in
7 the testimony? I didn't see that. I
8 have to go back and run this now so I
9 can see some of the people who talked
10 with you. Is that also in the notes we
11 were sent?

12 MASTER SERGEANT MACKENZIE: Yes, that
13 should be in the script of what you
14 were sent from our meetings that day.

15 MS. DAILEY: No sir, there was a -
16 focus group transcripts have not been
17 processed yet because that was our
18 last location. You have not received
19 that.

20 DR. GUICE: Now, we're kind of going
21 to wind up this particular session
22 this morning, but in thinking about

1 now in the collective three places
2 we've been, is the format that we've
3 designed to do our site visits
4 working? Does it need to be
5 reconfigured a little bit? Would you
6 do things a little differently the
7 next time you go make a site visit?
8 Are there things that our staff need
9 to be requesting differently, adding
10 on different components of it so we
11 get better clarity about what we're
12 receiving on an information way? Do we
13 need to add more time, less time?
14 Kind of think about the structure of
15 how we're doing the site visits, and
16 collectively puzzle through is it
17 working optimally to get us where we
18 need to be by July?
19 DR. OAKLEY: I would say that the
20 questions that we asked them, and you
21 touched on this as well, Karen, and
22 that was the way we formatted the

1 questions, what's your best practice?
2 We're speaking a lot with what appears
3 to be research speak to them, which
4 they do have best practices, but I
5 think we need to focus our information
6 that we want from them, on a more
7 basic level. Hey, like you said,
8 what's your metric? How many
9 patients? What's your outcomes?
10 I think that would be very helpful for
11 the task force. The focus groups I'm
12 going to back to what Master Sergeant
13 says, well, if we do them back to back
14 sometimes, it's - which you tend to
15 do. It's just human nature. We get
16 pigeon holed into, "Okay, we've got
17 that problem." Even though there were
18 some unique bases to that, there were
19 situations, but I think that the
20 questions that we asked the task force
21 were good overall - I mean of the
22 focus groups are good overall. I think

1 just in the information we want from
2 these sites, I think we need to maybe
3 retool that a little bit and that's
4 what you had recommended as well.

5 MASTER SERGEANT MACKENZIE: I think
6 the site visits are scheduled wise, I
7 think things are going very well. I
8 haven't seen any use of those who
9 wanted to talk and didn't want be part
10 of the focus group, but I have seen in
11 every situation some people who needed
12 to talk afterwards, wanted some more
13 information. There were some that were
14 your task force person for 90 minutes,
15 and then you spent ten minutes as a
16 caring human being that's involved in
17 processes. We all have experience in
18 our unique areas. They do capitalize
19 off of that a little bit.

20 So, making sure we have enough buffer
21 that we don't tighten down too tight
22 because there may be some flexibility.

1 The, but overall, I think it is going
2 well
3 scheduling wise.

4 MR. REHBEIN: Our groups -- I was
5 concerned initially that we had way
6 too much material to cover. I didn't
7 get that impression at Fort Benning in
8 our focus groups, but our focus groups
9 were more - well, I believe there was
10 five in one and six in the other. If
11 we would have had a dozen to 14 folks
12 in there, I think because as the
13 Master Sergeant said, I found myself
14 not reading the questions verbatim but
15 trying to give them the gist of what
16 we were looking for, doing some
17 translation. I guess I'm still a
18 little concerned if in
19 our next installation visit if we do
20 wind up with a dozen or 15 people in a
21 focus group, are we going to really
22 give them - all of them the

1 opportunity to express themselves.

2 The way it worked with five and six,
3 we were able to get it through - get
4 through everything in the period of
5 time that we were given.

6 MASTER SERGEANT MACKENZIE: I actually
7 had - we had several very full focus
8 groups, max participation and it was
9 tough. It does appear that you're not
10 going to get all the information out,
11 but it did actually work -- effective,
12 effective control of the side bars and
13 helping a lot of that conversation.
14 Even in one case, the commander and I
15 had a focus group where you would
16 swear the senior NCOs were briefed
17 because they were literally doing
18 their own segues into the next
19 question. It was like the information
20 we were looking for was the stuff they
21 wanted to tell us about.

22 But, I think the schedule works

1 effectively. We have to be willing to
2 sometimes allow some things; you've
3 got to be careful. You can't force
4 the questions because we did find
5 Commander Coakley and I in a couple of
6 our focus groups where the people
7 start helping themselves. You have a
8 collection of 12 NCOs or 12 junior
9 enlisted, and all of a sudden, they're
10 like, "Hey I've had this problem, and
11 this is what I did. How can I help
12 you?" Ran into that at Fort Campbell.
13 Ran into that at BAMC as well where
14 sometimes it's not really a side bar.
15 It's about a soldier taking care of a
16 soldier, and you kind of have to be a
17 little bit flexible with that
18 sometimes.
19 The family member groups will take the
20 full time whether it's six people, or
21 whether it's - Fort Campbell it was
22 six people, and we went over. At -

1 when we went to Wolford Hall and spoke
2 to the Air Force families, it was a
3 pretty large group, and we got done
4 early and had a little time to talk
5 afterwards. So, I think it will - I
6 think you'll find
7 that it will work. The time will work out. MS.
8 CROCKETT-JONES: We had a
9 disappointing
10 no family member response. Partially
11 -- once again, this might be a
12 function of it being a reserve
13 component. There are the population of
14 family members who are actually there
15 is much lower than it would be
16 otherwise, and there may have been
17 some administrative difficulties in
18 getting out the notice - the request.
19 That wasn't really clear to me.
20 I would say that one thing that might
21 have helped my take during the
22 installation visit is that I felt that

1 as a team, we spoke really as we
2 prepared for the out-briefing. But
3 really at the end of day one, we might
4 have gotten some more specific
5 questions answered on day two if we'd
6 had a little more chance to -- as a
7 full team -- to talk together because
8 we were dividing up duties. It wasn't
9 a full team, and the two of us doing
10 the focus groups did have an
11 opportunity to talk with the third
12 person going out there doing the
13 things that we can't do.
14 I might have had some specific
15 questions I wanted them to ask, so
16 that a little conference time
17 scheduled in at the end of day one to
18 say - for instance, it was apparent
19 towards the end of day one that there
20 was some question about who is a non-
21 medical case manager and does anyone
22 have a definition and do they

1 understand this, but it really
2 couldn't be asked. This didn't then
3 come up really again until the out-
4 briefing when we presenting what our
5 concern to the cadre when we could
6 have gotten even better information
7 out if we had a sort of a better time
8 in conference.
9 So, that's the only thing I would say
10 about the structure of the
11 installation.
12 LT COLONEL KEANE: One thing I'd like
13 to add is when the task force has to
14 be split, we had a site visit with
15 focus groups going on, I think because
16 the focus groups are our bread and
17 butter, that we not split off from our
18 focus groups. I think the task force
19 members need to, even if they're not
20 participating, attend the task force.
21 So, I would say in the future, I would
22 strongly suggest if the task force has

1 to split, not to split it during a
2 focus group meeting.

3 MS. DAILEY: I'd be happy to do that.
4 You're going to miss things on the
5 installation that unless you all want
6 to add a third day. So, you're going
7 to have to make that call. You want
8 to go places, do things, see the
9 facilities, I can add another day, but
10 keep in mind, there's always a trade
11 off.

12 LT. GENERAL GREEN: From my
13 perspective, and I'd have to say I
14 haven't gone out on one, but I do
15 think that the meat and potatoes is in
16 the focus groups where we're actually
17 listening to the people who are
18 experiencing the process. So, if that
19 means we need to add some time to the
20 visit, I would suggest we do that,
21 okay, but I do think I agree with you.
22 It'd be really good to have multiple

1 people hearing what's coming out of
2 the focus groups because that's the
3 bread and butter. When we want to hear
4 what's happening to the people.

5 MR. REHBEIN: I'm just going to make
6 one comment about the focus groups.
7 Suzanne and I did those at Fort
8 Benning. I would be very reluctant to
9 try to run a focus group alone because
10 I think it worked very well for us to
11 be able to look over each other's
12 shoulders and make sure that we really
13 covered everything that needed to be
14 covered.

15 So, even though - even though one of
16 us took the lead and the other one was
17 providing the back-up, I think having
18 at least two and potentially the whole
19 group there just from the standpoint
20 of getting the material covered is a
21 necessity.

22 MS. CROCKETT-JONES: I actually think

1 that the third person 'ears only' was
2 really significant. I think that
3 having someone there who didn't have
4 to worry about our covering all the
5 questions. The two of us making sure
6 we got through the agenda, which
7 really I felt like it took both of us
8 as well, was good, but I think that I
9 worried. I don't - I can't say that I
10 actually missed anything -- and it was
11 a small group. So, I don't think I did
12 miss anything that was being said, but
13 I know I was concerned that I was
14 looking down reading what's coming up
15 and trying to listen, and a third
16 person who has no - and I know we have
17 a transcriptionist who is getting all
18 of this, but sometimes inflection,
19 body language, you know.
20 So, I liked when we had all three of
21 us. I just felt a little more
22 confident that nothing was going to be

1 missed, and if we'd had a big group --
2 I'd say that was the significant thing
3 -- If we had a dozen people, we would
4 definitely need the third task force
5 member to keep filtered because
6 there's no way someone who is
7 transcribing can be getting nuance and
8 body language and inference when they
9 have such a large group to look at.
10 So, I would say that maybe if we know
11 what kind of response we are getting,
12 that might alter whether we need the
13 third person in the room or not.
14 DR. GUICE: Well, if there are no
15 further comments about our site visits
16 for the time being. We will take a
17 break. Back here in ten. Denise says
18 ten,
19 so make it ten. MS. DAILEY: Ladies
20 and gentlemen, can I bring the task
21 force back to the table, please?
22 Ladies and gentlemen, we're going to

1 start a service presentation. In our
2 last meeting, we covered the Army and
3 the Air Force, and in the next two
4 days, we will cover the Marine Corps
5 and tomorrow, we will have the Navy
6 presentations.

7 Today's presentation will be on the
8 non-clinical aspects of care for
9 wounded marines, and I'd like to
10 introduce Lieutenant - excuse me; I'd
11 like to introduce Colonel Mayer, the
12 commanding officer of the Marine
13 Wounded Warrior Regimen.

14 COLONEL MAYER: Thank you, Denise.
15 Hi, my name's Colonel John Mayer, and
16 I am the commanding officer of the
17 Wounded Warrior Regimen. On behalf of
18 my commandant, General Amos and all
19 the marines, especially the marines in
20 the Wounded Warrior program, I want to
21 say thank you. I want to also say
22 thank you for the task you have ahead

1 of you, and that we can always use
2 more eyes especially experienced eyes
3 looking at our program and helping us
4 making it better for the marines and
5 their families.

6 So, anyways, welcome to our world. I'd
7 like to quickly introduce my team here
8 - Sergeant Major John Pleskonka, a
9 wounded warrior himself, and you're
10 going to find that he is incredibly
11 knowledgeable asset to this team on
12 everything from his experience as an
13 enlisted man to his experience with
14 the Wounded Warrior program to his
15 knowledge on leadership and all things
16 marine. April Peterson is also running
17 our family
18 program, and she'll be briefing you
19 later on if we get to that. Mr. Tim
20 Clubb is our - in charge of our
21 recovery care coordination program.
22 In the back, we have our case manager,

1 Captain Ann Dalter, Erica Flores and
2 Miss Mary Petrella. They're all part
3 of my smart team and helped produce
4 this very detailed brief that I hope
5 helped the team here before hand.
6 We spent a lot of time trying to
7 answer the questions that came down to
8 us in advance, hopefully so you don't
9 have to listen to me talk too long,
10 and we can go right to your questions.
11 My intent for today was to give you a
12 quick command brief, and kind of lay
13 the foundation of the Marine Corps
14 Wounded Warrior Program, and then I'll
15 go right over to your questions. Fair
16 enough.
17 Now, let me just warn everybody, I'm a
18 passionate guy especially about
19 wounded warrior matters. So, if I
20 drift away or I get - it's not that
21 I'm angry; I'm just passionate about
22 what I'm talking about, and so when

1 you take a man like Master Sergeant
2 Gibson back there who is a wounded
3 warrior, and now an advocate for us up
4 with the Assistant Secretary in the
5 Navy's office and I can't get too
6 passionate or care enough.
7 So, and Justin is here, another
8 wounded warrior, and a great friend of
9 the Wounded Warrior Regimen and all
10 marines, and of course Lieutenant
11 Colonel Sean Keane. Okay, so I'd like
12 to go to the next slide. I guess I'm
13 in charge of that.
14 I want to make sure that everybody
15 understands, and I believe that all
16 the services are this way now too is
17 that we take care of the wounded, the
18 ill and the injured. We do not have
19 any distinction between either of
20 those categories, and now that we've
21 been at war ten years, most marines
22 have been deployed or been to combat.

1 So, a marine that gets in a car
2 accident or a motorcycle accident out
3 here on 95, we'll take just as good
4 care of him as we would if he was
5 combat wounded over in Afghanistan.
6 So, I think most of the programs are
7 pretty much the same now.
8 Our evolution -- you can kind of see
9 we did a timeline of the significant
10 events, and I just kind of want to set
11 the highlight the key points here is
12 that - but, I believe our program has
13 set the standards and kind of led the
14 way across DOD.
15 In April, we'll be four years old, and
16 so I think all the other service
17 programs are the same. Almost
18 immediately, we stood up our call
19 center. I'll talk about that later on,
20 and really it's grown now to be a
21 resource center that also includes
22 social networking. In January, we

1 stood up our ops center. That
2 gave us a current ops capability to
3 reach out and work with the immediate
4 concerns of the marines and the
5 families.
6 In April of '08, we started our Marine
7 Corps Wounded Ill and Injured tracking
8 system, which is our database that is
9 used by our staff and our commanders
10 to know their marines, know their
11 families, and to keep track of them.
12 That is, of course, being looked at as
13 the data system for all of DOD to use.
14 Our RCC programs stood up in November
15 '08. I know you all are very familiar
16 with the Recovery Coordination
17 program. We're very proud of it. We're
18 very proud of the people and the team
19 of civilians that are out there, and
20 -- odds are most of them are former
21 marines or married to marines, or very
22 much know marines, and they are a huge

1 part of our team.

2 In April of '09, we started our

3 research and analysis cell. That is

4 how we answer our questions; get our

5 feedback from the people we're here to

6 serve. We just recently started

7 Facebook. We know the majority of our

8 population that we are here to

9 advocate here are young guys that

10 don't communicate the same way that us

11 old guys communicate. So, we've gone

12 into the social networking realm, and

13 we continue to improve every single

14 day.

15 I'm excited about this summer, we'll

16 open our first open care center.

17 There's probably a technical name for

18 it. I call it an extreme fitness

19 facility. It'll be one on the east

20 coast, and one on the west coast. The

21 west coast opens here this summer, and

22 it'll give a place for our marines to

1 excel above all the rest, and I'll be
2 happy to brag about that in a moment.
3 Soon, we'll publish the strategic
4 plan. Quite honestly, it's written. I
5 just need time to sit down and tweak
6 it, but it's there, and we're already
7 implementing much of what's in it, and
8 I'll talk about that in a moment.
9 Next slide.

10 We take care of the marine from the
11 point of injury or wounding, all the
12 way to reintegration back with the
13 active force or out into the civilian
14 world. You can see we've kind of shown
15 pictures up there of our marines as
16 they are doing each of the phases -
17 the recovery, the rehabilitation, the
18 reintegration.

19 I like to tell folks this, and this is
20 what I tell the marines, and I've got
21 a simple message for each and every
22 marine out there is that you join

1 marines, not the army, not the air
2 force, not the coast guard. You
3 didn't become a civilian, and you
4 didn't stay back on the block. Every
5 single person volunteered to become a
6 marine, and the only things the
7 marines promise you is a chance to
8 fight, and not only fight, but be the
9 first to fight, and that's it. That's
10 what we all love about the marines.
11 That spirit that's in the marines when
12 he joined is what we constantly are
13 trying to maintain and reignite if
14 necessary throughout our program, and
15 that's what I think sets us apart and
16 makes us different, and I'm going to
17 talk to you about this in a minute.
18 I've got a great slide here. I love
19 this slide. This takes a wounded
20 Lance Corporal Mayer through our
21 process. Now, I spent an hour and a
22 half briefing my boss on this, and I

1 don't tend to do that, but I did want
2 to throw it out there in case anybody
3 in the - I guess the team - had a
4 question on exactly how the marines
5 work from the point of injury now, and
6 typically in Afghanistan now, although
7 it could be in the Pacific all the way
8 back to reintegration with society or
9 back on active duty or even into the
10 reserves.

11 It kind of follows a flow through
12 there, and our team threw it in there
13 for questions on, "Do you have marines
14 in Landstuhl, Germany?" The answer is
15 yes, we've got a great team out there
16 that as soon as the medevac bird lands
17 from theater, they receive them. We
18 triage them there, usually it's four
19 and a half to six days, send them back
20 to Andrews. The marines are waiting
21 for them when they land at Andrews.
22 From Andrews, all our sea cats go over

1 to Bethesda. At Bethesda, our team
2 picks them up there. We do the
3 initial ICU, intensive care. They then
4 become an inpatient, an outpatient,
5 and there's decision points all along
6 the way of where and what to do and
7 what's the best thing with the marine.
8 Our decision points, you can see down
9 here, and I'm going to talk about this
10 is done by what we call the recovery
11 team, very standard, I think
12 throughout all the services. The army
13 I think uses triad. We've got four
14 folks there, and it evolves around the
15 doctor and the nurse case manager. The
16 section leader, which provides
17 leadership in our small unit
18 leadership, the recovery process, and
19 then of course the recovery care
20 coordinator, which is our expertise.
21 That takes you through the process.
22 Are there any questions on that, and

1 I'll move on? All right, good.

2 I like to say that the sun doesn't set

3 on the Wounded Warrior Regimen. We're

4 headquartered here in Quantico, and my

5 small headquarters does strategic,

6 operational and tactical matters --

7 matters that matter to the wounded

8 warrior on a daily basis. Strategic,

9 I would call this strategic, but I am

10 focused primarily on the manning,

11 training, equipping and writing policy

12 for the wounded warrior regimen for

13 the Marine Corp on wounded warrior

14 matters.

15 Where the rubber meets the road though

16 is down at my two battalions, and I am

17 battalions at Camp LeJeune, North

18 Carolina. They have the east coast,

19 kind of the Mississippi divides and

20 all the things in between, and then I

21 have a battalion at Camp Pendleton on

22 the west coast. Each of them military

1 treatment facilities -- I also have a
2 detachment. Almost all of them are
3 lead by Lieutenant Colonel to include
4 out there a Tripler, and a Lieutenant
5 out in Landstuhl and we have an
6 attachment of liaison marines and
7 marines there that help with the
8 recovery process.

9 At the four poly-trauma centers, I
10 have a small liaison detachments that
11 helps with marines that are sent there
12 for recovery, and I like to also point
13 out and I'm very proud of this is that
14 these dots here - and we're about to
15 change that because I was told the
16 team it doesn't look very marinish
17 (phonetic spelling), these purple dots
18 -- but those purple dots represent
19 reserve marines that have been
20 activated and stationed throughout the
21 country. There's 30 of them out
22 there, and those marines work with the

1 community and we hand off a marine.
2 When he leaves active duty and
3 transitions and becomes a veteran or
4 reservist leaving active duty and
5 going back, that's our hand off to
6 what I call a district injured support
7 cell or coordinator who is helping the
8 marine continue to navigate through
9 his benefits and with the VA.
10 So, we have 30 of those, but they do
11 great things each and every day out
12 there. My RCCs, you can see where
13 they're the yellow dots, and they're
14 at most of the major, or all of the
15 major military treatment facilities.
16 They primarily work with active duty
17 marines, and they're of course the
18 ones that would do the hand off to the
19 disc.
20 I have 49 RCCs, and three of those are
21 designated to help with the reserves,
22 and of course, two coordinates that

1 work with me and Tim Clubb's here, and
2 we'll talk in detail about that
3 program later on. Those dots, orbs,
4 purple drops and all that
5 represent 523 military and civilian
6 staff that devote way more than I am
7 paying them on a daily basis to taking
8 care of the 825 wounded, ill and
9 injured marines and sailors that we
10 are stewards over. Okay, next slide.
11 (Inaudible.)
12 If you look at my chart there,
13 constantly we are asked for numbers in
14 the Wounded Warrior Regimen just like
15 all the other services, and this - I'm
16 telling you, this is - having been a
17 commander my whole life, numbers in
18 wounded warrior care is not an easy
19 thing to get across to folks. People
20 want numbers that are black and white
21 out there, and there's always this
22 grey area. I can tell you whether the

1 marine I own his record book which is
2 that 494 I physically own his record
3 book, and I say, "Fall in wounded
4 warriors," and that's the 494 that
5 would fall in across my commands and
6 detachments out there. I look after
7 them.
8 But, what you're missing is the non-
9 medical attendance. You're missing the
10 families. You're missing all the
11 others that fall in, and then you take
12 the ones fresh from battle, the ones
13 that just got in a car accident out
14 there, moving up and down highway five
15 or highway 95, the ones that have
16 taken ill and that have just gone to
17 the hospital but I don't own them yet,
18 but -- my folks have adopted them like
19 their own sons, and with them come
20 three people on individual travel
21 orders at the same time.
22 So, the numbers - I'm showing you

1 what's in a military uniform, but
2 there's far more that we support out
3 there, and that's what that 331
4 supports. Those are folks at the
5 hospitals that we are looking after on
6 a daily basis. Then you've got the
7 role up to 825.
8 Now, my RCCs because we have the
9 recovery care coordinator program, and
10 there are many other marines that
11 don't belong to me that aren't in a
12 hospital. They're also on limited duty
13 in some sort of recovery process,
14 through my battalion commanders and
15 myself, we also accept people that
16 aren't in the recovery process that I
17 own that are in a hospital that we'll
18 assign a recovery case coordinator to.
19 Our RCCs are helping 1,148 I think
20 that says - my eyes aren't as good,
21 yes 48, of people out there that are
22 in the battalions and commands

1 throughout our nation. Once again, a
2 valuable program of expertise of
3 people that care.

4 Now, my disc, I talked and bragged
5 about those discs. Right now, I have
6 629 active cases that my 30 discs are
7 supporting in some shape or form out
8 there across the United States. Now,
9 if you look down below, it's kind of
10 my roll-up of those that we have
11 touched, helped, supported, been a
12 shoulder to cry on or whatever since
13 we stood up back four years ago, and
14 you kind of see the numbers in the
15 roll-up.

16 So, numbers, I say it's been in the
17 26,000. Our call centers reaches out
18 and touches people, and follows
19 through on a daily basis. How many
20 does a disc interact with and help
21 when he's moving about Chicago out
22 there or talking to Marines, former

1 Marines and veteran Marines that
2 somehow, some shape still needs a
3 Marine Corps attention. It's
4 innumerable.

5 Okay. I'll move on. This is my
6 program, and it might look very close
7 to Admiral Mullins' total force
8 fitness, but I can talk all day on
9 this slide. Let me emphasize a few
10 points. The IDES system -- and I
11 don't think we're talking about -
12 that's this afternoon with Paul, but
13 IDES for Marines is currently 350 day.

14 Then, if you look at the recovery
15 periods, usually two periods in a
16 recovery period, I'm going to own a
17 marine for probably two years that
18 gets assigned to the Wounded Warrior
19 Regimen, sometimes longer than that,
20 sir. Now, last thing I want to do as a
21 leader and
22 a commander is look at the marine in

1 the eye, his wife in the eye, his
2 parents in the eye and say, "The best
3 I could for him is fix him medically."
4 Boy, if that's it, I have failed as a
5 leader. I have failed.
6 So, I have mandatory programs that
7 help the whole marine, the whole
8 family across the mind, body and
9 spirit. I don't get into detail, but
10 these are education programs. These
11 are picking a sport -- one sport and
12 then excelling at it. I'm not talking
13 about going to the weight room and
14 just lifting weights. I'm talking
15 about picking a thing, a sport out
16 there that will heal your body and
17 bring you to a level that is so
18 fantastic, so high that when you leave
19 my program and all this support,
20 you'll be able to do anything. You'll
21 be able to do more than you ever would
22 have done just left on your own

1 devices.

2 We have marines that climb the

3 mountains in the Himalayas last year.

4 We have marines riding with Ride for

5 Recovery doing phenomenal races out

6 there, and same with the Army, and we

7 have marines competing in the trials

8 last month. We brought out three

9 international teams from the Royal

10 marines, the Australians and the

11 Dutch, and in May, as you all know

12 here, we will compete in May at the

13 Warrior Games. That is a significant

14 goal setting life changing event in

15 the athlete's life. That's what I want

16 for all the Marines. Only about twenty

17 percent participate in the games. The

18 only eighty percent need a definite

19 thing such as that, also, and that's

20 kind of the body.

21 Then, rebuilding the spirit, I talked

22 about how important it is that people

1 join the marines -- not other
2 services, didn't stay back on the
3 block. I'm telling you I'm a believer
4 in that that everybody that's in my
5 program, I'm going to bring the Marine
6 back, and the best thing is when they
7 get to the end of all this support
8 here, what you have with the family
9 and what you have when you go out to
10 either employment or back on active
11 duty, you might have a wounded
12 warrior, but -- he's not focused on
13 his disability. He's like Master
14 Sergeant Gibson back there. He's
15 focused on his ability and all he can
16 do.

17 If you knew Master Sergeant, you
18 wouldn't even know he's a wounded
19 warrior unless you looked at his
20 ribbons and he chose to tell you
21 because he is a Marine. Does everybody
22 understand that? Man, that's my

1 message, and that's what we do to
2 bring out to everybody and the
3 families.
4 Total force fitness, okay? So, I'm
5 good and passionate here. I'll try to
6 calm down.
7 So, here's how we do it, and here's
8 really, I talked about the battalion
9 commanders where the rubber meets the
10 road. I'm telling you folks, where the
11 rubber meets the road is a young staff
12 sergeant out there who quite honestly,
13 I'm doing a lot I can to train him,
14 but there isn't anything that prepares
15 anybody that's a Marine for now
16 becoming part of the process or taking
17 care of wounded warriors. Our motto is
18 Semper Fidelis, always faithful.
19 This is the Semper Fidelis of being a
20 Marine. I look at a marine section
21 leader. We're working towards a one in
22 ten ratio of section leader to

1 marines. We're working at it, but that
2 is your small unit leadership. So much
3 is he held accountable for out here in
4 the stewardship, mentorship and
5 support of the marine and his family.
6 To help him is to recovery care
7 coordinator -- that's your expertise.
8 This is a complicated business,
9 absolutely complicated, and the beauty
10 of the RCCs is you have somebody that
11 has devoted - I mean it's their job to
12 understand and navigate the very
13 complex systems and make it simple.
14 So, you have a recovery team that also
15 consists of a nurse case manager, and
16 a primary care physician, and I know
17 Captain Kass is back here. She's going
18 to talk to you tomorrow about BUMED.
19 I'll let them represent it, but that
20 team, those four, we work hand in
21 hand, and if we're on an Army base or
22 - I'm sorry, an Army Fort like Fort

1 Sam Houston or BAMC, or out there at
2 Tripler, we work with the Army to
3 provide the best care possible medical
4 and non-medical for the marine and the
5 families.
6 That's where the rubber meets the
7 road, and that's the recovery team.
8 No decisions to be made unless you've
9 got the recovery team involved.
10 All right, my clinical services staff,
11 I'm very blessed. BUMED has supplied
12 us with 11 clinical services staff, so
13 to speak. I don't call them that. I
14 just hug them. I've got some folks out
15 there led by my surgeon who is Captain
16 Adams. He's out right now bringing
17 third battalion fifth marines home in
18 Camp Pendleton, and working with the
19 reserve marines, integrating them
20 back. They asked for him for an extra
21 day, and so I said, "Stay out there.
22 It's much more important than talking

1 to you all," but he's also - I've got
2 Captain Ann Dalter who's here who is
3 my nurse case manager.
4 They also have a team that's the BUMED
5 contract of absolutely great people,
6 nine licensed clinical clinicians -
7 did I say that right -- and two that
8 do admin duties for them, and these
9 are my advocates - really not mine.
10 These are the advocates for the
11 wounded warriors out there on
12 psychological health, traumatic brain
13 injury. They work hand in hand with
14 BUMED. They work hand in hand with
15 the surgeon of the Marine Corps Health
16 Services. They work with our
17 families.
18 They provide kind of a medically
19 credentialed, but an oversight for me
20 on how the medical community is doing
21 on our behalf. So, everybody knows Ann
22 Dalter. She is at every meeting, and

1 she is my advocate with the Navy
2 talking about how do we make the
3 program better, how do we integrate it
4 better, and how do we take it on the
5 next steps here. So, I'm very proud of
6 these folks, and I'm very blessed to
7 have.
8 Reserve specific, a lot of questions
9 on reserve and all things reserve.
10 When I joined the Wounded Warrior
11 Regiment, there's that sign that goes
12 over my door that says there's a lot
13 of things they left out of the job
14 description when I signed on for the
15 outfit. One of those is all things
16 reserve related falls underneath me.
17 I've got this great group of folks
18 called the Reserve Medical
19 Entitlements Determination Section,
20 RMED, and they maintain oversight of
21 all reservists, and specifically those
22 who require to stay on active duty

1 because of medical reasons beyond
2 their active duty service date.
3 You can see my numbers up there.
4 Currently, I'm working 160 medical
5 cases, or 285 line of duty benefit
6 cases for just over 400 cases. That
7 number has significantly shrunk in the
8 past year and a half or so out there.
9 What I talked about earlier was my
10 district injured support cells. Those
11 30 great marines are out there working
12 constantly with the reserve and
13 veteran marine population. And all in
14 all my folks help the marine
15 reservists return to active duty or
16 transition back to a civilian job and
17 structure as smoothly as possible.
18 So, and I'd like to point out I've got
19 my big note here, on the return
20 integration location process is where
21 my medical team meets the airplanes,
22 and I talked about where Doc Adams is,

1 that are returning from Afghanistan.
2 Right now, 3-5 took a tremendous
3 number of casualties last fall, is
4 coming back and my folks will be out
5 there screening and helping to
6 integrate them so we catch them coming
7 off the airplanes and not a month,
8 four months, five months down the
9 road. So, great program, and that's
10 where my doctor is now.
11 I believe, folks, that is my last
12 slide for the command program. What I
13 plan to do is sit down here with the
14 rest of my folks, and answer questions
15 on the rest of the brief. I'd like to
16 point out though this slide and this
17 picture, and that is a Navy corpsman
18 up there who recently received the
19 Silver Star, and that's Lieutenant
20 Colonel Friedrichson, and Sergeant
21 Major Scott Samuels.
22 Now, I'll talk a little quickly about

1 this Sergeant Major. He was a First
2 Sergeant when I was out there fighting
3 the fight, and that was 2005 when I
4 left. So, he deployed twice with me in
5 2004 and five, and now he's deploying
6 as a Sergeant Major out there. That's
7 the kind of Marines we're seeing four,
8 five, six and more combat deployments.
9 This corpsman here that's getting the
10 Silver Star, that citation reads, and
11 you all can envision it in your mind,
12 "When under heavy machine gun fire,
13 surrounded by 30 to 35 terrorists,
14 Petty Officer Third Class Peter Gould
15 without any worry for his own safety
16 exposed himself, saved a Marine, gave
17 him the immediate triage out there and
18 stuff with the Marine while taking
19 shrapnel throughout his body."
20 So, you can kind of see his neck
21 there, but that's the type of marine
22 and sailor that's in our Wounded

1 Warrior program, and also the type of
2 Marines out there supporting the
3 Wounded Warrior Program. So, you can't
4 do enough. You can't care enough about
5 these Marines.

6 So, what I'll do is sit down, and open
7 up the questions. Is that fair enough
8 for the panel, General?

9 LT. GENERAL GREEN: Colonel, if I
10 could ask just a quick question. On
11 your last slide, where you talked
12 about medical and line of duty benefit
13 cases, is the line of duty benefit
14 cases just people you haven't yet
15 adjudicated, whether they are entitled
16 to medical benefits? Is that what
17 that means?

18 COLONEL MAYER: Sir, as I understand
19 the question, the line of duty
20 benefits are those that they go home
21 back to - the return off of active
22 duty, but they still get their

1 medical. They go through tri-care and
2 all that.

3 SERGEANT MAJOR PLESKONKA: It's not
4 the same line of duty like an
5 investigation to find out if they were
6 culpable or not. That's not the same
7 on the reserve.

8 LT. GENERAL GREEN: That's what I'm
9 asking.

10 SERGEANT MAJOR PLESKONKA: No, sir.
11 It's back home receiving medical care
12 at home, not on active duty.

13 CAPTAIN DALTER: It's B like benefits
14 (inaudible).

15 LT. GENERAL GREEN: Okay, thank you.

16 MR. REHBEIN: Colonel, if I may for
17 one quick question out of your command
18 briefing. You talked about section
19 leaders that your goal is one to ten.
20 Can you give us some idea of where you
21 stand right now, and what the timeline
22 might be to reach that goal?

1 COLONEL MAYER: Sure, the manning is
2 always a tough question in this very
3 fiscally or becoming fiscally austere
4 environment. We have just completed a
5 planning session, and the Marine Corps
6 is going through their, "How do we
7 right size the force for the future?"
8 So, I am currently working with all
9 the way to the commandant's level, and
10 what do we need for Wounded Warrior
11 care, and the numbers. So, I would
12 imagine I will get my numbers up to
13 there by this summer, and a mix of -
14 currently my staff is 80 percent
15 mobilized reservists, and so I'm
16 looking at a mix of active duty,
17 active reserve and mobilized reserve
18 so we have a total force, which I
19 think is better in the long run
20 because it gives you a different view
21 point helping out the Marines.
22 So, I would say probably by the

1 summer, I should be at one to ten. Of
2 course, the enemy has a say in all of
3 this, and my casualty flow has not
4 slowed down any. So, well, it slowed
5 down a little bit here in the winter,
6 but I imagine come spring and when the
7 fighting season returns to
8 Afghanistan, the casualties will
9 increase again, sir?

10 MASTER SERGEANT MACKENZIE: Colonel,
11 you kind of touched on one of the
12 questions that I had which was you
13 mentioned 80 percent of your force is
14 activated reservists, and I know
15 there's a lot of challenges to keeping
16 active duty members on active duty,
17 but there's a lot of focus being put
18 towards some of these active duty
19 marines that could serve, but not
20 necessarily on the front line forces
21 being brought into your organization
22 to build up your force composition

1 with more active duty marines within
2 the Wounded Warrior Regimen.

3 COLONEL MAYER: He looks like he's
4 ready to go.

5 SERGEANT MAJOR PLESKONKA: I'm ready
6 to go. Is this working? All right.
7 Really if you look at force structure
8 and stuff like that, if I take from
9 one other unit, then that's less
10 people that they have over there. So,
11 we're able to maintain flexibility by
12 influx of patients by using the IMAs
13 because the IMAs can come on for a
14 year, and then they can be demobilized
15 as where an active duty, once you PCS
16 them, you have them for 24 months, and
17 you have to go down in numbers, you're
18 not going to get a PCS. So, it's
19 fiscally more manageable to do the IMA
20 and do a sixty-forty split of active
21 given reserve than it is to do a full
22 active duty component running all of

1 our detachments. So, you have better
2 flexibility on that 60 percent where
3 we're trying to get to that number
4 like the Colonel said for this spring,
5 or this summer, by the end of summer
6 to get to that forty percent solution
7 of active duty force structure, and
8 then having sixty percent being the
9 reserved component that can fluxuate
10 in between.

11 COLONEL MAYER: I'm in - in some of my
12 spots like the National Capital
13 Region, we're very close to the one to
14 ten, and in some I'm over the one to
15 ten - down at like BAMC, the Brooke
16 Army Medical Center. I'm over the one
17 to ten structure.

18 A lot of it is anticipation of the
19 Marines coming down there, and we just
20 haven't seen them yet, but we don't
21 want to pull people and reorganize.
22 So, it's very difficult to right size

1 each place right at one to ten. I can
2 tell you that we can - the big thing
3 we need to do as Sergeant Major said
4 is get the right force for the
5 population that's there such as BAMC.
6 Folks are burned and they're usually
7 very critical. They're going to be
8 there a long time.
9 Whereas you have a larger outpatient
10 would be out there like at the
11 National Capital Region, currently
12 over 77 amputees up there. You
13 probably need a little bit more closer
14 to the one to ten ratio because of the
15 nature of the population there. So,
16 when you say one to ten, a lot of
17 depends on the need at the specific
18 site.
19 LT. GENERAL GREEN: Just out of
20 curiosity, so the reservists and the
21 mandates you're using, how they are
22 all OCO funded -- contingency funded

1 dollars?

2 SERGEANT MAJOR PLESKONKA: If they are
3 an IMA sir, they are all OCO money.
4 If they're not an IMA, we do have AR
5 reservists that are pulled from the
6 SMCR that become the AR component of
7 the SMCR.

8 LT. GENERAL GREEN: Okay, thanks.

9 COLONEL MAYER: Okay, so what I'll do
10 is sit and this is kind of the
11 questions here. Maybe there are.

12 MS. PETERSON: What we can do is
13 continue to roll through the brief if
14 you'd like, and you guys can answer
15 questions as we go through.

16 COLONEL MAYER: Would you all like me
17 to continue briefing? I noticed my 64
18 slides, ma'am.

19 DR. GUICE: I think actually I'm going
20 to suggest that perhaps you go to the
21 podium because I see the glare at the
22 screen in your eyes. That must be

1 uncomfortable. I think probably for -
2 since hopefully the task force members
3 have had a chance to kind of review
4 this, and I know I've made some
5 questions. If you can just kind of
6 scroll through these, and then we'll
7 ask questions as we feel the need.

8 Does that sound --

9 COLONEL MAYER: Sounds great, ma'am.

10 I thought maybe that light was a
11 divine light.

12 DR. GUICE: It's the light of
13 questioning.

14 COLONEL MAYER: But, as you rightfully
15 pointed out, it was an electronic device shining
16 in my eyes. I'm trying to get that very staunch
17 looking Marine to smile over there.

18 DR. GUICE: I would go ahead and
19 start. If you can go to the next
20 slide.

21 COLONEL MAYER: Yes, ma'am.

22 DR. GUICE: First of all, thank you

1 very much for putting together the
2 robust answers to our questions.
3 This is a really nice way to do it,
4 and we greatly
5 appreciate the opportunity to see the
6 information and ask probing questions.
7 So, my question on this first slide
8 with each of this serving us, and you
9 don't have to answer it now, but if
10 you can provide the answers in writing
11 to us, that would be okay, perfectly
12 acceptable.
13 First of all, what were the numbers of
14 individuals in each survey? What was
15 your response rate, and then an
16 assessment of whether or not that
17 response - the number that responded
18 and the types of individuals who
19 responded was a representative sample
20 so that you know whether or not what
21 you have is - the answers that you
22 have are totally representative of

1 that entire group of what your
2 intended population was.

3 So, if you don't have that readily
4 available, you can provide - or if you
5 have it now, you can do it.

6 MS. PETRELLA: In your handouts, in
7 your folders, you have executive
8 summaries of those surveys.

9 DR. GUICE: Okay.

10 COLONEL MAYER: I'd just like to point
11 out in the Wounded Warrior Regimen, we
12 measure success, and it's kind of what
13 we've been using as our metrics are
14 the surveys, the ones that Dr. Guice
15 just pointed out on page 15 there.

16 That's the feedback have kind of been
17 our performance metrics, and the
18 satisfaction level of our population.

19 We try to include the marine and the
20 family needs throughout their recovery
21 and reintegration process, and on page
22 16 through 18, it kind of highlights

1 our findings and actions and the
2 actions we've taken from it.
3 Some of the actions, I just want to
4 point out is from a survey. That gives
5 us then the ability to do actions that
6 are meaningful back to the family,
7 such as assigning deputy family
8 support coordinators at each of our
9 sites out there, developing a family
10 handbook which I believe has been
11 handed out to everybody.
12 Enhanced communication - people now
13 don't use telephone like we use it.
14 They use texting and social media. A
15 financial support coordinator working
16 hand in hand with the Navy's and
17 Marine Corps' Community Service
18 program, having financial counseling -
19 many of these marines are all of a
20 sudden going to get lots of money
21 through like TS July and then also how
22 do I plan for the future.

1 So, we provide financial counting, and
2 we have such great tools such as an
3 employment toolbox that's on our
4 website and is web-based and a marine
5 get to and start building his plan for
6 reintegration.

7 DR. GUICE: And, then these are yearly
8 surveys and you can - by your dates, I'm assuming
9 they're yearly, and are you going to continue on a
10 yearly recurring frequency for these?

11 MS. PETRELLA: We haven't established
12 exact dates, but we will revisit the
13 satisfaction levels at intervals, but
14 not necessarily each year, but we
15 revisit those satisfaction levels.

16 LT. GENERAL GREEN: So, along the same
17 lines, is this the first time you've
18 done this survey, or you've been at
19 this for four years. So, do you have
20 any trended data in terms of how your
21 warriors are responding to the
22 programs you've put in place.

1 SERGEANT MAJOR PLESKONKA: We don't
2 have any trends at this point, sir.
3 Those surveys were started about a
4 year and a half to two years ago, and
5 we did again in '10 some more surveys.

6 So, we're now in the stage of
7 gathering all of that data sir as we
8 continue to go through our call center
9 and our MCWITS and the other programs
10 that we have in order to send out
11 those surveys as we require the need
12 for the information, sir.

13 COLONEL MAYER: You know, if you ask a
14 warrior that went through the Wounded Warrior
15 recovery process even a year ago or two years ago,
16 I think as a whole in the Marine Corps and
17 throughout DOD, we have gotten so much better in
18 what we know about TBI and PTSD, and just as an
19 organization on the non-medical side, I like to
20 think we are improving every single day. I know
21 that for a fact.

22 So, even stuff we had measured two

1 years ago
2 probably is not applicable anymore, but can we use
3 it as a benchmark? Absolutely, so that's a great
4 question. Okay, so the training, I'll run the
5 training now.

6 MR. REHBEIN: Colonel, before you go
7 on, if I may.

8 COLONEL MAYER: Oh, yes, sir.

9 MR. REHBEIN: That reintegration phase
10 needs assessment, those first two
11 categories; those are the satisfaction
12 numbers to me seem very significant.
13 I'm just going to ask how you - when
14 you receive results like that, how are
15 you translating them into raising
16 those satisfaction rates? What
17 actions are you taking based on these
18 surveys?

19 SERGEANT MAJOR PLESKONKA: Sir, a lot
20 of what we did was after we got that
21 in the reintegration and we saw there
22 was an issue there in the beginning,

1 that's when we started the DISC
2 program and started getting heavy in
3 to the DISC program on a post DD-214
4 side. We also started the section
5 leaders in order to get section
6 leaders and have a leadership ability
7 there to help meld it all together
8 because they were going down different
9 channels, and now we've got that
10 leader there that we're trying to do
11 that interlocking lanes of fire, if
12 you will in order to overlap
13 everything instead of just going down
14 a lane at a particular time in their
15 treatment and recovery process.
16 So, right now as we're doing our
17 gauging and our looking forward, once
18 we have all those key elements in
19 place and we start doing more
20 assessments, we seen that the numbers
21 are going up on satisfaction, sir just
22 by putting a few key people in there.

1 So, we did really look at those
2 assessments and start really attacking
3 all of those areas through all our
4 different programs.
5 Even with our warrior athlete
6 reconditioning program, when you focus
7 their mind on something other than
8 their disability, their satisfaction
9 level just go sky high because now
10 they've accomplished something. Most
11 of those marines have gotten a medal
12 around their neck by some general or
13 senator or somebody like that. When
14 you get that, you have a sense of
15 accomplishment, so your self-esteem
16 and confidence goes up, and now, when
17 you go home at the end of the day, you
18 relay that onto your spouse and your
19 mom and your dad and your siblings and
20 stuff like that.
21 So, everybody's satisfaction level
22 goes up that we're taking care of the

1 whole. So, we're really giving them
2 hope more than anything, hope for the
3 future, and when somebody has hope,
4 and we know that in a democratic
5 society, when somebody has hope, then
6 they can accomplish things. Their
7 self-esteem goes up, so we put a lot
8 of things in place for that sir.

9 MS. FLORES: Sir, to answer your
10 question in regards to those first two
11 areas. That is the IDES program which
12 is a program that we don't own, but we
13 did ask questions about it. So, as
14 far as those particular areas, we can
15 not address them specifically, but we
16 took them, created an IDES toolkit
17 that pocket guide that we have
18 distributed. So, in areas where we
19 may not be able to have direct access
20 or change, we have done other things
21 where we can support and hopefully
22 make change there.

1 MR. REHBEIN: In education.

2 MS. FLORES: Exactly, yes.

3 COLONEL MAYER: Sir, I try to explain
4 is that slide, the mind, body, spirit,
5 family, it's so important that this
6 panel understand that it takes a while
7 to process a marine through this
8 system, and a soldier and a sailor and
9 an airman. Hence what we did was I
10 can't change the IDES because I don't
11 own it, and Mr. Williamson will be
12 here this afternoon. We'll talk about
13 the IDES, and all of you all know
14 there is a lot of effort from Dr.
15 Stanley on down trying to streamline
16 the whole IDES, but what I said as a
17 commander, I can't effect that, but
18 what I can effect is exactly what the
19 Sergeant Major said is while he's with
20 me going through this process, -- I'm
21 going to build a marine and his family
22 that when they leave the program and

1 all the support, they are as recovered
2 as I can make them, and they're a
3 total warrior with that same spirit
4 that a marine has mind, body, spirit,
5 and with his family.
6 That's huge that you all understand
7 that, so when he says, "I'm
8 dissatisfied with the length of time
9 it takes me to navigate this,"
10 hopefully he's saying, "But I am very
11 satisfied that if I've got to be here,
12 I'm improving my education, my body's
13 in better shape than it ever was. My
14 self confidence has returned. I'm
15 very confident that I can leave here
16 and do something great as a citizen
17 and an American, and not only that,
18 but I'm a happy father and I'm a happy
19 parent to my family."
20 That's what my goal is. That's huge.
21 Okay. Does that answer that, sir?
22 Then, maybe more practical, and I'm

1 going to talk about it later, is there
2 are some great charitable
3 organizations out there that offer
4 transition courses. You know every
5 marine must go through DTAP or TAP
6 class. The Marine Corps as an
7 institution is making ours better, and
8 we're working on that. So, what every
9 marine must go through that program,
10 and also I use some of the charitable
11 organizations, vet foundations
12 compass, Mid-West Marine Foundation
13 has what they call FOCUS. What they
14 are is transition courses that help
15 Marines prepare.
16 To me, they're much more than that.
17 They're life school courses as well.
18 A lot of retired generals and fine
19 leaders, and I try to send as many as
20 I can to these organizations, and I
21 think it's win-win for the marine and
22 win-win for the organization. Okay?

1 MR. CONSTANTINE: Sir, I understand
2 that the first couple are, I guess,
3 you can only control so much, as we go
4 down, some of these areas that you
5 directly can control. On page
6 seventeen, it talks about family
7 support, which is something I know is
8 very important to you, information
9 provided TSCLI, stuff like that, and
10 still the results are only fifty
11 percent satisfaction. Maybe that's
12 what you talked about with (inaudible)
13 up to the time and that's different
14 now. Will you comment on that as
15 well?

16 COLONEL MAYER: Sure.

17 MS. FLORES: Sir, I can address that.
18 As far -- we wanted to show that the
19 majority of the respondents that did
20 respond to these surveys were
21 satisfied or very satisfied. One
22 thing that we didn't put on here that

1 we'll speak to now is that it wasn't
2 the other half were dissatisfied. We
3 had a very large majority -- 30
4 percent on most of the surveys that
5 just responded neutral, and these
6 questions were actually asked on a one
7 to five scale.
8 So, one was very dissatisfied, two
9 dissatisfied, three neutral, four and
10 five in the satisfaction levels. So,
11 for the particular questions that you
12 mentioned, the average response was
13 like a three point two, in the three
14 area, but the majority of our
15 respondents were really more in that
16 satisfied area. So, just to speak to
17 your point that they
18 weren't necessarily dissatisfied, but
19 there were a large majority that said,
20 "I'm not satisfied nor dissatisfied."
21 MR. CONSTANTINE: Well, do you think
22 that - how you feel about that number

1 that a three or three point two out of
2 five is the average?

3 COLONEL MAYER: Well, because I'm the
4 commander let me try to answer it because you're a
5 Marine, you read it the same way I do and go, I
6 said, "Holy smokes. That means we're mediocre out
7 there. Only 48 percent are satisfied." So, what
8 the data is trying to say is out of your
9 population, forty-eight percent of those were very
10 satisfied and the rest are kind of mediocre, but
11 that scale is tipped towards the very satisfied.
12 You don't read it that way either, but that's the
13 way I think it says. That's what Erica was trying
14 to say. These are positive numbers, not negative
15 numbers.

16 MR. CONSTANTINE: I understand that,
17 sir, but it says satisfied/very
18 satisfied. So, it's not just the ones
19 on the far end. Are you happy with
20 what you're getting?

21 MS. PETERSON: You know, in the family
22 program specifically, I think we saw it as an

1 opportunity to enhance some of our programs. We
2 saw it as a way to identify needs that families
3 address in those surveys and go out and create
4 some new programs. One of them is, you know,
5 families regardless of what the Marine status,
6 they're always asking for more information, more
7 communication. So, we saw it as an opportunity to
8 develop this resource of the keeping it all
9 together handbook and you two have it back there,
10 and in fact, your wife was an integral part in
11 developing this with us as well.

12 Just to point out - I don't know if
13 you
14 remember, but basically it was a way for us to put
15 information together on one resource, and then we
16 put family support coordinators in place at all of
17 our locations so they could do a page turn with
18 the resources in that book.

19 So, in terms of family awareness
20 programs, we
21 saw this as an opportunity. What will be
22 interesting now is now that we've put some of

1 these programs in place, they've been around now
2 for about nine to twelve months, it'll be
3 interesting now to go back and see how have things
4 changed.

5 COLONEL MAYER: Right, point well
6 taken though, Justin.

7 SERGEANT MAJOR PLESKONKA: We also use
8 the FOCUS program, Families Overcoming
9 Under Stress, which is a Marine Corp
10 initiative, and they're doing our
11 outreach for our remote areas. So,
12 they actually put together packages
13 for us for spouses and their children
14 and especially in our reserve
15 component. They send out and it has a
16 video camera in it. They can do one
17 on one counseling and stuff like that,
18 also, and we did that as a result. We
19 got our family support coordinators
20 and our FRO, our Family Readiness
21 Officer together to help answer all of
22 those questions in the remote areas.

1 DR. GUICE: I'm going to go back to
2 one item on page 16, if you'll
3 (inaudible) it's the second one,
4 aspects of the timeliness and
5 fairness. You talked a little bit
6 about it, but 43 percent of the
7 respondents were dissatisfied or very
8 dissatisfied. It kind of covers the
9 aspects. I'm sure that's a roll out
10 number, so I think it will be very
11 helpful for us to look at the
12 breakdown versus specifically
13 timeliness, satisfied, fairness
14 because it's okay to be dissatisfied
15 perhaps with the timeliness if you
16 think the fairness is really good.
17 There are qualitative differences in
18 those. And, so it would be very
19 helpful I think as
20 we try to puzzle through that to just
21 have that laid down for us if you
22 wouldn't mind. We'd appreciate it.

1 MS. PETRELLA: We can do that.

2 LT. GENERAL GREEN: Two quick
3 questions - one is this booklet that
4 you've given us, is this something
5 that's now given to a wounded warrior
6 for their reference?

7 MS. PETERSON: Absolutely. It's
8 produced by the DOD, distributed by
9 Military One Source. Right now,
10 Military One Source requires that you
11 call and request it. The problem is
12 that these wounded, ill and injured
13 family members are not going to call
14 and request a book. So, what we've
15 done in the Marine Corps through our
16 working groups is we've made it Marine
17 specific, and it also contains local
18 specific information.

19 So, the requirement on our family
20 support coordinators and our recovery
21 care coordinators is that they
22 distribute those at the point that a

1 family member enters a military
2 treatment facility, but more
3 importantly than just handing them the
4 book is that one on one training. So,
5 we developed a training manual for our
6 staff that goes along with that book.
7 That is truly a page turner, and it's
8 really dependent upon, you know,
9 families said in our surveys that they
10 want the right information, the right
11 amount of information at the right
12 time.

13 So, our staff is trained on how to
14 determine what should be taught to
15 those family members. So, it's a
16 great resource. We just enhanced it.

17 LT. GENERAL GREEN: A very nice tool,
18 actually.

19 MS. PETERSON: Okay.

20 LT. GENERAL GREEN: So, the other
21 question that I was going to ask you
22 was on your surveys because we're all

1 interested in basically how the
2 numbers came out, was there a place
3 for people to put comments, and can
4 the comments be shared with the task
5 force?

6 MS. PETERSON: Yes, sir. They're
7 actually in the report that we can
8 share with you.

9 LT. GENERAL GREEN: Okay, thanks.

10 COLONEL MAYER: Yes, so maybe in the
11 future, we'll switch from surveys to
12 just folks in the education process
13 and what have you. If you go to that
14 slide 18, you'll see some highlights.
15 This is how we test it, and I guess I
16 would want all of them to read, and
17 note with our recovery care
18 coordinators and that whole program
19 there, I'm very pleased with that
20 program. We're very proud.
21 So, that of course is the goal. So,
22 that's total respondents there. Okay,

1 any other questions on metrics and
2 surveys?
3 Okay, training, in your handouts, 21
4 slash 21 through 24 list the training
5 provided and required of a various
6 non-medical care managers to include
7 our recovery care coordinator.
8 And, training in this business, you
9 can't get enough of, and so we've
10 added - we now have a command
11 assessment team that is going to Camp
12 LeJeune next week. There's a training
13 part to it. It's not as much of an
14 inspection team as it's an assistance
15 team of experts from battalion and
16 from regimen that will go and help
17 with everything has to do with Wounded
18 Warrior Regimen and all of our
19 different functions and duties.
20 We've also started a mobile training
21 team that can go after high interest
22 items or things that we've seen that

1 we need to either teach or to
2 reemphasize or we're working towards
3 an online training program that we
4 will start developing here next month.

5 And I really think online because
6 there's so many detailed questions
7 about a system - who rates a non-
8 medical attendant and how is the pay
9 figured and all that, that you can
10 expect every single person to have the
11 details, but what you can expect is to
12 have a tool and a place where you can
13 go to that's web enabled through our
14 website in order to get the answer for
15 the family.

16 So, an online web based training tool
17 is coming in our future, and then you
18 can see, kind of, I'm looking at page
19 21, 22 and 23 just to kind of throwing
20 up there by each kind of duty what we
21 have training for.

22 COLONEL MAYER: -- and that is good as

1 experience. So what we're trying to
2 do cut that learning curve down to the
3 smallest portion.

4 DR. GUICE: Would you all mind
5 providing us with an example of the
6 curriculum under each one of those.
7 For instance, what's provided during
8 the annual OSD/RCC training and then
9 what's the add-on for the service
10 specific that's appreciated the at
11 snap shot if you will about the
12 materials, it's the agendas from all
13 the training events so we can see how
14 those go. That would be great. Thank
15 you

16 COLONEL MAYER: We said, yes, we can
17 do that.

18 SERGEANT MAJOR PLESKONKA: Yes, sir.

19 COLONEL MAYER: Okay, on slide 24,
20 what are we doing to get our message
21 out? The Wounded Warrior Regimen is
22 relatively new and the opinion on

1 somebody's - where he is in the Marine
2 Corps might not know about the wounded
3 warrior regimen. It's well advertised
4 in both the Marine Corps in our web
5 majors and all that, but the
6 specificates aren't known as well as
7 we'd like. And so, Sergeant Major and
8 I and our leaders down at the
9 battalion level on to detachments, we
10 go and talk to Marines and commanders,
11 mainly, and leaders, NCOs and staff
12 NCOs and officers as much as possible.
13 For example, the commander goes twice
14 a year to take colonel level and
15 colonel level commanders - I and
16 Sergeant Major will speak at that for
17 two hours. One session is the with
18 the commanders and other with the
19 spouses and then there is the breakout
20 groups (inaudible). Almost all of the
21 enlisted professional career
22 development courses - Sergeant Major

1 speaks, and I'll let him talk in a
2 minute, and then the major commands
3 were constantly engaged out at Camp
4 Pendleton with the staffs and going to
5 meetings for like the one (inaudible)
6 staff and the division staff and we're
7 integrated with the Marines and the
8 operational forces out there. And
9 also attends reserve conferences and
10 speak to the reserves and I talked a
11 little bit about the R-Lock program
12 that we're currently - we're right
13 there right now - we're integrating
14 the marines that are coming back with
15 the third battalion, fifth marines.
16 Sergeant Major, anything you want to
17 add?
18 SERGEANT MAJOR PLESKONKA: Yes, as far
19 as our education on the enlisted side,
20 April has worked extensively with
21 Deanna and we were able to inject
22 ourselves all the enlisted PME courses

1 for one year test pilot. They give us
2 one hour in each course. So we get an
3 hour in the Sergeant's PME; then the
4 staff sergeants, which we call the
5 career course, and the gunnery
6 sergeants which we call the advance
7 course. So we get an hour in each one
8 of those at each one of our academies.
9 So myself and Mr. Mallard, and Master
10 Gunnery Sergeant Jones were trying to
11 hit Quantico, every class that's in
12 there. I have Sergeant General Ben
13 Panghorn on the east coast down at
14 Battalion East. He hits everything at
15 Camp Lejeune, and I have Sergeant
16 Major O'Laughlin who hits everything
17 over at Camp Pendleton and I have a
18 Master Gunnery Sergeant Turell who
19 gets everybody in Hawaii. I will be
20 going out in two weeks from now out to
21 Okinawa for a week to brief all of the
22 courses and then hand over the

1 material to the two liaisons, a master
2 sergeant and a staff sergeant that we
3 have over there. I'll also hit all the
4 E8 seminars, that's our first
5 sergeants and our master sergeants in
6 the Marine Corps. I just came back
7 from - down at New River Air Station.
8 And I will also be hitting the E8
9 seminar over in Okinawa while I'm over
10 there. And I will also hit the first
11 sergeant's course. We do two first
12 sergeants courses a year. That's up
13 for all of our selected first
14 sergeants, which are E8s. We hit
15 those -- those are right here at
16 Quantico so it's much easier for us.
17 We also bring a bunch of the wounded
18 down, usually six to ten wounded, we
19 do breakout sessions and they get to
20 talk one-on-one with those on the
21 ground to make sure that we're
22 providing everything that we can in

1 the wounded warrior care.
2 Then I also talk to the senior
3 enlisted PME course, which is fairly
4 new in the Marine Corps. Its two
5 years old. I brief there and then
6 also, the E9 symposium, which we call
7 the Sergeant majors' symposium which
8 meets every year, and it's usually
9 about the July timeframe. And then as
10 the CO, we spoke to; we do the
11 commanders' course. We go over to
12 TBS, we help to brief over there at
13 times. We also have the EOS, which is
14 the three stars and the four stars and
15 then the GOS that the Colonel also and
16 all the general officers in the Marine
17 Corps. So I think we're getting the
18 message out to everybody and all the
19 Marines -- all the commanders want to
20 take care of their wounded, ill and
21 injured. It just depends on the
22 resources that they know are available

1 to them, which is all information
2 based and the same thing with getting
3 the time to put in their schedules
4 between deployment cycle and and
5 standup for deployment things like
6 that. So --

7 COLONEL MAYER: We'll give everybody a
8 break from my voice and we'll have Mr.
9 Tim Clubb talk about our recovery care
10 coordinator.

11 MR. CONSTANTINE: Mr. Clubb, before
12 we start, sir, one of the things I see
13 that you provide training on, on page
14 24 is quarterly education phase on
15 legal and military consequences of
16 PTSD and TBI. Anecdotally, I've heard
17 plenty of stories
18 about young Marines who are squared
19 away and fine, go to deployment, do
20 great, come back; and get in lots of
21 trouble and then get administrative to
22 separate it. Now that's going back a

1 couple of years before PTSD and TBI
2 became such a big issue, so could you
3 or Sergeant Major, explain what it is
4 you talk at breaks?
5 SERGEANT MAJOR PLESKONKA: We have a
6 policy on that in the Wounded Warrior
7 Regiment and in the Marine Corps.
8 There was a moral ad that came out, I
9 don't know the number and the data
10 offhand right how, but anyone that has
11 had PTSD or TBI prior to involuntary
12 separation, they must be evaluated by
13 a psychologist; they must get an
14 evaluation at least six months prior
15 to. So within that six months window
16 before the package gets up to the
17 first CG, commanding general, in their
18 chain of command, and we go off of
19 that to base any type of criteria for
20 follow-on care. Now we really look
21 extensively at this because we do not
22 want to discharge somebody that has a

1 medical issue and cannot get VA
2 benefits because they receive a BCD.
3 or an OTH. So we really look at this
4 and we give a second or third chances
5 on many occasions and I can break out
6 specifics, but I don't want to talk
7 about those individuals in front of
8 everybody. But we give two, three, or
9 four chances in some cases of these
10 individuals to try to give them the
11 help that they need to make sure that
12 it's not truly a cognitive impairment
13 from a TBI or something. But that it
14 was actually a conscious decision to
15 do those behavioral wrongs, which led
16 to any type of court marshals or
17 punitive separations. We are putting
18 extensive work into making sure that
19 nobody is -- at this point -- I can't
20 talk about years past and the rate of
21 business was conducted in the
22 beginning of those ten years ago, but

1 I know that we have put things in
2 place since then to protect the rights
3 of everybody. IE -- the IDES system.
4 We want to protect the rights of the
5 individual to make sure they're
6 getting the right care, but at the
7 same time, should the time be so long
8 that they become wavered in the
9 process because they're just so
10 disgruntled with it. So it's the same
11 on the punitive side of the house, we
12 don't want to slow down the due
13 process to the point that the person
14 continues to, do more and more
15 punitive behavioral things that are
16 going to be more detrimental to a
17 court marshal and stuff. So what is
18 the timeline in between there and we
19 juggle that every single day in trying
20 to look out for the rights of the
21 individual, along with the needs of
22 the institution.

1 COLONEL MAYER: We also have four IDES
2 attorneys now, that specifically are in place; two
3 in the east coast and two in the west coast that
4 counsel the Marines on their rights and benefits.

5 MR. CONSTANTINE: But you're talking
6 about Marines who were formally in the
7 system already, right? And I'm talking
8 about men who come back and engage in
9 this behavior and criminal activity
10 which they never would have done
11 before -- they don't have a record of
12 doing being. So maybe they don't
13 belong in the Wounded Warrior
14 regiment. They're just your average
15 3-5 Marine who came back or something
16 like that.

17 SERGEANT MAJOR PLESKONKA: Yes, sir.

18 MR. CONSTANTINE: And you're advising
19 these Marine Commanders to watch out
20 for this kind of stuff?

21 SERGEANT MAJOR PLESKONKA: Yes, we
22 are. We actually talk to a lot of the

1 lawyers. We get to the pretrial
2 confinement centers now, where they
3 used to be called brigs. But they're
4 pretrial confinement centers and we
5 talk to a lot of the LSSS lawyers.
6 And we've had them over at the Wounded
7 Warrior Regiment and I go to them on
8 that basis and are a major support in
9 the commands in our divisions and
10 wings and stuff like that. And I talk
11 to the lawyers all the time about
12 making sure we're looking at their
13 full medical record and their
14 character of service prior to this
15 incident and that's what that more
16 admin is specifically looking at is to
17 make sure that we're not discharging
18 someone that now has a medical issue
19 that's created the lapse in cognitive
20 reasoning and moral judgment at this
21 point since their injury in the ID
22 blast, cause we are now just coming to

1 understand really the effects of TBI
2 through research centers and all of
3 that stuff. And how much they do
4 really damage somebody's cognitive
5 abilities.

6 MR. CONSTANTINE: Okay. Thank you. I
7 certainly appreciate all the work that you're
8 putting on that.

9 DR. GUICE: Colonel?

10 MR. REHBEIN: Go ahead.

11 DR. GUICE: I was just going to ask
12 you to go back to slide 28. Thank
13 you.

14 You actually have nice data on this
15 one. But I'm going to ask you the
16 same question. What was the number of
17 individuals who responded to the
18 survey and what was the population you
19 surveyed? You have seven -- almost,
20 ballpark 20 percent, from that survey
21 that said they're having financial
22 problems. Is that people still on

1 active duty, and were you able drill
2 more into figure out why they're
3 having those financial problems
4 because if you don't understand the
5 why, you can't actually provide the
6 right solution. So, again, how many
7 responded to this survey and what was
8 the population and can you help us
9 understand a little bit more about the
10 details from the respondents?

11 COLONEL MAYER: Ladies, can we do --

12 MS. FLORES: Yes.

13 COLONEL MAYER: What we've done about
14 it, well the district entered support
15 sells out there, working in the
16 civilian across America, in the
17 communities, we work with the VA, the
18 OIF/OEF and the coordinators, the
19 VSO's out there are big. There's a
20 representative from the American
21 Legion in the room back here; the
22 Marine Corps league; the American

1 Legion; all the VSO's out there, we
2 work with to help the Marines as well
3 as private donors and charitable
4 organizations. So the question is what
5 do we do with the marine that's in
6 need? By golly, that's we set-up the
7 whole district standard support
8 coordinator is to help with once a
9 marine, always a marine. And then our
10 chief financial specialist in support
11 with the community services across the
12 bases and stations and I talked to
13 that a little bit earlier on. But
14 yes, ma'am, we can get you that data
15 point that you asked for. I think
16 there was one more question.

17 MR. REHBEIN: If I may, Colonel? The
18 training of your staff is one subject, but
19 selection of your staff is another, particularly
20 section leaders on up to the battalion commanders.
21 Inside the corps, are these jobs seen as
22 sufficiently career enhancing, that you have more

1 than you need to choose from or are you having to
2 go out and recruit staff because these jobs not
3 seen as something that's going to be good for my
4 career?

5 COLONEL MAYER: Well, and Sir, and I'm
6 being honest. Being a guy that's in
7 that place right now -- is two things.
8 One thing, I think it's too early to
9 tell.

10 I mean, you know, this -- four years
11 is not a long time for an
12 organization. But I'll tell you this
13 is that, those in the position have
14 their responsibility of the Marine
15 Corps -- really of America on their
16 shoulders. Because there's not
17 anybody, whether you are for the war
18 or against the war; regardless of your
19 political leanings. I have never met
20 anybody who wasn't all about taking
21 care of the wounded, ill, and injured,
22 especially the Marines out there. And

1 by golly, every single person that
2 does it is recognized. They get the
3 support of the Marine Corps and the
4 Marine Corps will take care of them,
5 all Marines are commanders, are
6 officers, are staff NCOs and NCOs that
7 are out there working. And what I've
8 seen is they all have gone on, if
9 they've left us to successful next
10 careers. My battalion commander on
11 the west coast, Lieutenant Colonel
12 Greg Marreden, he is gone off to top
13 level school and he has been selected
14 for colonel, which in the Marine
15 Corps, that means you are still
16 eligible to become a general later on.

17 I just saw -- Sergeant Major, go
18 ahead.

19 SERGEANT MAJOR PLESKONKA: I can add
20 a couple of things also on a promotion
21 and things like that and future career
22 stuff. The first thing that we did

1 when we looked at this, we said wanted
2 somebody that is able to use wisdom,
3 experience, and knowledge in order to
4 gain resources so we're trying to make
5 it a staff Sergeant in E6 to be the
6 section leader, who we advocate in the
7 Marine Corps to have six to eight
8 years in the Marine Corps upon
9 selection. So we could get somebody
10 potentially that has ten to 12 years,
11 up to 20 years, because a staff
12 sergeant can stay in the Marine Corps
13 by enlisting career force control up
14 to twenty years of service.
15 The next thing is we're working on a
16 precept in our boards. What our
17 precept is the information that they
18 give the board members before hand.
19 Now if you already knew what V billet,
20 an SDA, a special duty assignment
21 where you get SDA pay and you get
22 special consideration on a board if

1 you have a successful tour --
2 recruiting, marine security guard,
3 drill instructor duty, those things.
4 In the precept it says that those
5 people are highly qualified for that
6 next rank if they have a successful
7 tour and were not terminated early due
8 to their own indiscretions or
9 whatever. So we're looking in the
10 precept that somebody that has a
11 successful tour as a section leader or
12 a platoon sergeant with the Wounded
13 Warrior Regiment, that they will be
14 considered that same way. So that way
15 we can draw those higher quality
16 people to us -- to come to us because
17 if we're looking for a staff Sergeant
18 or a gunnery Sergeant and the average
19 time in grade on the enlisted side is
20 about three years per grade, do you
21 come to us or go to the SDA which is
22 going to move you up that step? Now I

1 can't make this an SDA because we know
2 how funding goes and things like that.
3 So I cannot do that right now, but I
4 am looking at injecting that into the
5 precept that the commandant and the
6 sergeant major of the Marine Corps
7 give to the board for selection so
8 that we can hopefully put our people
9 above that, so that we get a much
10 higher quality of individual that is
11 willing to come here. Now I will say
12 that those IMA's that we spoke about
13 earlier, those ones under the OCO and
14 stuff, most of them come on for the
15 first year. We've got a more admin out
16 now saying that we would rather have a
17 PCS of two years for those reservists.
18 And we know the reservists it's really
19 difficult, you have a family, you may
20 have a job, you may have a business
21 that you own that you would have to
22 leave to come do this, and their

1 dedication is incredible. But many of
2 those that come on will extend for the
3 second, third, or fourth year and they
4 just love it. And once they get here
5 and figure out what we're doing and
6 they've learned a skill. I mean, I've
7 got some at Bethesda that are just
8 top-notch, if I could clone them, I
9 would in a heartbeat. They're just
10 incredible. So we're trying to get
11 that base fixed based on all of the
12 surveys we have done, help the family
13 readiness, trying to help with the
14 section leaders, we're trying to help
15 in this whole recovery and integration
16 process based on all those surveys
17 through all those things.

18 MR. REHBEIN: Thank you, Sir.

19 MS. DAILEY: Sir, Ladies and
20 gentlemen, we work through lunch, so I
21 have a 15 minute break in here on our
22 agenda. I would like to take that

1 break. I need to run the members
2 through lunch, but the rest of my
3 audience, seek sustenance in the
4 building, but we will start again in
5 15 minutes and the members will work
6 through lunch. So 15 minute break,
7 please. Thank you. Members, your
8 buffet is out this door and gentleman,
9 can I ask the task force to reconvene
10 for our next briefing?

11 [Cross talk.]

12 For my members that just arrived, we
13 are in the tab B of the briefing book,
14 and we're on page 29. We're talking
15 about the recovery coordinator
16 program. And our next briefer is --
17 MR. CLUBB: Tim Clubb. Good
18 afternoon, I'm Tim Clubb. I manage
19 the recovery care program and the
20 three wounded warrior call centers for
21 the Marine Corps. If you can flip,
22 I'll give you a little background on

1 where we've been and how we got to
2 where we are and where we want to go.
3 As you know, the program, for the
4 Marine Corps started in November of 08
5 with 13 RCC's. I came on board as
6 program manager in September of 09.
7 At that point, the Marine Corps
8 brought on additional RCC's with a PM
9 and brought the total up to 41. When
10 I came in the door, there was not a
11 defense instruction written for the
12 recovery care program. We did not
13 have procedures in place, I really
14 characterize this as more a lot of
15 good people doing a lot of good
16 things, but doing them differently.
17 So we're really a mom and pop type of
18 organization. There were different
19 stores. We had 13 RCC's, at that time
20 about nine different locations using
21 seven different variations of
22 comprehensive transition plans,

1 different methods of assignment of
2 getting cases, how cases were
3 assigned, all doing great work but not
4 standardized. I'm a process guy in
5 that I look for how do we standardize
6 things. You can't standardize because
7 every case is different. Every case
8 is different and every location is
9 different. But what we do is 80
10 percent of what we do at every one of
11 those places is the same. It's that
12 ten to 20 percent that's actually
13 different. We have focused our
14 program, at least on the program level
15 is to move forward with standardizing
16 what we do as a program and doing it
17 all the same and then deviating from
18 that common base. You'll see as we
19 talk through this, that's been my
20 focus as a PO. It is a little
21 different at each place, they're doing
22 the essentially the same thing, the

1 same way. The real benefit to that is
2 not the efficiency of the program, the
3 benefit to the marine and his family
4 because that's a great deal of their
5 frustration is the confusion. And if
6 the people executing it are confused
7 about the process then the marine and
8 his family are going to be on the
9 receiving end of that. So, I'm a big
10 focus on process. Next slide, please.
11 Our program itself -- you can see our
12 highlights up here. We are embedded
13 within the Wounded Warrior Regiment at
14 all the locations. The RCC's at each
15 place, they work for me, but they're
16 in are direct support on site, they're
17 embedded within those detachments and
18 battalions. They are part of Colonel
19 Mayer's recovery team. They are the
20 working piece of that. I have fully
21 -- absolutely, fully support his
22 section leader effort. In fact, I

1 thought since day one, that's been the
2 missing piece is that day-to-day
3 supervision and mentoring of that
4 marine from somebody in uniform. They
5 trust an RCC but they need a marine in
6 uniform also, to guide them and do
7 marine things. I think this is a
8 great initiative on what he's got on
9 that. Our RCC's within our program,
10 they're very unique that each and
11 every one of them for the most part
12 has a tie to the Marine Corps.
13 They're either retired Marine, a
14 Marine who did four years and got out;
15 combat injured marine, an ill or
16 injured marine, a spouse of a marine,
17 a brother or sister of a marine. You
18 name it, they've got a tie. There are
19 a certain few RCC's we have who
20 because of their unique backgrounds
21 maybe not specifically marine, but
22 we've brought on. We've brought on

1 folks who've worked as raiders for the
2 VA, for an X number of years. Simply
3 because of their qualifications that
4 makes them very valuable to our
5 program. So we have a wide degree.
6 The philosophy we've used with our
7 RCCs is -- essentially is that the
8 first thing we want them to do is to
9 establish that rapport with the
10 marine. I tell them to grab the low
11 hanging fruit. You do something for
12 them upfront, show them that you can
13 deliver and they're going to come back
14 to it. And that's typically what they
15 do; they develop their the resources
16 that they need to support a specific
17 area, they validate those resources so
18 that they don't send somebody to
19 something that doesn't exist and then
20 they follow up.
21 MR. CLUBB: And the ones who are
22 successful, that's the simple game

1 plan they use. We have at this time
2 about 1,150 cases assigned to our
3 RCC's for the Marine Corp. That
4 includes Marines who belong to Colonel
5 Mayor and Marines who do not belong to
6 him, who belong to other units. Two-
7 seven, 3-5, you name it. So, probably
8 40 percent to 50 percent of our cases
9 are actually external to wounded
10 warrior regiment for the RCC's. We
11 use a - what - we use the term
12 comprehensive transition plan and we
13 maintain a ratio of - of 95 percent or
14 above have a working comprehensive
15 transition plan. And that's one of
16 our bench marks we use. When we
17 started this we were really closer
18 down in the 60 percent range. So
19 we've come a long way in keeping it.
20 The five percent -- 95 to 100 accounts
21 for transients for the new cases. You
22 don't - you don't get a case within a

1 day and start and - and develop a
2 comprehensive transition plan. It
3 takes a couple of days to do that if
4 you're going to do it right.
5 So, 95 percent is the number that I
6 use. If I see it
7 dip below that we certainly jump onto
8 it and say why is this number low?
9 But we've been able to consistently
10 maintain that number.

11 LT. GENERAL GREEN: Can I ask one?

12 MR. CLUBB: Sure.

13 LT. GENERAL GREEN: How do you
14 determine who's in and whose out? So,
15 what are your criteria for putting
16 them into your wounded - your
17 regiment?

18 MR. CLUBB: Actually assigned to the
19 regiment as opposed to whose not?

20 COLONEL MAYER: Sir, we have a - it's
21 done by the battalion commanders and -
22 kind of the policy, man train equipped

1 and the battalion commanders have the
2 - actually lure the Marines down
3 there. And so it's a process that's
4 requested by a commander, an
5 operational commander and then it's a
6 dialogue back and forth. Kind of the
7 key criteria reward we look at is, is
8 the recovery process going to be a
9 long term main thing that the Marine
10 is going to do in his life? Usually
11 we have 90 days where he's in this
12 kind of a state of recovery -- or
13 rehab before we even consider looking
14 at him, but we'll still take care of
15 him if he's in the hospital. And then
16 and is that going to be the main
17 activity he's going to do for the next
18 six months or longer? And that's
19 really our criteria.

20 LT. GENERAL GREEN: And the reason I
21 am asking is because it's very
22 different across the services. We've

1 found out with the Air Force that to
2 be in their ill and injured when they
3 brief you have to have made the very
4 seriously ill or seriously ill list
5 and so they use that criteria to use
6 us if you're - if - and that's why I
7 ask. If it is a hard six months where
8 somebody comes up with a tumor for
9 instance it's going to take six months
10 of chemo therapy; they would probably
11 make it over? Is that what I'm
12 hearing from you?

13 COLONEL MAYER: Well sir, once again,
14 if he's in the hospital we're going to
15 look after him just like he was my own
16 son. It just has to do with who owns
17 the record book or not in the
18 reporting. The Marine Corps' kind of
19 philosophy is we try to keep the
20 Marine with this unit as long as
21 possible, but at some point it just
22 doesn't make sense any more because,

1 you know, we're force readiness going
2 to war. So at that point that's why
3 you need a wounded warrior regiment
4 out there is to move those that are
5 not going to be recovering quickly to.
6 LT. GENERAL GREEN: The other trend
7 we've seen is for the Army for
8 instance there's a much larger number
9 of people in the warrior transition
10 units at places that have the active
11 deployment mission. So if they have a
12 TOE and that you'll see a lot larger
13 number of people over. And so that's
14 why I keep coming back to are there
15 criteria. So, with your mobility
16 mission, would it be safe to say that
17 you may see an influx of people coming
18 over to the regiment at a time when
19 they're preparing to go out when they
20 need the - if they need to have
21 somebody that needs ongoing care that
22 could take months and yet not take six

1 months? They might come your way to
2 give them a new home as a regiment -
3 as another battalion got ready to
4 deploy?

5 COLONEL MAYER: Sir, it's case by case
6 and you know in this business every
7 individual has - has a set of concerns
8 and needs that's different than the
9 next one, so it's hard to completely
10 classify and put a stamp on, yes we
11 would take that Marine. By in large
12 we would have to look at how we
13 estimated the recovery process to be.
14 And if it looked like he'd be healed
15 in six months, no we probably would
16 not take that Marine to the wounded
17 warrior regiment; although we do have
18 many services that we could provide
19 him; transportation to and from,
20 counseling and what have you that we
21 would help out the operational
22 commander with. Once again the

1 Marine's philosophy is to keep the
2 Marine with the unit as long as
3 possible and only in those exceptional
4 cases do they come over to the wounded
5 warrior regiment.
6 MR. CLUBB: A large percentage of our
7 cases that are external to the
8 regiment, they're - they're not going
9 to be your very seriously injured
10 ones, General. They're going to be
11 your Marine who's done two or three
12 tours in Iraq or Afghanistan and he's
13 back and he's now in another support
14 billet somewhere. He's been through
15 11 IED blasts, he may not even be
16 Purple Heart, but he's got TBI and
17 PTSD and he's with the unit and he's
18 on his second or third LIMDU. Those
19 are - those are a lot of the external
20 cases that will and the regiment will
21 end up assigning an RCC to support
22 externally. Because that Marine is

1 involved in that whole process now of
2 is he - is he going to be returned to
3 duty? Is he going to be retained? Or
4 is he going to be transitioned out?
5 And that's where the RCC can
6 particularly help because those units,
7 if you're a 2-7 on staff at 2-7 or a
8 wing or wherever you are, you're not
9 versed in how to help these Marines
10 through that process. And that's what
11 the RCC does for them with these
12 external ones. Yes, ma'am?

13 DR. GUICE: Could you provide us in
14 writing with the criteria for entry
15 and acceptance by the wounded warrior
16 regiment for participation in the
17 regiment versus kind of what I'm
18 hearing you're saying is providing
19 assistance to other support assistance
20 to additional individuals who not -
21 won't necessarily be reassigned but
22 just need some kind of limited

1 assistance. And the same thing for
2 you, the criteria that - that gives a
3 - a Marine an RCC.

4 MR. CLUBB: Okay. Actually ma'am,
5 that criteria comes from them though.
6 All assignments are done by the
7 regiment so but we will -

8 DR. GUICE: You'll just fight to
9 assume writing that report.

10 MR. CLUBB: Right. We will give you
11 that but its two separate pieces.

12 COLONEL MAYER: Will we have a policy,
13 ma'am affects sheet that - so that we
14 can give you a -

15 DR. GUICE: Great.

16 MR. CLUBB: Yes, next slide.

17 MS. CROCKETT-JONES: Actually before
18 you

19 leave -

20 MR. CLUBB: Sure. MS. CROCKETT-JONES:
21 The CTP used a
22 standardized format for the comprehensive

1 treatment plan?

2 MR. CLUBB: A comprehensive transition
3 plan, yes.

4 MS. CROCKETT-JONES: A transition plan
5 and is there - and is it possible to
6 get a copy of that standardized
7 format?

8 MR. CLUBB: Actually we have
9 transitioned now to DOD's the WWCTP's
10 RCPSS; recovery coordination planed
11 software solution.

12 MS. CROCKETT-JONES: Okay.

13 MR. CLUBB: So, yes we can get you
14 that. But now we are using that one.
15 In fact, the Marine Corp is the pilot
16 for that program for executing.

17 DR. GUICE: And they're, Rick, I think
18 we have to be very clear that there's
19 a CTP and there's an RCP so there's
20 the comprehensive transition plan and
21 then there's the comprehensive
22 recovery plan and depending on the

1 service, they're sometimes a little
2 blurred and then they're sometimes
3 separate.

4 COLONEL MAYER: All right, can I just
5 say ma'am, from my perspective as the
6 commander, the Marine is going to set
7 his goals; mind, body, spirit, and
8 family goals, and then I'm going to
9 help him achieve it. And - and the
10 comprehensive transition plan is kind
11 of the formalized ways of these saying
12 it, but by golly, he's going to you
13 know on the platoon commander's
14 section leaders down there are going
15 to do the basic leadership things that
16 you would expect of anybody in the
17 military of tell me your goals and
18 I'll help you achieve it, if that
19 makes sense to you. And the
20 comprehensive transition plan is the
21 formalized way of showing it.

22 MR. CLUBB: Okay. We are currently

1 staffed. We have 49 individual RCC's.
2 We have a PM -- myself, a deputy PM
3 and we've recently brought on a
4 dedicated quality assurance and
5 training rep. for our program as well.
6 We have -- of our 49 we have three in
7 Quantico who
8 are specifically dedicated towards the
9 Reserves. Our training -- and we will
10 get you a copy of the - the schedules
11 that they're typically used; starts
12 off as a baseline with OSD, a week
13 that all RCC's goes through. And then
14 we will go to a two to three days that
15 the wounded warrior regiment provides
16 for the individual RCC to bring them
17 into tune with what wounded warrior
18 regiment does in Marine specific
19 terms. Then myself and my training
20 team will do program specific, what
21 are procedures internally within the
22 program and how we function and then

1 we will push them out to their
2 individual sites where they will have
3 a team lead, or a site lead who will
4 do site specific, and then they will
5 do OJT with them at that. We conduct,
6 with all hands we conduct a weekly
7 with the program management pieces
8 teleconferences and each month we
9 conduct all hands training and
10 discussion points with the RCC's. We
11 are - we also conduct an annual, one
12 week long refresher training for the
13 RCC's as well. Besides that we will
14 send RCC's to various training events
15 and then bring them back and share
16 them with as the group. Next slide.
17 These are our current locations and
18 how we are staffed at each one. We
19 have recently made some adjustments in
20 where our RCC's are placed. In the
21 national capital region between
22 Bethesda and Walter Reed we previously

1 had five RCC's there. We've
2 experienced a large case load growth
3 there so we've - we've actually moved
4 some RCC's and changed it so that we
5 have seven RCC's total, three at
6 Walter Reed and four at Bethesda. We,
7 at Quantico itself we have - we have
8 nine there, we have three at BAMC and
9 then you can read the rest of the
10 numbers. We, typically, our retention
11 rates within RCC's are pretty darn
12 high. We run about an 80 percent to
13 85 percent retention rate of RCC's.
14 We do have a vacancy right now; in
15 fact, the vacancy I had was a - the
16 wife of a Marine who had just retired
17 and they were going back to Utah. And
18 so, the vacancies, we have a couple of
19 years at the most is what we have, but
20 we have a very good retention rate.
21 The case loads at each location, they
22 vary. And so they vary with the

1 RCC's. We try as much as we can with
2 the regiment to distribute those, but
3 you will see variations in how much of
4 a case load an RCC has. High volume
5 places, you - that's one of the
6 reasons we made the change is like at
7 - at Walter Reed we found that our RCC
8 there was running a case load of 35 to
9 38 cases. That's way too many cases
10 for one RCC to handle for
11 predominately amputees who are there
12 for long term and many who have their
13 families there. So, we made the
14 adjustments to bring more RCC's there
15 to handle that.

16 DR. GUICE: But before you leave -

17 MR. CLUBB: Yes ma'am?

18 DR. GUICE: The case load piece of it,
19 while we understand that the one to 40
20 ratio is specified by the DOTI so that
21 it's not to exceed. You know, that
22 number was based on a by guess and by

1 golly?

2 MR. CLUBB: Yes.

3 DR. GUICE: So based on your
4 experience, how would you better
5 adjust the case load and what would
6 you do and what would you implement,
7 design, create in order to balance an
8 individual RCC's caseload?

9 MR. CLUBB: The - I agree with you
10 totally. Forty is - is - you know it
11 was a dart board. Yes. Thirty - 30 is
12 a better number, but it's not perfect
13 because you can have a - you can have
14 a very seriously injured double
15 amputee with a very good home support
16 system who doesn't require a lot of
17 support. In other words he doesn't
18 require a lot of the RCC's time on a
19 daily basis. But they could have
20 three cases of someone with severe
21 PTSD and a terrible family support
22 system that eats up 90 percent of

1 their time. So we have to - we - we -
2 ideally, you would want to wait to
3 look at what is the time committed by
4 that RCC to their cases. In other
5 words there's a balance of what - what
6 are my hours that I have to put into
7 each one of these cases and what's the
8 work flow come out of that? And that
9 would really tell you what - what
10 their case loads should be.
11 If you go to BAMC, they run a caseload
12 of nine to ten and when they first
13 come in they're very -- they're
14 obviously -- they're in very acute
15 condition health wise. Their families
16 are there with them. It's very high
17 maintenance for an RCC. But after
18 they've been there awhile they reach a
19 plateau. So, work wise they reach
20 what I call the plateau. Nothing - it
21 flat lines out until they get close to
22 being, if they're going to be

1 transitioned out, then it suddenly
2 peaks up again because there's a spur
3 if activity if things will have to
4 happen. So, ideally you would want
5 something that's able to
6 gauge what is that RCC's level of
7 effort per case and then I could tell
8 you what they could maintain. Does
9 that answer your question ma'am?
10 DR. GUICE: Sort of; yes, thank you.
11 MR. CLUBB: Well, if it didn't, I can
12 -- I can try a different way; but I
13 mean that's, that's --
14 DR. GUICE: That, that's the answer;
15 but then what are you how are you
16 going to fix it? If -- if your sense
17 is that you need to, to balance the
18 work load based on the, the intensity
19 needs of the individual that the RCC
20 is assisting; then what are you
21 planning to put into place to allow
22 you to better parse that out? Or, are

1 you leaving it entirely up to the
2 RCC's assessment about this one needs
3 X, this one needs Y; therefore, I
4 should only have five.

5 MR. CLUBB: No, we're, we're not
6 leaving it there, it's, it's more of
7 a, what can they handle is where we're
8 at. That's definitely an area that
9 needs to be focused on that we need --
10 that we could use some assistance in
11 fixing. The, but it's not something
12 that I in place have a tool for right
13 now.

14 COLONEL MAYER: All right Ma'am, as I
15 tried to state earlier, it's a
16 recovery team on every one of these
17 marines and sailors; and it's medical
18 and non medical are just as important
19 decision making and the mentoring
20 process of -- of the Marines. So,
21 you're going to see when Captain Cast
22 talks to you tomorrow about the great

1 works on the BUMED side on case
2 managers. My emphasis on section
3 leaders and having that one to ten;
4 and as Tim just said on the RCCs, it's
5 the team working together is what's
6 making the difference and it can
7 balance it. It's very difficult to
8 just say one to 20, and it's fixed, as
9 Tim tried to articulate I think very
10 well, it's very difficult. And so,
11 that's why it's a team thing; and I
12 know you understand that, so --
13 DR. GUICE: Well, and I totally agree
14 with you that, and this is something
15 that we struggle with because we come
16 up with case load numbers, you know
17 one to two, one to ten, one to 220.
18 And it's based on, again, sort of, by
19 guess and by golly. And what we
20 really don't have is that way to
21 assess the amount of time or the
22 intensity of a service provider needs

1 to deal with the -- the specific
2 problems that crop up and on a
3 cyclical basis and across time.
4 Because, it, an individual's
5 portfolio, a RCCs' portfolio, an FRC's
6 portfolio, a non clinical case
7 manager, of course, it's all based on
8 the intensity of needs. So, in order
9 to kind of drill down to that, we do
10 need a better way to -- to bend that a
11 little bit. We just don't have that
12 kind of tool. There isn't one that
13 currently exists anywhere.
14 It's not like you can go buy it off
15 the shelf; but it's
16 -- it's something that, I think, we're
17 struggling with a little bit all of
18 our programs. And that, it's
19 something that I would hope that we
20 could kind of drill down on a little
21 bit; because it, the one to forty it
22 creates and artificiality that may or

1 may not hit the target on the given
2 days, as we all know.

3 CAPT. MAYER: Right, you know the --
4 what the medical community has done
5 for a long time, and that we're doing
6 now, and you'll see it weekly across
7 our detachments and battalions is --
8 is what is maybe known as a multi
9 disciplinary team, where you the
10 medical and non medical providers all
11 meet. They all discuss case by case,
12 line by line the needs of the marine
13 and his family; and that is the --
14 that is the winning, I mean, that's
15 where it really is what's making the
16 difference out there; because you get
17 the integration and the synergism that
18 comes out of the team effort. So --

19 MR. CLUBB: Excellent.

20 MR. CONSTANTINE: Mr. Clubb?

21 MR. CLUBB: Yes?

22 MR. CONSTANTINE: How come there are

1 so many RCCs at Quantico?

2 MR. CLUBB: I'm sorry?

3 MR. CONSTANTINE: How come there are
4 so many RCCs at Quantico?

5 MR. CLUBB: At Quantico there, there
6 Quantico has three RCs that's three of
7 those are the RCCs that are dedicated
8 to the reserves; because we could
9 never put those in the right place.
10 So they're, they are there. We have
11 three additional RCCs who work
12 strictly Quantico cases. There is a
13 large population of marines at
14 Quantico who have done numerous tours
15 who are almost that Seri typical one I
16 talked to you about, you know -- I
17 explained earlier. So, that, that
18 shows you that. Then you have
19 management is also resident there; so,
20 that's -- that's where we all are. We
21 also have one RCC there who works
22 local and supports Portsmouth back and

1 forth. Under best practices, we spent
2 -- we spent a
3 lot of time, as I told you from where
4 we were and where we've come. We --
5 we tried to capture what was working
6 and what would work best. And the
7 first thing we tackled was -- was
8 eliminating our internally the Marine
9 Corp was, we used a comprehensive
10 transition plan; and we had -- we
11 literally had six to seven different
12 variations of what we were using at
13 the time. And it was -- it was, they
14 were good; but they weren't
15 standardized. And that -- it kind of
16 turned into what the RCCs -- what they
17 liked at that certain location. So,
18 that was one of the first things we
19 tackled; what was the best
20 comprehension transition plan.
21 And so we settled on one plan and, and
22 that's what we pushed and then we made

1 refinements to it. Now, we have -- we
2 have moved forward with the RCPSS; and
3 we're working very closely with WWCTP
4 in implementing that. In fact, of our
5 1,100 plus cases we have already
6 converted nearly 1,000 of those right
7 now into RCPSS; and we work very
8 closely with them on making
9 modifications and improvements to
10 RCPSS also. We have also --
11 internally, we have focused on case
12 transfer procedures. I believe early
13 on there was, there was a lot of
14 intent that when you got an RCC, that
15 would be your RCC forever; and that's
16 what we would like to stick to. But
17 we also know that doesn't necessarily
18 always work, particularly if you're
19 somewhere like Bethesda or Walter
20 Reed. A marine may come through there
21 and only be there for ten to 14 days.
22 So, they'll get an RCC; because they

1 need one while they're there. But,
2 that won't be the one that they will
3 necessarily have if they're -- if
4 they're returning to Camp Pendleton.
5 So, there has to be a transfer
6 procedure; because you certainly can't
7 -- they'll have an RCC on site at Camp
8 Pendleton. So, we -- we are -- we
9 have worked to refine what our
10 transfer procedures are; or exactly
11 what needs to be transferred between
12 RCCs. Who oversees and Q As that? And
13 then, more importantly is, there is a
14 hand off, a discussion of that case
15 between those RCCs. Case assignment
16 is -- is another area, the regiment --
17 the regiment makes the determination,
18 the Marine Cop makes the determination
19 on whether a marine gets an RCC or
20 not. It's cut and dry across the
21 board. The RCCs are all contractors.
22 We don't make the decisions. We'll

1 make recommendations, if we're asked
2 to do a needs assessment on a case or
3 wherever it came from. We'll
4 certainly provide that; but all
5 decisions on assignment is, and should
6 be, a Marine Corp decision on whose
7 going to receive a RCC. We have, we
8 have worked to, also, do that. We
9 have, also, within the -- the
10 regiment's tracking system, MCWITS,
11 we've made a number of modifications,
12 and more coming, to improve that also
13 as a tool of sharing information for
14 cases, good.
15 I think that we -- we earlier went
16 over some of the slides of some of the
17 assessments we've done; and the RCC
18 program has -- has been assessed and
19 reassessed. And, each time we take
20 that and we go back and we -- I'm a --
21 I'm a pusher, if I'm at ninety
22 percent, and I want to see what I can

1 do to get to 92. I probably drive my
2 people nuts, because I'm never happy;
3 but we're continually pushing to
4 improve this. The numbers in that box
5 -- those numbers were for the most
6 part most of those assessments were
7 done within the last year, or at least
8 up to a year ago. At that point, when
9 they were done, the program
10 essentially with -- with procedures
11 and policy coming into place was
12 probably about six months old. So,
13 those -- those are pretty high
14 numbers. Certainly, not something that
15 I would be happy with long term in my
16 program; but that's -- that's what we
17 look at.
18 The -- the measure of success is a
19 marine, as Colonel Mayer has, has said
20 repeatedly, though, is a return of
21 that marine to duty or transferring
22 out becoming civilian and fully

1 complete. I mean, that's, that's the
2 in state; and I can't put a number to
3 that; but I, you know one when you see
4 one. That's our in state, as well, is
5 a successful transition. Want me to
6 keep going on this one?

7 UNKNOWN SPEAKER: (Inaudible.)

8 The call centers -- the regiment
9 actually
10 maintains three separate call centers. As we said
11 before, call centers is really, is -- was the term
12 that was originally applied to it, but they've
13 grown to be much more than a call center. They,
14 they don't function in the regard that they sit
15 waiting for a phone to ring. They -- they are an
16 outreach center. They are a resource and support
17 center. We have -- we have three separate ones,
18 with the largest one being in Quantico, which
19 focuses on retired and separated marines and their
20 families. We predominantly do not focus on anyone
21 who is active duty. There is also a contact
22 center which is staffed at each of the battalions

1 that focuses on active duty personnel.

2 The call center at the -- at Quantico

3 runs 24

4 seven. We have three shifts. We focus on a

5 population of combat wounded anywhere from VSI or

6 very seriously injured, to not seriously injured;

7 and we have developed a contact frequency in which

8 we check on those marines and their status. And

9 it can be anywhere from someone who is very

10 seriously injured to we contact them monthly; to

11 someone who is not seriously injured to annually.

12 They can always contact us back directly, and many

13 do. We try and use the same contact person with

14 each case so that they build some type of rapport.

15 We run this 24 seven, as I said. We have focused

16 -- when we -- when we took this center over, we

17 focused on -- a lot was focused on via phones to

18 be quite frank with you; and we found,

19 particularly with the younger generations, I know

20 I'm the same way, is I don't answer my phone in my

21 house. You know, I you -- you use your cell. If

22 you have one, you let it ring and you see who it

1 is. So, we have, we have moved ourselves towards
2 contact either via cells or social media; and we
3 have stepped off into that quite heavily as in
4 using that. In fact, we're doing mass texting
5 now. We use texting to contact marines. They're
6 very comfortable with that. In fact, most of them
7 will say, we'll say, "Do you want me to call you
8 next month", "No, but go ahead and text me and
9 check on me"; and many of them will actively text
10 back, "Hey, how's it going"? So, they develop that
11 it's -- it's -- it's mindboggling to me; but it
12 works; and when something works, we're going to
13 keep using it. So, that's, that's one of the
14 things that we found. Within the call center
15 itself, we brought in a media specialist and a
16 media intern who worked this collectively. Our
17 rates of contact, of the marines that were tasked
18 with contacting, I didn't think we'd ever -- we
19 changed our metrics on how who we were contacting,
20 how we checking, I didn't think we'd ever achieve
21 it; and literally, within of the first month of
22 doing it, we contacted 100 percent of who we were

1 supposed to contact within the first two weeks of
2 the month. I was simply amazed; but if we had
3 done it the way it was done before of dialing the
4 number -- the home number, we never would have
5 done it. So, we -- we're not there on where I
6 totally want to be; but we're definitely making
7 progress on that piece. As I said, we launched,
8 we launched our Face book site on February 11th.
9 I believe the next slide gives you - I believe,
10 some of the figures on it. Our intent there was
11 to use that as a -- as a center, a method for
12 marines and their families to come to discuss and
13 learn while they were there; and we launched this
14 thing, and you can see where our numbers where we
15 are. I'm in the over 50 crowd, so I have to have
16 them explain it to me quite a bit; but I know it
17 works. When we maintain the site and we update it
18 on a daily basis, the usage is very high. And I
19 guess, it goes to human nature. If you go to a --
20 if you check X number of sites a day -- if you go
21 to the site that looks like it did -- the same as
22 it did yesterday, you check off of it. So, we

1 found that the key to our Face book site is not
2 only keeping it updated every day; but also,
3 providing something they're interested in. When
4 the -- when the warrior trials for the Marine Corp
5 for the games started, we found almost a ten
6 thousand spike in users that week; because we were
7 posting information from those games; so, the clue
8 bird landed with this, this is where we got to go
9 and what we got to do. So we -- we are intensely
10 focused on how do we keep this thing updated on a
11 daily basis with something that they're interested
12 in?

13 DR. GUICE: Have you thought about
14 partnering with the National Resource
15 Directory, because they also have a
16 Face book page; and they have daily
17 updates; and it's -- some of the times
18 it's the news articles that are in,
19 either on the Spot Light Feature or in
20 the news that get posted to Face book.

21 That might be another way for you all
22 to continue to add fresh content every

1 day using a resource that you already
2 rely on for other -- in other
3 dimensions but already has that
4 automatic feed that would be easy.
5 MS. FLORES: Certainly, yes.
6 COLONEL MAYER: I -- I'll talk about
7 this; you've heard me speak already
8 all morning; so, but once again, in
9 the Wounded Warrior Regiment we don't
10 focus on the disability. We focus on
11 the ability. That picture there of
12 Corporal Green, that hopefully, shows
13 you what can be accomplished at least
14 in the physical for a Wounded Warrior
15 Regiment marine; and we have launched
16 the campaign across the Marine Corp
17 advertising these very simple things.
18 Focus on your ability and not your
19 disability; and so, that's our message
20 -- that's one of our pictures. I
21 don't know if we gave you all
22 calendars; but we've got our pinups

1 for the month. Our other marines like
2 Corporal Green out there; and that is
3 the type of goals we are setting in
4 the Wounded Warrior Regiment; and so
5 there's -- that's one campaign to
6 advertise in the such. That's the
7 best practice, normally, so --
8 GEN. GREEN: Can I ask on the Face
9 book outreach? Again, I'm -- I
10 actually do have a Face book account;
11 but I am not very knowledgeable as one
12 of those over 50 users. So, can you
13 actually create links back to web type
14 activities --?
15 MR. CLUBB: Yes, sir. Yes, sir.
16 GEN. GREEN: And things that are
17 valuable to them go from that site --
18 MR. CLUBB: Yes.
19 GEN. GREEN: To get to other
20 information.
21 COLONEL MAYER: Yes, sir, you
22 certainly can. Well, sad to say

1 because you're an old guy like me.

2 GEN. GREEN: Yes, sir.

3 COLONEL MAYER: Is the, probably the
4 smartest thing we did is, the folks
5 that run our Face book, is a Captain
6 whose my PAO; but it's two contractors
7 that are probably right out of
8 college; and so, you know, don't hire
9 old guys to run something that's
10 suppose to communicate with 18 year
11 olds. And so, anyways, I'm very
12 optimistic and pleased where this is
13 going. So, I just I -- I think it's
14 right. I mean the texting and all
15 that and Sergeant Major --

16 SERGEANT MAJOR LESKONKA: And, also,
17 with the Face book thing. I'm a
18 member and I post all the time on our
19 regimental page; and I've done videos
20 and things like that for the page.
21 But the good thing that I did is that
22 people come over to my Face book and

1 they start talking to me off line; and
2 then I can direct them to other
3 things. I don't know that everybody
4 has the time to do that when you start
5 getting, you know, five, six, seven
6 hundred fans. It gets a little
7 tedious to try to keep up with them;
8 but it's a great resource for
9 connecting people together. So,
10 marines taking care of marines, once
11 they get on that Face book they start
12 talking to each other; and that's
13 sometimes the best healing that occurs
14 because somebody already went through
15 that process. And it's the same thing
16 with our focus on ability instead of
17 disability. Corporal Travis Green who
18 was up there, I remember when he was
19 in ICU at Bethesda. He almost died
20 three times while I was there on a 45
21 day period. He was our second longest
22 stay in an ICU. He was allergic to

1 antibiotics, I shouldn't tell his
2 whole HPPAA stuff. Hopefully nobody
3 goes with it; but he was allergic to
4 antibiotics. He caught funguses. He
5 had all these problems. I looked at
6 his poor parents every weekend that I
7 went to visit there; and then I saw
8 him at the Warrior Games last year
9 when we were doing the camps at Fort
10 Carson; and he couldn't even remember
11 me because he was on so many drugs.
12 He did not remember who I was; but he
13 did remember my coin that I gave him;
14 and he was like, "Oh you're that guy",
15 you know. And so this is what a lot
16 of our struggles are upfront when they
17 first come into the treatment facility
18 when they're on dilaudin and morphine
19 and all these other things. They
20 don't remember all of that up front;
21 but their family does. But the family
22 doesn't speak marine or army or sailor

1 or anything like that. They don't
2 speak that language. So, there's that
3 disconnect there for the first few
4 days of all that medication and stuff
5 when they don't realize what was going
6 on. So, what we always ask them to
7 keep a log book and things like that;
8 but our focus on ability when we show
9 Travis Green what he's done the other
10 guy or gal that's in there now missing
11 a limb has hope for the future. And
12 they can look forward to that; and
13 that's why it's very important
14 psychologically to get them going
15 through that process. Because I can
16 tell them all day, "These are the
17 programs, these are the programs".
18 Until they actually have to use the
19 program, really, you didn't tell them
20 anything; because out of necessity is
21 how we work as human beings. So,
22 until I lose a leg, I really don't

1 understand disability; but when I lose
2 that leg, now I go through my phases.
3 I go through anger. I go through self
4 acceptance, affirmation, all of these
5 different things; and once I start
6 going through that then I start asking
7 about the programs. So, I tell the
8 marines all the time, and their
9 families, we know everything in the
10 Wounded Warrior business. We just
11 don't have ESP. So, you have to tell
12 us that part. You have to ask us that
13 question, so we can get you the
14 resource; and a lot of times they're
15 expecting everybody to -- to
16 understand when they need that
17 resource available. And that's the
18 tough part; and that's why we do the
19 "Keeping It All Together" handbook.
20 And we have the RCCs and the section
21 leaders and we're -- we're trying to
22 be so adaptive at this point to take

1 care of all those needs, so that
2 nobody falls through the cracks.
3 And we are going to have those that
4 fall through the
5 cracks. I hate to say it, but as soon
6 as we get those names, we are on it
7 like that. Unfortunately, sometimes
8 those make it to congruents and
9 newspapers and things like that; and
10 we're all trying to get left of the
11 boom instead of right of the boom on
12 all of those events as -- as we look
13 at our service members and their
14 families' needs.

15 MR. CLUBB: The one -- the one final
16 thing I'll say in closing for you on
17 Face book that allows us to do, which
18 makes me extremely happy, is that it
19 allows us to, to not only educate but
20 allows us to correct information;
21 because the sea lawyers will say you
22 don't want this or you don't want

1 that. And then if it pops up in, on
2 our wall, we're able to come in and
3 say, "Well, that's actually not
4 correct itself this is", and they
5 actually site where the references
6 come from and correct that. One of my
7 favorites is, "You don't want to be
8 100 percent rated because you're never
9 allowed to work", which routinely pops
10 up; but it's out there and it exists
11 everyday. And you'll -- I'll hear it
12 constantly. So, that's, that's
13 another side benefit of this thing is
14 I, it helps us correct this, so --

15 COLONEL MAYER: Thank you Tim. I'd like to introduce our
16 family support programs - a person, Ms. April Peterson, and she has
17 worked so hard preparing for this moment and for
18 our families that -- that I can't hug her enough
19 or tell her how much we appreciate her; and so,
20 I'm going to let her brag about her program. If I
21 could get you to look at the picture, though, up
22 on the screen real quick. I think a picture
 paints, I don't know, a million words, a thousand

1 words. That's, that's a particular couple that's
2 currently at Walter Reed right now. Clearly, that
3 family needs everything that America can offer to
4 them for their sacrifice in combat for our
5 country; and that's why the task force exists and
6 why I exist is support a couple like them. Where
7 the rubber meets the road in this case is through
8 April Peterson and -- and our other family support
9 coordinators and our leadership out there each and
10 every day looking at this particular lady in the
11 eye and saying, "There is hope for this family".
12 And there is a great opportunity that we can help
13 you with along the way. MS. PETERSON: You know,
14 was a former active duty marine, but she was
15 quoted in -- at the Wall Street -- Washington
16 Journal was taking this photo and got an article
17 and was speaking to her, and she said that it was
18 difficult being a marine, but it was more
19 difficult being a marine spouse. And looking at
20 the job that she has here, that's really what, you
21 know, we base our program on, these unique
22 challenges that these families face. And a big

1 part of our program is not only the assessments
2 that we've talked about here, but it's also the
3 two way feedback between the marines and families
4 and us. So in that spirit, I'll set a foundation
5 for you, but I would really like to take questions
6 from you and have a
7 discussion about our Family Readiness Programs, rather than brief to
8 you. Just as a foundation, one of the things that we found very early
9 on, the Marine Corps has Family Readiness officers
10 in all of our units across the Marine Corps. And
11 really their job is to take care of the units,
12 families and marines.

12 At the regiment and our battalions, we
13 have a unique
14 requirement because not only do we have regimental
15 families and marines to take care of, we also have
16 the wounded, ill, and injured marines and
17 families. And while they all require the same -
18 they all require communication, information,
19 resource and referral, there are unique challenges
20 to the wounded, ill, and injured population. So
21 what we did early on is develop a staff position
22 called Family Support Coordinators.

1 And we have two full-time Family Support
2 Coordinators located at the
3 battalions. And then we have Deputy Family
4 Support Coordinators located at all of our
5 locations. And that's roughly about twelve. They
6 go through special training. They do the one-on-
7 one resource identification referral with families
8 through the KIAT book that we talked about
9 already. But additionally they serve as experts
10 for the staff because the RCC's will work hand-
11 in-hand with the marine and family. But sometimes
12 the RCC, you know, may need themselves to know a
13 little bit more about some of the Family Readiness
14 resources available especially in the local areas
15 and that's what are FSCs are there to take care
16 of. So do you have any questions for me? Or would
17 you like to flip through the slides? This stuff is
18 a little bit our policies. At the regiment, we
19 have a specific policy for the FSC program, and
20 our FSC's also go through training on local
21 resources; how to do the one-on-one
22 orientation to the KIAT handbook. We've also developed a care for the
caregiver workshop, which is something that is executed a little bit

1 differently at all of our sites. So when you go
2 out, you'll see it just a bit differently. And
3 it's actually in that KIAT book, but it's a way
4 for us to get the spouses together for spouses to
5 be able to - and family members - to be able to
6 get together and network, talk to each other about
7 some of the caregiver challenges; and it's been a
8 pretty successful program at our sites. Yes,
9 specifically you asked for the resources for how
10 we help our caregivers, and really what I'd like
11 to note here is that the resources aren't
12 necessarily any different than the ones that you
13 would offer to any military family member. What's
14 important, and you can see it on the next slide is
15 how we deliver those resources. So I've been a
16 military spouse for almost ten years now. You may
17 tell me, "Hey, go to Military One Source, you
18 know, here's the website; here's a phone number;
19 make a call." And I might be able to go and do
20 that. For one of our wounded, ill, and injured
21 family members, what we would do as staff is make
22 the phone call with them, or we would walk them

1 down to a resource provider and actually introduce
2 them to the person. And more importantly, we
3 would do follow through. So not only would we send
4 them to say the Army's Family Assistance Centers.
5 We would walk them down, introduce them to
6 somebody, and then we would follow up and make
7 sure whatever their need was, that that's taken
8 care of.

9 DR. GUICE: Do you know how many of
10 your families have used the Tricare
11 Respite Benefit?

12 MS. PETRELLA: I don't think we have
13 those numbers. We could
14 potentially go through Tricare, but we don't have those ready for you.

15 MS. PETERSON: These are some of our, sort of, unique
16 programs at our various sites. Again, everything
17 is executed just a bit differently because of the
18 local resources that are available. But one of
19 the real jobs of a family readiness officer or a
20 family support coordinator is to create unit
21 camaraderie. One of the challenges we face,
22 spouses are used to units doing family days and
that sort of thing when their marine is out in the

1 fleet. Now, when they're taken out of that
2 environment and put in a military treatment
3 facility, sometimes they're missing that unit
4 camaraderie. More importantly with our families -
5 parents, fathers -- who may have never experienced
6 that unit camaraderie, now being in a military
7 treatment facility, it's a new education
8 experience for them to kind of see what the Marine
9 Corps is all about. So at our various sites, we
10 do all sorts of family support group activities to
11 make sure that we keep the families engaged with
12 each other and with the staff. Talked a little
13 bit here, there was a specific question on the
14 Army's Family Assistance Centers - certainly at
15 BAMC and at Trickler; we use all of the family
16 readiness assets that the Army has to offer, just
17 like we would our Marine Corps community services.
18 And again, it's just a it's another resource
19 that they
20 utilize at those areas. And this talks a little
21 bit about the success of our programs and how we
22 define it. As we've already talked about the

1 assessments, satisfaction is going up, and one of
2 the things that we know through our assessment
3 efforts is that prior to the stand-up of the
4 regiment till now, satisfaction has increased. So
5 we're doing better. There's certainly more work to
6 do. And as we start to evaluate how some
7 of these programs are working, our family support coordinators our
8 keeping it all together - handbook; our care for the caregiver workshop;
9 those types of things. We'll be able to see if
10 it's working, and know where to make enhancements
11 in the future.

11 LT. GENERAL GREEN: Can I ask a
12 clarification question?

13 MS. PETERSON: Sure.

14 LT. GENERAL GREEN: Your family and
15 caregiver support, obviously, is now
16 geared towards the regiment, but the
17 actual positions and things that --
18 was there a marine family support
19 system that you were a part of and
20 just were reassigned over to the
21 regiment? Or is this an entirely new
22 effort?

1 MS. PETERSON: The family support
2 coordinators? I'm sorry.

3 LT. GENERAL GREEN: Correct, I'm
4 trying to understand the mission that
5 you're talking about that you do now
6 for the regiment. Was, is it something
7 that's only been stood up since the
8 regiment was stood up, or was it
9 something that existed on the bases
10 before?

11 MS. PETERSON: Well, family readiness
12 officers existed prior; they've been
13 around in one capacity or another.
14 The Family Support Coordinators, we
15 realized really in that first year
16 that the family readiness officers are
17 great, and they're supporting the
18 regimental and battalion families.
19 However, we have a unique population
20 now, a population of wounded, ill, and
21 injured families who require a
22 separate set of services. So we

1 establish that family support
2 coordinator.

3 LT. GENERAL GREEN: So you understand
4 where I'm coming from. In the Air
5 Force, we have an Airman Family
6 Readiness centers that
7 existed prior to all of the 2007 issues. And so I'm wondering whether
8 you have something that has now been aligned to the regiment or if it
9 was something that's been newly developed for the
10 regiment?

11 SERGEANT MAJOR PLESKONKA: Yes, sir.
12 We've always had Marine Corps
13 community services that stood up in
14 the early nineties as we kept
15 developing as a Corps, and that Marine
16 Corps community services has always
17 helped with family outreach and all of
18 that stuff. Then the Marine Corps in
19 every unit we have a collateral duty,
20 normally was Your supply officer or
21 something like that became your
22 family readiness officer. And that
person did the weekly meetings or the

1 monthly meetings -- I'm sorry -- and
2 then we had KV's, which were key
3 volunteers, which were normally
4 spouses that assisted. And you would
5 have family meetings and then do like
6 barbeques, family days, and things
7 like that on a relatively frequent
8 basis throughout the year. Then what
9 happened was the deployment cycles
10 picked up, and we didn't know we were
11 going to be at war this long. So the
12 Marine Corps, a little over three
13 years ago, General Conway came up with
14 the idea of having a FRO, a Family
15 Readiness Officer that was a full-
16 time member of battalions and
17 squadrons and higher in the Marine
18 Corps. So through the NAF funding, on
19 the MCCS side, non-appropriated funds,
20 we put those in every one of the
21 units; the FRO system. And so then
22 when the regiment was stood up, we put

1 a FRO at the regiment level, and then
2 we put one in each one of the
3 battalions. But we found that our
4 family base was much higher because of
5 the needs of having, you know, that
6 one individual comes in and then you
7 three on invitational travel orders,
8 and the dynamics of that family. So
9 we made two FSC's, one of the east
10 coast

11 and one on west coast to help the FRO, and then we made all of the
12 coordinators at all of our DETS. So it's a collateral duty at all of the
13 DETS, except for where those two FRO's are. So we
14 just expanded the program that was already in
15 place.

16 LT. GENERAL GREEN: Just so that my
17 questions make sense to you, okay?
18 It's a very good - I actually am very
19 appreciative of what you've done, and
20 your explanation is exactly on the
21 mark. So that helps me. what I'm
22 worried about, and one of the reasons
I asked about who's in, who's not in

1 and about how you've set up these
2 programs is I'm wondering the
3 sustainability of the programs as we
4 move into new phases? We're coming out
5 of Iraq. We don't know yet what's
6 going to happen in Afghanistan, but if
7 we do see curtailing of the casualty
8 stream, which we all hope to see, my
9 questions really are about how are we
10 going to continue to support the ill
11 and injured? So as we've set up new
12 infrastructure, I'm kind of also, at
13 the same time, trying to find out what
14 will persist and what will basically
15 go back into the way we always did
16 things before we had the war?

17 SERGEANT MAJOR PLESKONKA: Yes, sir,
18 and I think on our side is the service
19 is looking forward at that and how
20 with fiscal constraints and the
21 downsizing of the forces and all of
22 that that have been publicized, we're

1 looking at how we shrink the FRO's and
2 where we pull those to, so would they
3 just be at regimental levels and group
4 levels? Or would they be at major
5 subordinate commands like divisions
6 and wings and then supported by those
7 collateral duties again within that?
8 And we strive, Colonel Mayer does
9 constantly, to prove that our program
10 needs to exist into the future because
11 historically the numbers
12 go up after combat, not down because of PTS and stuff people then come
13 out and say, 'Okay, I need to help myself now that I'm done doing all
14 these deployments.' So our numbers go up pretty
15 high on that. So Colonel Mayer has been fighting
16 tremendously to keep those resources available as
17 we start to wind down, and is probably going to be
18 needed for five to ten years afterwards.

18 MS. PETERSON: You know, and the
19 Marine Corps has always had a very
20 strong family readiness program. So
21 the family support coordinators are
22 simply an enhancement to something

1 that was always there and will always
2 exist.

3 GENERAL HORST: I have a question for
4 you. Are your family support
5 coordinators a volunteer position, a
6 paid position or a uniformed position?

7 MS. PETERSON: Okay. Two answers
8 one, the two full-time family support
9 coordinators, one at each battalion,
10 that's full-time paid support. The
11 deputy family support coordinators are
12 active duty. So it's a collateral duty
13 on their part, but it makes sense
14 because at each of our detachments,
15 there is that detachment liaison staff
16 and at several of those locations, you
17 know, they're the first person that
18 that family will meet. So it only
19 makes sense that it's them that are
20 trained in this role.

21 GENERAL HORST: Okay, good. I'm just
22 trying to compare to the system that I

1 know because we learned some very
2 painful lessons having volunteer
3 family support coordinators, and we
4 found that given the volume complexity
5 of the duty we ask them to do, we
6 really needed to do it right, and make
7 it a paid position rather than a
8 volunteer

9 position.

MS. PETERSON: Absolutely.

10 COLONEL MAYER: Yes, sir, and that's
11 the way Marine Corps did it, I think
12 up to 2006. Now, it's paid positions.

13 MS. PETERSON: Thank you.

14 MS. DAILEY: Before we move on, I'd
15 like to ask some questions. For the
16 change of command, Colonel Mayer and
17 Sergeant Major, we are going -- the
18 task force visit next week six and
19 seven April is to Twenty-Nine Palms.
20 So we are looking forward to meeting
21 with the families out there. Now,
22 families are traditionally very

1 difficult to gather, and your Marine
2 IG just came through last week, and
3 they were successful in getting two
4 family members to their focus group.
5 I would like to be able to say we got
6 three or four. So some interested at
7 Twenty-Nine Palms would be helpful.

8 MS. PETERSON: Okay.

9 MS. DAILEY: Now in my work with them,
10 and I've had several phone calls with
11 them, they never - they never threw
12 their deputy family coordinator under
13 the bus, so to speak, to talk to us.
14 They are referring us to Mrs.

15 Hildebrandt. She's going to do a
16 phone con with us Willete -- Melinda
17 Willete will be talking with us. She
18 is the family coordinator at the
19 Pendleton. Is there no deputy family
20 coordinator at Twenty-Nine Palms?

21 MS. PETERSON: There is. Actually,
22 it's the Sergeant Major at Twenty-

1 Nine Palms.

2 MS. DAILEY: He didn't identify
3 himself as that, okay.

4 MS. PETERSON: Actually, and they may
5 not because honestly

6 the detachment staff, they kind of all consider themselves to be family
7 support coordinators because at any point, we can get a family 24/7 into
8 one of our facilities. And so they all have to be
9 trained on how to speak to families. So a lot of
10 them won't identify one person because they felt
11 they're all subject matter experts on it. Melinda
12 Willette is the right person to go to because she
13 is actually a family readiness officer at
14 battalion west, and she'll for sure be present at
15 the Balboa one, but we have strong family support
16 program at both Balboa and Twenty-Nine Palms. So I
17 don't see it - I don't think it'll be a problem
18 for you to get families to your focus group.

19 MS. DAILEY: Okay. I wouldn't over
20 reach on that.

21 MS. PETERSON: I'm not.

22 COLONEL MAYER: Let me just say the
demographics at Twenty-Nine Palms is

1 far different than Bethesda or Balboa.

2 Now, when you go to Balboa, you'll
3 get lots of families. Twenty-nine
4 Palms though is a little bit different
5 demographics. I don't have them here,
6 but you're not - Marines there are not
7 in - they shouldn't be VSI or even
8 wouldn't be too many SI out there. So
9 you're not going to see a whole large
10 population of non-medical attendants
11 or families. So it'll be small numbers
12 out there.

13 MS. DAILEY: Yes, we're eager to talk
14 with the small numbers, so Twenty-
15 nine Palms is looking up. Again, we
16 have spent some time on the phone with
17 them, and I can provide you the 90
18 percent solution agenda for when
19 members go out there. So if there's
20 anything you can see on it that we
21 should look at, or that is not on
22 there yet, please let me know. I'll

1 give you hard copy before you leave.

2 COLONEL MAYER: They're looking forward to your visit ma'am,
3 and the DOD IGs visit is going simultaneously. So as I always say I'm
4 here from Quantico, and I'm here to help.

5 GENERAL HORST: We're not the IGs.

6 COLONEL MAYER: They're coming at the
7 same time. It's kind of interesting
8 that Sergeant Major Templeton's out
9 there, and you have of course
10 Lieutenant Colonel Greg Martin will
11 come up from Camp Pendleton when
12 you're out there. So if you haven't
13 been to Twenty-Nine Palms yet, you'll
14 enjoy it. I love it. It's a warrior
15 camp in every sense of the word. So if
16 Twenty-Nine Palms doesn't inspire you
17 to be a marine, then by golly, that's
18 probably why you're not a marine. I
19 could even get my sailors back there.
20 I think we're moving along in the time
21 line pretty well. I'm on Regiment
22 Transition Assistance, and I have a
young major named Bilsky. If you don't

1 know Bilsky, he motivates me just
2 saying his name, but unfortunately, he
3 had annual leave, and he's in England
4 right now. Maybe he planned it and
5 he's just smarter than I am. He could
6 do justice to our program here.
7 There's kind of my staff, and you can
8 see it there. I've got transition
9 coordinators at the regiment and the
10 battalion level. We work hand in hand
11 with marine family programs, which
12 owns the transition process for the
13 Marine Corps. Marine for Life, as many
14 of you already know, Marine for Life,
15 we grew out of Marine for Life, that
16 was the initial program that Wounded
17 Warriors kind of spawned out of, and
18 we still work hand in hand with them
19 as they do the transition for the
20 other 29,000 marines that leave the
21 Marine Corps every year. I'm very
22 proud to say that we have agreements

1 with the VA and with the Department of
2 Labor. As a matter of
3 fact, your very own Sean Keane there works up at the Department or the
4 VA up at headquarters VA, and they also have provided us an exchange
5 liaison officer that works down at our
6 headquarters. It's similar with the Department of
7 Labor. So we are doing our best to integrate so
8 it is - I won't use the word seamless because we
9 know in this business there's no such thing as
10 seamless, but as smooth a transition as possible.
11 We go to numerous conferences, and are actively
12 involved in the transition, and I think you'll see
13 throughout our slides that this is a large concern
14 for the marines. It is probably also as you will
15 find the trickiest and probably the most elusive
16 for a commander of constantly asking why is it
17 we're not getting more marines jobs? Why is it
18 we're not seeing more marines employed? I know
19 you've seen the stats and all that. I literally
20 went to a conference and spoke at a consortium of
21 DOD type businesses - McDonnell Douglas and others
22 along that line, and they talked about hiring
wounded warriors, and they have quoted. I have to

1 hire ten a month for the next twelve months to
2 meet my - Mayer, where are all these wounded
3 warriors? I'm telling you, it's elusive why we're
4 not getting jobs for the marines out there.
5 That's what we're all about is a transition. It
6 isn't because the jobs aren't available. It's why
7 they're not taking the jobs, and that's what maybe
8 you all can help us figure out as you travel
9 around. I almost think that they need to - this is
10 Mayer speaking, but I guess for you all, I think
11 they wounded warriors need to become veterans for
12 a bit, and see that there is a reality out there,
13 and then they almost better at the six month mark
14 or so of tackling, tackling the jobs and all that.
15 Anyways, it's a tough one, and this whole
16 process, my guy get beat up by me weekly on why is
17 the numbers not higher on the employment side? We do great things such
18 as the vocational rehab program. I'm a big believer on that. Let me see
19 you talk about the stats? You've got the chart.

20 MS. PETRELLA: Yes, per the VA for
21 FY'10, we had about 14,500 marine
22 participants in VRNE, and that's about

1 twelve and a half percent of all DOD
2 participants. Then, for
3 rehabilitations, which essentially
4 means employed in a suitable
5 occupation, that was about 1,100
6 marines or 11.2 percent of all
7 participants, and again that's for
8 FY'10.

9 COLONEL MAYER: As I understand it,
10 the vocational rehab program is going
11 to raise it up so that it's the same
12 amount of money as the GI Bill, which
13 when talking to marines, they'll say
14 the reason I didn't do that is because
15 I would lose the amount of money I get
16 from my GI bill, and I understand it's
17 going to be equalized here soon. On
18 the mentorship program --

19 MR. REHBEIN: Colonel, can you back to
20 that previous slide. Something kind of
21 jumps off of that slide at me. Up
22 there in the blue box of answers it

1 says, "Required to meet with VRNE
2 counselor prior to release," but then
3 if you drop down to the bottom,
4 reasons for not using VRNE services,
5 "didn't know how to apply." There's a
6 disconnect there if they're meeting
7 with a counselor. Are they not getting
8 the right information? Are they not
9 listening?

10 COLONEL MAYER: Every marine, sir,
11 goes to DTAP and to TAP program.
12 That's where the counseling is coming
13 from. Marine Corps is retooling the
14 way we do transitioning, and that is
15 yet to be released.

16 So what happens in reality a lot is that the marines get it towards the
17 end of their career when they're getting ready of leave. So I think the
18 focus is to leave and not listen to all the
19 different benefits that could be and how best to
20 apply it.

21 MR. REHBEIN: Having been a 22 year
22 old soldier with only hours left to
 serve, I understand how that is, but

1 I'm hoping we can develop some more
2 effective tools to keep it in their
3 hand and in their mind until maybe two
4 months later.

5 COLONEL MAYER: Yeah, the Marine
6 Corps' philosophy is going to be - is
7 as I understand it is it's not
8 something that we just focus on in the
9 last couple of months. It's something
10 that we focus on throughout their
11 career. So the education and the
12 understanding of what's available and
13 where I can take that when I
14 transition is knowledge to every
15 marine, not just as part of a class
16 that he gets towards the end.

17 MS. FLORES: Sir, when this data was
18 captured, that was in 2010, and just
19 recently actually, just this week, the
20 policy that that second bullet was put
21 into place. So prior to that policy,
22 it wasn't a requirement for all

1 individuals to make.

2 COLONEL MAYER: On the mentorship

3 program, I'm a big believer in it. The

4 challenge with mentorship as you all

5 know is you can't just say, "Mayer,

6 you're going to be Pleskonka's mentor

7 today," and that's going to work.

8 You've got to throw people together

9 constantly in different situations,

10 and then they're kind of finding each

11 other. As I always say just as there a

12 woman for every man, there's a mentor

13 for every woman warrior. The

14 difficulty is the meeting

15 together in my time as a commander. So I try to give them as much

16 opportunity. Some of the opportunities that we use, there are

17 organizations. The Marine Corps has a mentorship

18 program which we use. There is a Marine Corps

19 charitable organization here in DC, and in other

20 parts of the country, which we use and we work

21 with to try to find mentorships that are

22 successful in business and in life to support the

23 marines. We try to send the marines through some

1 of the charitable organization that I talked about
2 earlier - COMPASS run by Vet Foundation and FOCUS
3 run by Midwest Marine Foundation to their week
4 long kind of transition courses that focuses on
5 resume building, interview processes and all that.

6 We are very active in Operation War Fire Fighter
7 which is

8 internships especially here in the DC area that
9 exposes the marines to different occupational
10 skills, but also to different ways of doing
11 business, with such places as the FBI and almost
12 all the other federal law enforcement programs.

13 Through our surveys we know that 38 percent of our
14 wounded warriors are interested in some type of a
15 law enforcement or security type occupation when
16 they transition. So we're big believers in
17 exposing marines as much as possible to mentors
18 and internship type programs.

19 MASTER SERGEANT MACKENZIE: Colonel?

20 COLONEL MAYER: Yes, sir?

21 MASTER SERGEANT MACKENZIE: Do you

22 find not very effective use of this

1 program to those who are trying to
2 stay in the Marine Corps, and don't
3 necessarily look at some of these
4 programs as viable to them because why
5 would a wounded marine want to talk
6 about getting out of the service when
7 he's trying to stay in?

8 SERGEANT MAJOR PLESKONKA: Sir, when you're talking about
9 the combat wounded, not the ill and injured, the Marine Corps has the
10 expanded limited duty program, which we always had
11 the PLD for anyone that's injured, and you can
12 apply for up to 24 months to stay in and help with
13 your transition if you have a medical injury. The
14 issue on the wounded side is initially when you
15 come out of the blast; your mind is still with
16 your unit. So you want to get back to the unit
17 where those young men and women are on the
18 battlefront, and you want to stay there. So you're
19 motivated to get back to your unit. As time
20 progresses, we find that actually most of those
21 want to transition out at that point. We've
22 ordered about 35 marines for the ELPD program. We
 currently have 26 on active duty in the Marine

1 Corps that have gone through that ELPD program. We
2 just boarded two more yesterday. I was at the
3 board. So we're at 28 people really that have
4 taken advantage of that. We have almost 19,000
5 marines that have the Purple Heart since the
6 beginning of this. Out of those, how many were
7 VSI, SI, I don't have the data on at the top of my
8 head. But really in the beginning the expectation
9 is yes, I want to stay in and I want to be with my
10 marines out there on the front lines, but then as
11 time goes on, that weans back a little bit, and
12 then they start looking at other things. So many
13 of the factors that we have in a transition play
14 are really difficult, and they're really touchy
15 situations. The first thing is if I (inaudible)
16 TSG alive, that could be a lot of money, up to a
17 \$100,000. To me, if I'm an E3 or E4 in the
18 service, I'm rich when I get that. That's what
19 they're thinking, and that's why we give financial
20 management. That's the first thing they look at.
21 Then, the next thing is, "Okay, what percentage am
22 I going to

1 get on my medical retirement now that I'm missing a limb or eyesight or
2 something like that?" "Oh, I'm going to get a hundred percent I think so
3 I don't have to work again." So now I'm not
4 thinking about job transition or that stuff. Now,
5 some people like Master Sergeant Gibson over there
6 are self-starters and they were before, and
7 they're going to go on to do education and start a
8 business or a charity, and we have many that have
9 done that. The next thing that plagues us is
10 unemployment. So here I am. I'm thinking, "Okay,
11 the next thing I can do is apply for unemployment,
12 and I can do that up to a year now because I was
13 extended the benefits of unemployment." So when
14 Colonel Mayer was talking initially that some of
15 them really don't want to put in to start the job
16 that we should probably look at that after their
17 transition a little bit more and their needs at
18 that time because then they get out there and the
19 reality sinks in. So now they're looking at
20 benefits overtime, and so you get thirty percent
21 or more - you're medically retired and you're
22 getting a check every month. You could be
collecting Social Security at the same time. You

1 can do that in service and out service depending
2 on your disability.

3 Then, you also have TSGLI, and then
4 you have - so they start
5 getting all of this, and then the charitable
6 giving's, and sometimes they just become needy and
7 entitled to stuff, and so we have a fine line that
8 I know this is a touchy situation, but that sense
9 of entitlement may kick in, and then they don't
10 want to take advantage of these programs that the
11 VA has offered and the services are offering and
12 putting many man hours and dollars into to try to
13 assist them in this transition.

14 MASTER SERGEANT MACKENZIE: So with all that being said do
15 you find a positioning requirement for that information? In other words,
16 the standard marine who may be thinking about
17 getting out, you can roll this stuff out within a
18 certain period of time, where as a guy who may be
19 trying to stay in, he may need to reengage this
20 later on when he realizes he's not staying in. Do
21 you have that flexibility within the program, or
22 is it just kind of a cut and dry deal?

22 COLONEL MAYER: Clearly, while he's in

1 on the left side of the DD2-14, he's
2 got a lot of support. The beauty of
3 our program is we hand off the marine.
4 If he transitions and says, "I want to
5 go home. I don't have a job. I'm not
6 going to school. I just want to go
7 home and chill." He still gets handed
8 off to the district support
9 coordinator. So that way we have a
10 link back to us. We can always call
11 our call center, and we can link the
12 marine back into all the services, and
13 as Sean Keane knows, Colonel Keane
14 knows we're constantly calling him
15 saying, "Hey, how can we help this
16 marine attain whatever it is?" for
17 Sean through the VA or through the
18 DISC through jobs is a network of
19 former Marines that take care of
20 marines, and the job opportunities are
21 out there. Quite honestly, we do this
22 all the time with the VA population.

1 I'd much rather do it on the left side
2 of the 2-14, and the opportunities are
3 there. It's jut getting folks to take
4 advantage of it. That's the challenge.

5 It seems to be. It isn't doing to a
6 lack of trying though. See what I'm
7 saying?

8 MASTER SERGEANT MACKENZIE: No, and
9 that's not - me being a wounded guy
10 myself, during that time frame seven
11 years ago, what little was available
12 to me, I wasn't having any of it. I
13 don't care how cool

14 you made it look, I don't care what kind of bow you wrapped it up, I was
15 going to stay and continue to serve my country, and I was going to do
16 whatever I had to do to make it happen. Anybody
17 that talked to me from a perspective of getting
18 out of the service or being a veteran or medical
19 retire or percentages, I wanted nothing to do with
20 it, but yet at the same token, I have one of the
21 guys I flew with who also became a wounded warrior
22 did the same exact thing, but three years later,
he's looking to get out. Now, none of those

1 resources were necessarily right up front and
2 center as part of the program because he had been
3 returned to duty. So that was kind of where I was
4 going with this question was it's a very important
5 part of the process in transition. The question
6 is, is it mobile enough to catch those guys that
7 we may be missing because we're not taking a look
8 at them when they passed it up the first time.
9 That's what I was getting at.

10 COLONEL MAYER: I hope that -
11 hopefully that they - so you're saying
12 what about the guys that stay in and
13 return to active duty which we have
14 quite a few of those folks. Is the
15 same level of support going to be
16 there later on when they're ready to
17 retire and all that?

18 MASTER SERGEANT MACKENZIE: That is
19 correct; sir.

20 COLONEL MAYER: I would say
21 absolutely, but probably that's
22 something we can look into though.

1 SERGEANT MAJOR PLESKONKA: Yes, sir,
2 and the service is looking at that.
3 The Marine Corps is revamping the
4 transition assistance program through
5 Marine for Life and everything. So we
6 are looking at that and trying to
7 capture every marine, and that would
8 capture all of those as they start
9 their transition starting them at the
10 one year, two
11 year, three year mark out from where their EAS is or their retirement
12 date and stuff through all those other programs.
13 MR. CLUBB: Additionally, the wounded
14 warrior regiment calls every Purple
15 Heart recipient even while they're on
16 active duty to find out if they need
17 any support services from us. So
18 there's the opportunity to make that
19 catch at that point as well.
20 MASTER SERGEANT GIBSON: Sir, can I
21 provide input? I'm in the back here.
22 COLONEL MAYER: I've been waiting for
you to stand up and be accounted for.

1 MASTER SERGEANT GIBSON: Do you mind
2 sir?

3 COLONEL MAYER: No, come on up. They'd
4 rather look at you than me anyways.

5 MASTER SERGEANT GIBSON: I'm right in
6 the middle of the IDES right now. I
7 work for the sector, the navy sector
8 Garcia who runs Manpower refers. I do
9 wounded warrior hiring support for
10 both Navy Safe Harbor and Wounded
11 Warrior Regiment advice to the sector.

12 I've been on permanent limited duty,
13 expanded permanent limited duty now
14 for four years. I'm at the end of my
15 cycle. I've opted to go ahead and
16 separate from the Marine Corps. I've
17 got almost 22 years in. I'm above the
18 knee amputee from wounds resulted in
19 2006 when I was shot. What I wanted
20 to bring up as to answer a lot of what
21 Mack was talking about and some of the
22 things that are out there, I get my

1 call every month. I redeployed for a
2 year in 2008 as an above the knee
3 amputee; and it threw off the new - at
4 the time because I'm legacy - the new
5 Wounded Warrior Regiment callers that
6 were calling me every month during my
7 transition back on
8 active duty. It threw them off. I returned, came to DC, started working
9 here, started getting - so brings forward. I dropped off. If you think
10 about it, I dropped off the horizon. I came back
11 to the horizon. They found me. As I have gotten
12 now in the past two years started talking about my
13 transition when I get my monthly call, hey, I'm
14 getting read to get out. I'm going to grad school,
15 etc., etc. Now, as I'm getting closer to the
16 summer, finishing my IDES, they're calling me even
17 more frequently. They're really -- and, maybe part
18 of it is because I'm Master. Maybe part of it is
19 because I deal so much with the Wounded Warrior
20 Regiment, but I hope it's not, and I don't believe
21 it is. So they're trying to force, and this is
22 when it comes to answering your question - they're
almost forcing us to tell them, "Quit calling me."

1 No, I'm fine. I know what I'm going to do. I'm
2 going to school. I need a job, I don't," whatever,
3 but they ask those questions every few weeks or at
4 least once a month. So to add to that ladies and
5 gentlemen, I just want to say from the proof
6 source side, from ones going through it, they
7 really over-exaggerate what our needs can
8 sometimes be, and I'm also a peer mentor to the
9 new amputees at Bethesda and Walter Reed, and I do
10 a lot peer - I'm a peer mentor to almost 180
11 amputees, and that's one of the things that I do
12 from the outside source because I kind of because
13 of my job with the secretary, I ask them, "Hey,
14 how's it working for you? Are you getting your
15 calls? How are the recovery care coordinators
16 working with you? What's going through your
17 medical process?" etc., etc. I'll tell you from
18 personal experience and from what I get from a lot
19 of the young wounded warriors is it really seems
20 to overlap. So a lot of that support that we're
21 talking about, it does overlap, and I'm
22 going through it right now, and they bug me to the point where, "Listen,
I'm a forty year old man. I'm a master sergeant. I know what the hell

1 I'm going to do in my life. You don't have to bug
2 me every month." They keep getting worse. I'm
3 sorry I had to come from the back, but I wanted to
4 through that out as a proof source in front that
5 it's not part of the regiment, and not part of the
6 panel. So thank you.

7 LT. GENERAL GREEN: Do you know how
8 they capture you as are you captured
9 through the Purple Heart or through
10 your expanded permanent limited duty?
11 That situation, is that where they're
12 capturing you?

13 MASTER SERGEANT GIBSON: For me
14 personally, yes, sir. I'm actually a
15 trifecta, and that's really what it
16 was because I was legacy, and now that
17 from what I've noticed being a legacy
18 wounded warrior meaning pre-2007, I
19 actually got back on active duty the
20 same month, April of '07 that the
21 regiment stood up because I'm still on
22 active duty, because I'm a Purple

1 Heart recipient, because I do
2 outpatient amputee care at major
3 treatment facilities, they've
4 recoupled me in there. That's part of
5 I think their outreach to get to us
6 that are legacy, and those that are
7 pre-07 is the Purple Heart gets them
8 there, etc. So yes sir, I get tapped
9 from multiple directions.

10 LT. GENERAL GREEN: Thank you.

11 COLONEL MAYER: I couldn't have said
12 that better. So thank you Master
13 Sergeant Spanky Gibson. What I'd like
14 to do is transitional order of Mr.
15 Paul Williamson who just arrived from
16 the Pentagon, and he's been part of
17 the IDES Tiger Team, a new initiative
18 led by Dr. Stanley's direction, and
19 Paul is probably the Marine Corps, is
20 the Marine Corps' premiere IDES
21 expert, and I'm very proud to say he's
22 my

1 command advisor down there, and I couldn't think of a more
2 knowledgeable, more experienced, more dedicated American, and even
3 though he's a sailor, by golly, you'd never know

4 it. So Paul's here to talk to you about.

5 MR. CONSTANTINE: Colonel Mayer,
6 before I transition, sir. Before we
7 jump over to Mr. Williamson, I do want
8 to ask you a little bit or Sergeant
9 Major about deployment. Now, during
10 my involvement with the regiment at
11 some point I received periodic emails
12 about deployment opportunities. I
13 didn't need a job, but I was very
14 interested in that because I think
15 that's the number one thing for a
16 successful recovery. This was before
17 your time Major, but I always thought
18 there was room for improvement because
19 it seemed like a lot of the emails
20 coming out were, "Here's an
21 opportunity at USA jobs that you might
22 care about," something along those
lines. So that in your - when a

1 wounded warrior is competing against a
2 zillion other people. I am very
3 interested in what the regiment is
4 doing especially concerning the high
5 unemployment rate not only across
6 America, but for the young veterans,
7 it's extremely high. So can you or
8 someone in your staff just kind of
9 drill down a little bit on what you're
10 doing to get them jobs?

11 COLONEL MAYER: Yes, sure. In -
12 remember I told you and you know
13 Justin, this is one of the most
14 challenging aspects of leadership
15 business, and one of the most baffling
16 to me. So what am I doing? So once
17 again, I'm telling the marines, "You
18 will make goals whether you want to or
19 not, I'm going to make you make a
20 goal, and such thing as I'm going to
21 return to active duty or do we want to
22 transition out and what is it you want

1 to do?" Tell me, "I'm going to
2 school." Guess what? That
3 ain't good enough. I'm not buying it. You've got to tell me what you
4 want to major in school because while he's with me, we're going to help
5 find an internship or a return to work type
6 program that would be say for a law enforcement,
7 man with a law enforcement goal. I'll try to get
8 him a job with the MPs. So he's learning a craft
9 and a skill along the way, and once again, when he
10 leaves me, he's ready for it. My transition cell
11 and my coordinators and my section leaders, we
12 know the goal. We're helping you achieve it. So
13 what I'm counting on is happening down there is
14 that the section leaders and the transition cells
15 at battalions and regiment know the marine's
16 goals, are looking for the jobs and helping him
17 find it in the home town or wherever he wants to
18 transition to. Is it as clean as what I just
19 said and it's easy to say that from Quantico, but
20 hopefully that's what we're trying to achieve,
21 which might be a little different than what you
22 went through when you went through the program.

MR. CONSTANTINE: Sure that does sound

1 good. It sounds a lot more hands-on
2 than what I saw, and I guess at some
3 point, I don't know if the practice of
4 sending out those emails was
5 discontinued. I don't get them
6 anymore. They're all gone for me
7 obviously. However, I just wondered if
8 besides the men and women who you have
9 a hold of, it sounds like you - I know
10 you have the very best interest in
11 their well-being, but the ones that
12 aren't in regiment or battalion level,
13 if I'm not receiving any emails
14 anymore. I'm on that Purple Heart
15 list. I'm on some other lists, or I
16 was. What is going out there to
17 everyone else, kind of like me who is
18 off the (inaudible).

19 COLONEL MAYER: I would say the good
20 thing about you Justin

21 is you've got a job. So there's a success story right there. Let's talk
22 about

MR. CONSTANTINE: It wasn't through

1 the regiment though. I just want to
2 know what's going on.

3 COLONEL MAYER: The emails, you know,
4 you're part of a mass communication
5 society now, so those are usually from
6 Mr. Waller who is part of Marine for
7 Life that saw how you got on that, so
8 you're getting blanketed with, "Here's
9 all the different jobs that are
10 available," but there's also a process
11 out there, and it's mainly the marine
12 that's a Lance Corporal, Corporal,
13 Sergeant, who are mainly concerned
14 about - and I'm telling you there is
15 no end to opportunity. I told you that
16 I went to the conference and folks
17 like McDonnell Douglas. I've got to
18 hire X number of marines in the next.
19 That work should all be advertised and
20 getting out to the transition
21 coordinators who work with the section
22 leaders and the RCCs. So what I think

1 is happening is they're looking at
2 their ten marines that they have under
3 their charge and saying, "Here's a
4 match. Let's go talk to the Marine
5 about this." So I mean, that is the
6 program that's in place. The jobs are
7 out there. Many are only in the
8 national capital region which I like
9 to see more in Texas or Montana or
10 Idaho or some place like that, but and
11 that's what we're working at, but
12 there is it's a continuing challenge
13 that we're trying to get better at and
14 also raise the standards on so to
15 speak.

16 MR. CONSTANTINE: Thank you, sir.

17 MR. WILLIAMSON: I'm going to spend
18 the next few minutes talking about the
19 Department of Defense Integrated
20 Disability Evaluation system process
21 and what the Marine Corps is doing to
22 help the Marines

1 that we have under our care understand how this process works, what they
2 can do to help contribute to the outcome, and what the expectations that
3 they should anticipate as they go through it. I
4 was late getting here this morning because I was
5 on a joint DOD VA Task Force, Tiger Team Task
6 Force, if you will to define some improvements to
7 the process. Right now, there are some problems,
8 and the processing times that are impacting all
9 the services in terms of how long does a service
10 member take to get through the process. We are
11 transitioning from the decades old legacy system
12 into an integrated disability evaluation system.
13 I'll describe a little bit about how that's of
14 benefit to the service member, but I want to first
15 explain that the process is something that will
16 probably impact every one of the service members
17 who have come under the care of the Wounded
18 Warrior Regiment. So we're very keen about helping
19 our marines understand this process and receive
20 the support that they need to get through this
21 process as efficiently as they can with an
22 understanding of what the long term effect of what
23 decisions they'll make as they go through this

1 process will be. This is just a representative
2 slide of the counseling efforts that's going on.
3 The gentleman in the blue shirt there is our
4 disability evaluation MEB/PEB expert, former Navy
5 Chief Petty Officer who is a PEBLO with the
6 department of the navy, worked for me when I was
7 the president of the Department of the Navy's
8 physical evaluation board. Next slide please.
9 These are the authorities that currently are
10 implementing the Department of Defense Disability
11 Evaluation system within the Marine Corps. Down
12 at the bottom, I want to focus on the training
13 efforts that we have. As I had pointed out to you
14 before, Mr. Trio is a former Navy PEBLO. So he
15 works with our battalion level and detachment level folks to understand
16 the process so they can council the individual marines and provide them
17 through the process. One of the things that I
18 hope you understand from what you've received from
19 the regiment here is we have the tactical levels
20 support. We have the operations support, but
21 there's also interest in fact impacting the
22 strategic level through the regiments. So it all

1 feeds up from the bottom. We do a lot of
2 assessments. We do a lot of surveys. We do a lot
3 of interviews with our marines to find out what it
4 is that they're missing, not understanding,
5 appreciating about the process, and we use that to
6 influence the products that we develop for them to
7 help understand in bite sized forms if you will
8 the information that they need. The IDES process
9 is a very complex process. It takes a lot of
10 people a long time to try to figure out how to
11 understand how it works and how the decisions are
12 made by the various boards along the process, and
13 I can spend an hour plus explaining that to you,
14 and at the end of it, you will still have more
15 questions than probably you thought you would have
16 had when you started this process. But that's our
17 objective is to try to help our marines understand
18 how this process works. Next slide, please. One of
19 the tools that we've developed was this little
20 pocket guide here that explains to the marine in
21 pretty simple language, and it's not just written
22 for the marine. It's written for the leadership of

1 the Marine Corps, the family member of the marine,
2 the marine himself and providers along the way.
3 It's broken down into bite sized pieces so that
4 you'll understand when you're in the medical
5 evaluation board phase, what is actually going on,
6 and it provides you
7 the individual marine with information on what they can do to help
8 facilitate the process. Make sure your records are up to date if you've
9 been seen by an outside provider, make sure that
10 that information is contained in your health
11 record, on and on and on, so that they understand
12 their role in this, and they need to understand
13 that this is not a passive. This is an active role
14 that they have in this process, and that's our
15 message to them. We've also established on our
16 website an IDES tool kit. This facilitates our
17 counselors, our section leaders, our recovery care
18 coordinators in the field. Ladies and gentlemen,
19 if you could unscrew people's head and pour into
20 it all the information that they need to know in
21 order to be effective as counselors and as
22 processors; you'd have an amazing system. You
can't do that. So the practicality of this

1 toolbox is such that the section leaders and
2 recovery care coordinators know where to go to
3 provide the answers to the marines, and if they
4 can't find it there, they can still reach back to
5 the regimental level to the subject matter expert
6 to get that direct feed of information and how to
7 understand it. But, I think you'll find if you
8 have an opportunity to look through this tool box
9 and through that pocket guide book, it does a very
10 good job of explaining to the individual marine as
11 to how the system works. Now, when it gets to the
12 adjudication process, it's the record of evidence
13 that determines whether the service member is fit
14 or unfit, and the quality of that information is
15 something that we work very hard to help them
16 understand.

17 We have brought on board the Marine Corps has,
18 four DES attorneys that
19 are at our highest concentration points in
20 marines, Lieutenant Colonel Fritz Melkie is over
21 here. Fritz, if you have anything to offer at any
22 point in time, raise your hand, and I'll ignore you. The purpose of the
attorneys is to in addition to the independent medical review authority

1 at the tactical level is to advise a marine as to
2 what their package should contain. Fritz, can you
3 offer anything on that?

4 COLONEL MELKIE: I'll just offer
5 quickly that the National Defense
6 Authorization Act mandated counsel
7 after the informal physical evaluation
8 board results came back. Should the
9 marine appeal or not and keep the
10 rating that was given from the
11 informal board? That was the mandate.
12 In the NDAA 2008, it was given
13 discretion whether or not to
14 provide counsel before the informal
15 board, and from the field our
16 experience is that the need is greater
17 for counsel before the informal board
18 than afterwards because otherwise
19 garbage in, garbage out, and as we
20 look ahead to perhaps tighter finances
21 in the future, bang for the buck. The
22 counsel that the member gets before

1 the informal board is going to be in
2 my opinion from the experience we've
3 had more valuable to him or her rather
4 than waiting for what might be an
5 inappropriate result than having a ten
6 day window to try and cure problems
7 which really are insurmountable at
8 that point.

9 MR. WILLIAMSON: Thank you, Fritz.

10 LT. GENERAL GREEN: Can I ask, how do
11 you gain just a timing question, so
12 once the program - it's set up to the
13 IDES, in essence where does the IPEB
14 do? In our system, let me be simpler.
15 We go through an MEB process to the
16 IPB, which then kind of - well, MEB
17 says they have to go through the IDES
18 in essence, and after you finish all
19 the physicals that go through with the
20 VA, now goes back to the IPB. So when
21 are they actually getting the member
22 involved with counsel?

1 COLONEL MELKIE: As soon as a doc says, "Marine, you're
2 going to a medical evaluation board." At that level, then counsel would
3 be potentially available to help with the
4 independent medical review, to help track down a
5 line of duty investigation which may be missing
6 UA, and with a non-medical assessment from the
7 command. So it's during this MEB process where
8 marines will fall in the cracks. A marine I met at
9 3-8 phone watch for eleven months. Eleven months
10 is phone watch because his package was lost in the
11 cracks at the MEB office. With counsel, you're
12 able to identify those cracks and patch them up.
13 As the PEB looks to speed things up, I would argue
14 - I would assert that the counsel that we're
15 offering helps the process because we can help
16 identify weak links that need correction. You're
17 looking very puzzled general.

18 LT. GENERAL GREEN: It just changes the
19 process a little bit because now
20 you're taking what ordinarily would
21 simply be a documentation of the
22 medical condition, and turning that
into a legal documentation that in

1 order to influence the disability
2 board. I'm just a little concerned
3 that it may change the process to
4 where you're getting involved. Okay,
5 because the medical board technically
6 is supposed to be a simple
7 documentation of what are the
8 conditions, and then when it goes to
9 the IPEB, that's a personnel action
10 that determines whether or not that
11 disability is associated with what's
12 been documented now rises to the level
13 of disability. So the question I have
14 is kind of if you're going to
15 influence the MEB before it ever goes
16 to the VA exam, the question is,
17 what's the influence? It's changing
18 the process a little bit.

19 COLONEL MELKIE: General, the VA exam,
20 the CMP exam runs on
21 its own course, but the non-medical assessment missing investigations,
22 these are all check in the box items before the PEB will even accept a
package up to his office, in our case at the navy

1 yard. So if the marine is at phone watch for
2 eleven months because the investigation is missing
3 and no one is tracking it down, he's just sitting
4 there answering phones everyday.

5 LT. GENERAL GREEN: The investigation
6 is a line of duty type thing.

7 COLONEL MELKIE: Yes, sir, and non-
8 medical assessment may be drafted in a
9 way which isn't accurate to his
10 concern, and he's a PFC Lance
11 Corporal, and with counsel, there may
12 be a way to more accurately portray
13 what is going on with his
14 circumstance, and if we can help
15 provide a better picture as to what is
16 the truth of the marine's condition,
17 then the informal board, that panel
18 will have more accurate information
19 upon which to base their decision as
20 they rate and determine fit or unfit
21 for the marine at that informal board.
22 I'm getting conscious I'm stealing

1 your thunder.

2 MR. WILLIAMSON: No, no, no, not at

3 all. I think it's what Fritz is

4 alluding to there is so the counsel is

5 providing some degree of advocacy at

6 this point. It's truly not legal in

7 nature. It's more of a marine have you

8 contributed to your medical board?

9 Have you identified all the conditions

10 that you're enduring? Well, I don't

11 know. Okay. Here's what you need to do

12 next. Well, I don't know if the

13 commander will give me a favorable

14 endorsement on my EDLP package or

15 whatever. Well, let me help you with

16 that. It's more of an advocacy role.

17 In the true sense of legal

18 representation, that occurs after the

19 informal

20 physical evaluation board has rendered their determination, and now it's

21 on the individual service member to decide in their election of options

22 whether they want to proceed with a formal board

 appeal. That's where the legal folks get into the

1 role of legal advice, if you will. They do not
2 actually represent the marine at the formal
3 physical evaluation board. They could if they were
4 locally available, but normally that attorney is
5 provided by the navy legal service office at least
6 in the navy and Marine Corps out of the
7 Washington, DC office over here at the navy yard.

8 LT. GENERAL GREEN: I just want a
9 little bit more clarification. So I
10 understand that after the IPEB why the
11 congress would want to make certain
12 that you have legal advisement in
13 terms of what this really may mean to
14 you in the long term. I'm not as
15 familiar with what goes on by the
16 personnel system when you go to meet
17 the IPEB, and so if I understood the
18 lawyer just now, there's a process
19 separate from the medical evaluation
20 board that's actually something that
21 rounds up personnel records to make
22 sure that when it marries up with the

1 IPEB that the personnel records are
2 accurate. Is that what you're telling
3 us?

4 MR. WILLIAMSON: There are several
5 components to the medical evaluation
6 board report that actually is
7 transmitted from the military
8 treatment facility to the physical
9 evaluation board, and the components
10 of that include the full medical
11 record, the narrative summary that
12 describes the condition, the
13 examination report provided by the VA,
14 a
15 line of duty determination or line of
16 duty investigation as well as the unit
17 commander's non-medical assessment of
18 the impact of those identified medical
19 conditions on the performance of that
20 service member.

21 So it's ensuring all those elements are present in that package when
22 it's sent from the MTF, which is the PEBLO's responsibility at the MTF
to insure it's accomplished, but the attorneys

1 again in more of an advocacy as are our recovery
2 care coordinators, as are our section leaders, as
3 are our MEB liaison folks within the battalions.
4 It is to insure that the marine has the evidence
5 before the board at the informal board level
6 complete enough such that that board can make a
7 finding on that evidence and reduce perhaps the
8 numbers of marines who request to go to a formal
9 board because all was not considered at that
10 point. So our education efforts with the Marines
11 and the families don't start at that point where
12 the doctor says, "Shipmate, I can't fix you. I've
13 got to refer you on the physical evaluation
14 board." Those who are in our barracks and our
15 detachment elements are introduced to the concept
16 of the disability evaluation system early on. The
17 first thing that a Marine wants to know is that
18 they can stay in the Marine Corps. At some point
19 they realize that the reality of that may not be
20 as attainable as they had hoped it would be, and
21 that's the point in time, and when's the right
22 time? When is the marine ready? It's not a cookie

1 cutter approach.

2 But our section leaders and our RCCs are intended
3 to be familiar enough
4 with that marine and family to introduce these
5 topics. As we know, those individuals can be on a
6 protracted period of limited duty to allow them to
7 recover and receive treatment for the condition
8 that they're afflicted with, but at some point,
9 that provider will make that determination of
10 referral to the DES process. And currently, the
11 intended time line for that IDES process is 295
12 days. Sadly, none of the services are currently
13 meeting that time frame, and that again is the
14 purpose of the Tiger Team that I'm currently on to
15 try to draw that number back to a reasonable
16 point. Dr. Guice?

17 DR. GUICE: Could you describe the
18 origin of the target time frame
19 because that may too be an
20 artificially guessed at number?

21 MR. WILLIAMSON: Yes, ma'am. It is somewhat artificial. Back
22 in the summer of 2007, congress was very concerned about the fairness of
the disability evaluation system process, and the

1 impact of the gap that very often occurred when a
2 service member completed the DOD disability
3 evaluation system process and then left the
4 service and began a long veteran's claim. What
5 often occurred was the individual service member
6 received a different disability rating from
7 department of defense than the did from the
8 Veterans Administration, not that they received a
9 different rating necessarily for an individual
10 condition, but the overall combined rating was
11 more generous on the VA side because the
12 department of defense rates those conditions for
13 which cause the service member to be specifically
14 unfit for continued military service. Whereas the
15 Department of Veterans' Affairs rates those
16 conditions that have been incurred in the line of
17 duty, that were either service aggravated or
18 incurred while they were in service. So there you
19 have conditions that let's talk about Master
20 Sergeant Gibson for just a second. Master
21 Sergeant Gibson depending upon his motivation,
22 desire to stay in service and ability to perform

1 could convince a physical evaluation board that he
2 is fit for continued military service, and many
3 marines have done that. So that doesn't mean that
4 he wouldn't necessarily be found unfit for his leg
5 amputation, but some of the other conditions that
6 he may be afflicted with do not contribute to him
7 being military unfit, but when he goes to the
8 Veterans Administration, he would potentially be
9 rated for those conditions. So he could receive a
10 sixty percent disability rating from the
11 Department of Defense for the military on fitting
12 condition, and an overall hundred percent
13 disability rating from the VA.

14 Again, that's how the concern of congress and the concern of the
15 American people that we had a process here that was creating a gap
16 between care as a service member left active duty
17 and went to the VA. So now to answer Dr. Guice's
18 question, how were these timelines determine?
19 Well, the VA and the Department of Defense
20 literally sat down and said, "Okay, these are the
21 various stages that must be accomplished within
22 this integrated disability evaluation system
process." The goal was to eliminate the need for

1 these two separate processes, integrate them,
2 conduct one physical examination that will serve
3 the needs of the Department of Defense to
4 determine fitness for continued military service,
5 and the second one was to serve the VA for rating
6 purposes. The working groups got together and
7 said, "Okay, it's going to take this amount of
8 time to accomplish this stage," and that number
9 came out to be 295. The MEB phase to shorten this
10 for discussion purposes, the MEB phase was
11 intended to take 100 days. The PEB phase was
12 intended to take 120 days that included the
13 appeals process at the formal board level, and the
14 petition for relief which is a term on the navy
15 side of the house, 45 days for transition, and the
16 rest of the time in between that does not add up
17 to 295 was considered to be administrative time.
18 Right now, DOD is recognizing as is the VA that
19 the MEB phase is taking longer than a hundred
20 days. There's some design problems with the
21 process. Again that's what this Tiger team is
22 looking at. The PEB phase currently is being met

1 by the army, but the other services are very close
2 to busting that 120 days. That's a lot for the PEB
3 phase. So again, the marines are told that this
4 is the timeline of this process, and how they can
5 contribute to it. Now, there are human behavior
6 factors
7 that come into play here. Some of our marines don't want this process to
8 move along as even to meet that 295 day time frame, various reasons for
9 that. Our intent is to help our marines
10 understand that referral into the IDES system does
11 not necessarily mean an end to your career. As you
12 heard Master Sergeant Gibson explain up here that
13 he is currently on an extended permanent limited
14 duty process, which allows him to post PEB
15 determination to continue on active duty at the
16 discretion of the commandant of the Marine Corps,
17 and the commandant has said if you're a combat
18 wounded marine, and you want to serve, we will
19 find a place for you. There are currently 26
20 marines who are currently serving on expanded
21 permanent limited duty, and there's also a shorter
22 term option for marines who are found unfit to be
retained in a permanent limited duty status up to

1 their normal EAS or to some other period of time
2 identified by them to meet a specific personal
3 goal or objective. So this is what we've done to
4 help our marines understand how the process works.
5 The next slide, please. This is the role of the
6 PEBLOs. I won't go through every one of these for
7 the sake of time, but I just want folks to know
8 that there are PEBLOs at the MTF level who are
9 intended to serve as the medical evaluation board
10 development clerks who work with the medical
11 providers and the individual's commander to bring
12 together those elements I described earlier which
13 will make up the MEBR that will be transmitted
14 into the physical evaluation board. Also, at the
15 larger MTFs, the secretary of the navy counsel
16 review boards has placed disability evaluation
17 system counselors down there to deliver the
18 findings to the marine and help them understand
19 how that process works. Also to conduct disability
20 transition assistance program briefings,
21 primarily to help the marine that's transitioning out to understand that
22 if you're going to be a military medical retiree, you are a military
retiree and you need to be concerned about such

1 things as SBP elections, survivor's benefit plan.
2 Who would think a 22 year old should be thinking
3 about survivor's benefit plan, but they're a
4 military retiree. They have to register for Tri-
5 care. If they're conveying to the VA healthcare
6 system, they need to enroll in the healthcare
7 system of the VA where it is that they're going to
8 live. Many of these things are caught by our call
9 center because when we transition a marine out of
10 the service, guess what? We know where he's going,
11 and we know how to get a hold of him, and we call
12 him and ask him those questions. Are you having
13 problems with SBP? Now, here's an interesting
14 thing. Some of our younger marines who are
15 transitioned out as a military retiree and also
16 receive compensation from the VA are in that
17 offset world where they must forfeit their DOD
18 compensation to receive their VA payment. When
19 that happens, and they are signed up for SBP, DFAS
20 has no money to take their enrollment in SBP out
21 of so the marine six months down the road gets a
22 bill from a collection agency that says, "You owe

1 the federal government X number of dollars because
2 you haven't been paying your SBP payments." Those
3 are little things that are big to a young
4 individual out there trying to make his world now.
5 All of a sudden, he's getting the bill from the
6 government saying, "You owe us money." That's the
7 efforts of our call center to try to diminish
8 that. Every marine that goes on the temporary
9 disability or the permanent disability retiree
10 list gets a call from our call center to cover
11 those options with
12 them.MR. WILLIAMSON: Next slide,
13 please. This is the role of the
14 military service coordinators I pointed out to you. This is an
15 integrated system where once the individual is referred into the
16 disability system by the medical - military
17 medical system, they are offered the opportunity
18 to submit a claim with the Veterans'
19 Administration. And the Veterans' Administration
20 has embedded at the MTF level their military
21 service coordinators who will sit down with that
22 marine and take their VA claim. Their VA claim
conditions, their DOD referred conditions; all

1 become a part of that medical evaluation board
2 report that then goes into the PEB. When it goes
3 to the PEB, the PEB will take a look at those
4 conditions. Let's pick a number - five
5 conditions. Two of them are referred by the
6 Department of Defense. Three were claimed by the
7 service member. Here's the reality folks: Right
8 now, the average claim - excuse me -- combined
9 referred for a marine is between nine and twelve
10 conditions. Previously under the legacy system,
11 the referred conditions were typically two. So
12 you can see the amount of medical evidence that
13 must be developed and the work that must be done
14 by the Physical Evaluation Board to consider those
15 new conditions to determine whether or not they
16 are military unfitting or not. So again, we're
17 talking about five conditions - two referred,
18 three claimed. Those go before the Physical
19 Evaluation Board. The Physical Evaluation Board
20 says, "Confirming the medical evaluation board
21 referral, you are unfit for those two referred
22 conditions. Those three claimed conditions, no,

1 you're not unfit for those." Notwithstanding, all
2 five conditions go to the VA rating activity site,
3 who appoint a disability rating for those
4 conditions, which they agree were incurred in
5 service or aggravated by service to come up with
6 an overall, combined
7 disability rating. Those conditions, which were identified by the
8 Department of Defense as being military unfitting, those two conditions
9 serve as the basis for determining what level of
10 benefits that individual service member will
11 receive from the Department of Defense. Right now,
12 the threshold for a military medical retirement is
13 a disability rating of thirty percent for the
14 specifically military unfitting conditions. So
15 now the service member knows what his disability
16 rating award is from the Department of Defense.
17 He also knows what his overall, combined
18 disability rating is from the Veteran's
19 Administration, and he -- at the time he is issued
20 his DD2-14, within thirty days, he'll receive his
21 disability benefits and his access to healthcare
22 through the Veteran's Administration, which is a
benefit, huge benefit to these service members;

1 again, who had previously been experiencing a gap
2 between active duty and veteran's status. Next
3 slide please. Legal support, Colonel Melkie had
4 covered most of that, and we'll slip through that.

5 Go ahead, next slide. So the way ahead, as I
6 said before the Tiger Team is aggressively looking
7 at the current IDES process. The Undersecretary
8 of Defense for personnel readiness has committed
9 to Secretary Gates that we will get this process
10 down well below the two hundred ninety five days;
11 very ambitious goal, ladies and gentlemen. But
12 the Tiger Team is looking at making all
13 improvements that we can to this process.

14 At the end of the day, the intent is
15 to always be concerned
16 about the interest of the individual, as well as
17 the interest of the government. We always have to
18 be mindful of those Marines or any service member
19 who is remaining on active duty in a not-fit for
20 full duty status
21 impacting the overall end strength of the Department of Defense. We
22 continue to pay full pay allowances while that marine is in the IDES
process. And we are unable to bring on a new

1 recruit who will eventually take that service
2 member's place in the field, but there is no rush
3 to judgment. We want to make sure that our Marines
4 understand how this process works; that they
5 contribute to it and they receive the support that
6 we, the Marine Corps, can provide them as they go
7 through it. And once they have gone through it,
8 we want to insure that they still understand that
9 the Marine Corps is here to support them as they
10 make that transition out of service, whether it be
11 through direct linkage to capabilities that we
12 have within the Marine Corps or referral into the
13 community or to other federal agencies, when
14 they're out of service.

15 But our link back to us is through our
16 call center. Again,
17 we call them. They have the ability to call us.
18 We can send them messages through Facebook
19 accounts, email accounts. We have DISCs in the
20 field. We have HTLs in the field, and we have an
21 incredible network of Marine Corps league members
22 and others who are out there asking our marines,

1 "What do you need, marine?" And if they need it
2 and we can provide it, we're going to make sure
3 that they get it.

4 LT. GENERAL GREEN: Do you know the
5 percentage that return to duty after
6 going through the IDES system?

7 MR. WILLIAMSON: The IDES process -
8 are you talking about the all of the
9 Department of Defense, or are you just
10 talking about the Marine Corps?

11 LT. GENERAL GREEN: Just for the
12 marines.

13 MR. WILLIAMSON: Marine Corps right now, the fit call from
14 the Department of Defense - I'm sorry the Department of Navy Physical
15 Evaluation Board is right around seventeen
16 percent. It's difficult for us to pull out of
17 that those who have, as maybe Colonel Mayer's
18 already described; we don't own all the Marines
19 that go through the disability evaluation system.
20 When I say "own," I'm talking about have been
21 joined to the Wounded Warrior Regiment. So those
22 marines who are referred to the DES process still
attached to their parent unit, and not receiving

1 support from us, we don't necessarily have a good
2 awareness of their outcome for that DES process.

3 DR. GUICE: For the people, the
4 marines that do go through the entire
5 MEB/PEB/IDES process, what's the
6 average DOD rating and what's the
7 average VA disability rating?

8 MR. WILLIAMSON: Ma'am, I do not know
9 that number. I can certainly get that
10 back to you. Any other questions?

11 Thank you, Dr. Guice, General Green
12 for the opportunity to present to the
13 task force members.

14 LT. GENERAL GREEN: I did have one
15 final question, and you said that you
16 couldn't give us the marine breakout
17 in terms of what came back after IDES.
18 What percentage on the expanded
19 permanent limited duty
20 program - you said there were twenty-
21 six marines that were in that? Are
22 those the only twenty-six that have

1 applied for that? So in other words,
2 it's a hundred percent if they
3 requested, they get to stay?

4 MR. WILLIAMSON: That's exactly true.
5 There's only been two marines, and I,
6 to be more honest about that hundred
7 percent. The commandant personally
8 looks at every application for
9 expanded permanent
10 limited duty. So it may be that the total number has been sixty-two
11 since we began the program. But there are twenty-six who are currently
in a PLD now.

12 SERGEANT MAJOR PLESKONKA: Sir,
13 actually yesterday the poll that we
14 did from our internal electronic poll
15 was thirty-five, sir, that actually
16 applied; that actually went all the
17 way through to the board. There were
18 some that pulled before they even went
19 to the board. So the number that,
20 that said they wanted to do it was
21 sixty-seven. Thirty-five actually went
22 to a board, of which we still have

1 twenty-six that are actually still on
2 active duty. And two that got boarded
3 yesterday that are going to the
4 commandant at this point.

5 MR. WILLIAMSON: Some of those who
6 have been accepted for expanded
7 permanent limited duty at some later
8 point decided that I can't be the
9 marine I want to be. I think it's time
10 for me to retire, but that's a
11 decision they made on their own.

12 COLONEL MAYER: And that completes all
13 sixty-five slides, ma'am. I think it
14 completes our time. Are there any
15 final questions for the team marine
16 here from the panel?

17 DR. GUICE: I think we've exhausted
18 our questions, and thank you, very
19 much for your presentation, your time,
20 your attentiveness to detail. It's
21 very, very helpful for us as we
22 continue on this information gathering

1 portion of our assignment. And as we
2 start to then turn that into
3 development of recommendations back to
4 the Department of Defense and to
5 Congress. But we appreciate your time
6 and effort. Thanks.

7 COLONEL MAYER: Thank you.

8 LT. GENERAL GREEN: A very thorough presentation, thank you,
9 very much. And thank you for bringing your team. It was very nice and
10 refreshing to get the answers immediately when
11 they were available. Thank you, very much to all
12 of you.

13 COLONEL MAYER: Hoorah.

14 DR. GUICE: Ms. Dailey, do you want to
15 take a break now?

16 MS. DAILEY: Yes, in fact, I think
17 everyone's eager to take a break,
18 ma'am.

19 MS. DAILEY: Ladies and gentlemen, can
20 I get the task force to reassemble,
21 please? For my individuals in the
22 audience, the task force's formal
23 presentations are complete. We are

1 basically going to be working with
2 what is considered administrative
3 information. The task force
4 operations are now closed at this
5 time, but I'm not sure you'd be all at
6 all interested in what administrative
7 issues we're going to be taken on. So
8 the formal portion has completed.
9 You're welcome to stay, and I can't
10 kick you out. However, you might be a
11 little bored by who's got what
12 contract and whether we like that
13 contract or not?

14 DR. GUICE: Okay. Well, we have a
15 series of -- as Denise just outlined
16 for us, a series of administrative
17 stuff and things to talk about. The
18 first thing is to puzzle through the
19 senior oversight committee requirement
20 for data gathering, as is our charge
21 to look at the effectiveness of the
22 senior oversight committee. And we

1 probably need to have a little bit of
2 a discussion because that's not kind
3 of like an installation visit. We've
4 probably ought to think about how we
5 want to, need to, how we would
6 structure a data gathering and what we
7 would -- what's the level of evidence
8 we want to see for our
9 documentation for certain things. So I think this is under tab C of our
10 binders.
11 So if you look on the second page,
12 there are some questions
13 for us to kind of consider and see if we think
14 that these would be the effective queries to get
15 to some level of a recommendation or at least to
16 tee up some thoughtful discussion about the
17 effectiveness of the senior oversight committee as
18 was part of our legislative mandate.
19 LT. GENERAL GREEN: So if you can just
20 help me understand. So by these
21 questions, we're going to submit to
22 something else, or are we just going
 to talk about these questions

1 internally? What's -- what's the
2 plan?

3 MS. DAILEY: I think that's what we're
4 determining.

5 DR. GUICE: Yeah, I'm telling my plan,
6 but my plan is here for your
7 adjustment. So this was a data
8 gathering methodology for the senior
9 oversight committee. I was not going
10 to have them come in and brief, but
11 was going to take one or two of our
12 task force members on private so-to-
13 speak interviews, with the leadership
14 of the senior oversight committee.
15 Secretary Gould and Deputy Secretary
16 Lynn, transcribe it and have a
17 recorder in there, and work through
18 this set of questions. That's my
19 strategy. I am open now, and it's not
20 my plan in that until I get your input
21 to it; we have no plan.

22 GENERAL HORST: I would offer that the

1 senior oversight committee is probably
2 an advisory body. I think that the
3 decision making lies with the
4 secretary and the assistant secretary.

5 So I would offer they're an
6 independent group that looks at,
7 assesses, reviews, may make
8 recommendations, but does not make
9 decisions; advising the

10 secretary; advising the deputy assistant secretary, but not a body that
11 makes a decision.

12 DR. GUICE: Having said in those
13 meetings, I think that it's probably a
14 hybrid. They do make decisions, and
15 in fact, one of the requirements for a
16 SOC meeting is to have a set of
17 decisions to make based on
18 recommendations that are formulated
19 out of the overarching integrated
20 product team. So the -- and part of
21 those if there's a policy review that
22 needs to be done, there was a whole
effort at the DES evolution. So all of

1 those things were brought up as
2 decisions for the SOC to make.
3 They've made a variety of decisions
4 about the integrated mental health
5 strategy, about IDES rolling out. So
6 I would think that it's probably a
7 hybrid. Obviously, they're not going
8 to make a decision unless it's sort of
9 coordinated and everybody understands
10 what that decision is and the
11 implications, but I think it's
12 probably a hybrid.

13 GENERAL HORST: I just kind of look at
14 where the authorities of decision
15 making lie within the Department of
16 Defense, and so the thought that there
17 is a body below that that's making
18 decisions on behalf of the secretary,
19 and I've never sat through one, so my
20 --

21 LT. GENERAL GREEN: Technically, Carl
22 you're right. Although, there is some

1 delegated authority to Dep Sec because
2 you've got both Dep Sec VA and Dep Sec
3 Def; that are actually sitting at the
4 top of the table for these things. So,
5 I think it is a hybrid, but if we
6 could come back to the best way to go
7 and if we're going to talk with the
8 senior leadership, one of the things
9 that I would be curious about rather
10 than simply going to them and asking
11 questions is that the people who have
12 to actually execute this are the MNRs
13 of each of the
14 departments. So it would be fairly useful to have a panel of the MNRs,
15 their representatives, to come and answer some questions regarding the
16 SOC and where they've seen it's going, and whether
17 it's helped, hindered, advanced, slowed, whichever
18 they choose to share with us regarding their
19 perceptions of how this helped each of the
20 departments to basically move forward. So that
21 would be my suggestions before we would go and
22 simply talk with, to deputy secretaries. I throw
that out, and I don't know if we need to have a VA

1 representative on that or not. I don't know if
2 there is an MNR or execution activity in the VA
3 that would participate or not.

4 DR. GUICE: Well, we have, we would -
5 at VA, we would take that particular
6 activity because they're usually in
7 line with our administrations, and we
8 would put it into the administration.
9 So if it were a health related thing,
10 it would go into VHA for
11 implementation. If it were benefits,
12 it would go into VBA for that. We
13 don't seem to send much over to NCA,
14 but that's probably --

15 MASTER SERGEANT MACKENZIE: One of the
16 things that I would ask along with
17 that is a level of accountability. Is
18 this an organization - are they just
19 putting this stuff out there for
20 action? And, what is their level of
21 follow-up? I mean, are they actually
22 holding true to their recommendations

1 and seeing to that they're followed up
2 on, or is it just, "Hey, this is what
3 we recommend," and they let the
4 services do their thing? Is there any
5 kind of answer back required on what
6 they're doing? I don't know if I'm
7 wording it correctly, but I guess that
8 level of accountability for action is
9 something that I see missing at times.

10 DR. GUICE: Yes, there's also a confounding feature with
11 this because there is the joint executive council as well, and there's
12 been, you know - how do you determine the SOC's
13 defined area is wounded, ill and injured, but the
14 jack is really sort of everything. So how do you
15 make decisions in this realm, and then either use
16 the jack structure to implement and to follow-up?
17 Is that a wise strategy, or is it better to keep
18 it all coming back to the SOC? There's - know
19 that the people who actually implement things are
20 more likely the same people. So we've got some
21 overlapping at some what we called dueling slide
22 decks because the format is a little different,
 but it's the same content.

1 LT. GENERAL GREEN: And there's a lot
2 of discussion on both sides whether or
3 not you need both the jack and the
4 SOC, and whether they should be
5 reintegrated now, and a lot of it has
6 to do with where they are with the DES
7 program, and that. So it falls right
8 back to the follow-up and how the
9 follow-up is going to be insured based
10 on whatever the way ahead is. That's
11 why I think the MNRs would be able to
12 give us some insight into what their
13 service perspectives are. I don't
14 just know where exactly they interface
15 with the VA, because I do think it
16 would be interesting to have all four
17 come and talk with us as a panel, just
18 to give them some questions similar to
19 this about what they sense, what they
20 see is the future in terms of the
21 follow-up, and even the sustainability
22 of these programs would be nice to

1 hear from them.

2 DR. GUICE: I would like to do that,

3 but I'm getting this sense that what I

4 would like to have is kind of a

5 scorecard, rather than have just a big

6 broad question, I think if we selected

7 a few very specific things that we

8 know have been under the purview of

9 the SOC, and

10 then to travel that. So things that were put into the SOC structure and

11 came out as a defined program or a defined recommendation or a go do it,

12 how is that specific thing first identified, who

13 got the assignment to take care of it, how was the

14 follow up done, and did it matter? So I think if

15 we can put that into context about the things that

16 Congress has asked us to look at, that we know

17 have fallen under the SOC purview, and then ask

18 very targeted questions about how did the level -

19 the follow-up, the accountability, that whole

20 stream of things work for IDES roll out, work for

21 blank, and I think if we thought about it a little

22 bit, we could come up with those specific things.

GAO did a study shortly after a couple of years

1 ago, and they're sitting in the audience, maybe
2 they can help me remember, but it was about all
3 the tasks that came out of NDA and the
4 recommendations, how the two organizations, two
5 departments were working together to kind of
6 implement all of those, and there were over 600
7 recommendations, but perhaps we can kind of glean
8 from that the high target areas that visit - the
9 important ones that we need to address for the
10 report in September.

11 LT. GENERAL GREEN: Have the
12 researchers looked at the SOC minutes
13 to see what's been followed up on and
14 what hasn't? Have we looked at them
15 at all?

16 MS. DAILEY: In an effort not to
17 second guess the SOC, we have not gone
18 down the road, nor have we gone down
19 the road about program execution and a
20 score card on program execution. We
21 have not gone down those roads at all.
22 I'm going to be starting from ground

1 zero

2 if we go down that road.

3 LT. GENERAL GREEN: One of the things when we stood up the
4 task force was because of the high level of the senior oversight
5 council. I was very hesitant when Denise and I
6 talked early that I did not want this group to be
7 simply second guessing the SOC, and I still feel
8 that way in terms of we don't necessarily want to
9 be second guessing people who are trying to make a
10 difference, and clearly as we hear the programs,
11 the perceptions of at least all the programs are
12 that they're making a difference for folks, and
13 we'll see more of that as we continue the site
14 visits and have seen some of it already. So the
15 question then is all right, so when you ask about
16 SOC effectiveness, where do we go with this? Are
17 there two or three themes that we want to pull out
18 of the minutes to see what was actually requested,
19 and then we can compare that to what the services
20 are presenting, and then in terms of a way
21 forward, I still think - I do believe, and we can
22 ask the MNRs to give us specifics, but we may want
to actually look at some of the minutes, and look

1 at some of the more important things that were
2 rolled out of the SOC like the IDES and then get
3 perspective on where they are now. I can talk to
4 the Air Force. So they're rolling these things
5 out.

6 I mean by the end of this September, the
7 accountability about the SOC
8 is that you'll have this up worldwide. So there
9 are things that I know are being followed-up on in
10 terms of the IDES. The hard part is some of the
11 things that were rolled into all the reports early
12 on that the SOC had to deal with the 600 things.
13 I'm not certainly want to go after the 600 things
14 that were there, but maybe. I'm not saying no.
15 I'm just over to you guys.

16 MS. DAILEY: May I also talk about the
17 language of the
18 legislation, and which uses two very interesting words - facilitating
19 collaboration for the transition. Am I correct? You're facilitating
20 collaboration for the transition between DOD and
21 VA. When one of the congressional people came to
22 talk to me, and it was kind of the book so to
speak, that's the first thing she launched into

1 is, "What is the SOC doing to facilitate this
2 transfer from DOD to VA? My senator doesn't seem
3 to think someone's got their arms around it yet."
4 So we might can be in that lane also.

5 LT. GENERAL GREEN: Correct, and
6 actually probably one of the more
7 visible reason there's been so much
8 follow-up on the IDES system is that
9 although everybody's very concerned
10 now that we're not reaching the 295
11 days and trying to get it lower than
12 that. The reality was that I think
13 that the initial cuts and time for how
14 long it took to get to VA benefits was
15 it took about 200 days off if I
16 remember.

17 DR. GUICE: It cut about 50 percent,
18 600 days.

19 LT. GENERAL GREEN: So there's been a
20 significant change from somewhere
21 between five and six hundred days to
22 get to those VA benefits from the time

1 things started to today, the goal is
2 295, and actually they're reaching
3 350. So it's not a - don't
4 misunderstand it as you listen today
5 about what everybody's talking about,
6 what they're driving to and not catch
7 the fact that they actually did reduce
8 it by half. So there's those kinds of
9 things that we need to kind of capture
10 as well. This isn't - some of this is
11 true success. It's just now we're in
12 a new system and we're trying to
13 figure out can we go further.

14 DR. GUICE: Maybe given the words that
15 Denise has just read from the
16 legislation, so facilitation and
17 collaborating transitions. We
18 know that two things are sort of key to that. One is just information
19 transfer, and that certainly has been a concern of Congress in terms of
20 interoperability and all that, but if we think
21 about information transfer, it's to the individual
22 and the family who are making those transitions,
and it's also between the organization so the

1 pitching and the catching team have the
2 information that's needed to make benefit
3 determination, decisions to make and to apply
4 those benefits in the right way. So maybe if we
5 narrowed it to maybe just two things that we ask
6 them specifically about this year because we have
7 another opportunity of biting the apple next year.

8 So maybe that, and because IDES is such a high
9 visibility and important part and we know that
10 it's done some really good things, maybe those
11 would be the two specific things that we would
12 want to really get that information about
13 facilitation and collaboration and how the two
14 departments have worked together to effectively
15 work on these two things.

16 LT. GENERAL GREEN: I can be even more
17 specific. The other area that SOC was
18 very involved in was establishing the
19 RCC concept. So the RCC concept,
20 which actually would create a warm
21 transfer supposedly over into the VA
22 case management system essentially.

1 So that would be another one you might
2 want to include in terms of the
3 specific areas to show that
4 transition.

5 MR. CONSTANTINE: I agree. (inaudible)
6 a couple of things because when I was
7 council for the senate veteran affairs
8 committee, the DES is always a big
9 (inaudible) going back a couple of
10 years, and we - and that was a SOC,
11 got updates on them. Rolled out the
12 PowerPoint on the timeline, and all
13 that. So other (inaudible) I'm sure
14 he'll publish

15 a lot about this, and it would be I want to say just ingenious, but it
16 would be very surface level if we went in without the represent
17 expertise and try to come up with some grandiose
18 observations about the SOC. I think we should try
19 to limit it to what - exactly what we're trying to
20 do here, and how it ties in to the other groups
21 that we're talking to on more the ground level and
22 see if there is consistency between very high
23 level and what's going on at the sites.

1 MASTER SERGEANT MACKENZIE: And that's
2 one of the things, the reason that
3 brought that on is when we got the
4 briefing from the Army, and the
5 colonel stood up there and talked
6 about the potential for trying to
7 change the program, and yet it hasn't
8 even been fully implemented yet across
9 the services. Now, somebody is
10 already trying to make a change, and
11 it's like okay, is that army specific
12 or is that IDES across the board for
13 everybody, and how can you say that
14 change is effective if not all the
15 services have pulled them aboard yet.
16 So that was one of those things where
17 I just kind of perked my interest to
18 that.

19 LT. GENERAL GREEN: The problem with
20 IDES is when you look at the actual
21 timing, and look at the between 200
22 and 300 days that it actually has

1 saved to get people to their VA
2 benefits, nearly all of that time is
3 based on the very early VA physical.
4 And so time at one physical brought
5 that time together. So the
6 frustration on the DOD side is that
7 there hasn't been a lot - and I
8 shouldn't just say DOD, but on the VA
9 and DOD side is that we haven't found
10 a way to really shorten the DOD time.
11 So that's why there's so much interest
12 right now in what's next in terms of
13 the DES, but again, that's what you'll
14 find out I think. So to summarize then
15 as we look at the language, in essence
16 what
17 we want to try and do is get some specific questions answered where we
18 would bring in the MNRs and a VA rep hopefully to be determined, two VA
19 reps, and essentially as a panel have them discuss
20 rather than separate presentation, have them
21 discuss the success of the DES program, the
22 success of the RCC program in terms of
facilitating the transfer, and then you had one

1 other which was?

2 DR. GUICE: Sorry, that information
3 transfer in terms of - and that would
4 probably dovetail into our discussion
5 at some point with the IPO because
6 that is what congress used as a
7 forcing function to kind of create
8 that system level, but I think beyond
9 the system level, we've heard a lot
10 through all the programs that we
11 talked to us about the more the family
12 knows, the more the member knows, the
13 better the information they have, the
14 better off they are, and the more
15 satisfied they are that they're
16 getting a fair shake. So it's
17 information dissemination sort of two
18 different ways. It's the human/human
19 and then it's the systems that help to
20 inform that consistent good
21 information across individuals. I
22 think we all suffer from

1 misinformation, and we know that once
2 you get
3 an urban legend, it's really hard to
4 get it back in the box. So the better
5 our information systems are at
6 capturing and maintaining that good
7 foundation of information, the better
8 off our humans in making sure we
9 disseminate it in a correct
10 appropriate way that people can
11 understand and immediately grasp,
12 "Okay, this is what this means. This
13 is what it doesn't mean."
14 MS. DAILEY: Sir, we were going to
15 kind of do sort of a 360 on this. So
16 one of the other players we were going
17 to talk SOC about was the Joint Chiefs
18 of Staff. Would they be a panel
19 member? Would you
20 like to bring them in on the panel for that? They would get the same
21 series of questions.
22 GENERAL HORST: I'm not sure this
 rises to the level of service chief

1 interest where we would bring the
2 service chief of the JCS to discuss
3 it. I think there are certainly
4 subject matter experts within each of
5 the services that could do that for
6 us.

7 LT. GENERAL GREEN: That's why I was
8 targeting the MNR because I know the
9 MNRs have done it. I don't know what
10 the equivalent to the MNR is on the
11 joint staff.

12 MS. DAILEY: Joint staff surgeon sits
13 on all the SOCs in the RPOs, and
14 integrated product team oversight
15 reports directly to a staff officer
16 who serves as the joint chief's
17 liaison to the SOC.

18 LT. GENERAL GREEN: I think that would
19 give us broader representation. So
20 then we'd have the VA, the fed three.
21 Do the Marines have an MNR function as
22 well, or is the Navy taking care of

1 that?

2 MS. DAILEY: The Navy.

3 LT. GENERAL GREEN: So the Navy does
4 that for them. So basically the three
5 MNRs, the VA reps and then the joint
6 staff surgeon would be probably an
7 appropriate level then, or whoever the
8 joint staff identified as the MNR
9 equivalent; that would be fine.

10 MS. DAILEY: Okay, are some of these
11 questions about barriers to
12 effectiveness? Again, we're talking
13 about - and when we talk about this,
14 it's going to have to be a public
15 panel. Are some of these questions
16 about barriers to effectiveness? Are
17 you comfortable with those? What would
18 facilitate better collaboration? Are
19 you comfortable with those?

20 GENERAL HORST: I think Dr. Guice's point, if we pose it to
21 them as what your assessment of our ability to facilitate and
22 collaborate? If we do it as an assessment,
they're giving us their thoughts as opposed to us

1 asking penetrating questions that could
2 potentially put them on the defensive. We really
3 need an objective assessment without ruffling
4 feathers.

5 MR. CONSTANTINE: This doesn't relate
6 to the questions, but I have a friend
7 who rather recently went to a DES
8 system, bounced back and forth between
9 both of them actually, and it was a
10 real nightmare story. I only know
11 that because we had a conversation
12 kind of out of the blue. I wasn't
13 soliciting. So I've come to believe
14 that I hear about it one time, it
15 probably exists a lot of other times
16 out there. I wonder if it would be
17 helpful to have someone come in who
18 has gone through it recently, or maybe
19 we can get their story on paper to be
20 with the panel, so it's not just
21 talking heads or about how it's
22 supposed to work, but really - not

1 necessarily a horror story, maybe a
2 good story and a bad story, but to
3 have them testify what they went
4 through, and then to hear from the
5 panel on what went wrong, and why it
6 won't happen again, and how many other
7 ones they've seen like that or
8 something along those lines, just my
9 curiosity.

10 DR. GUICE: My guess is that the
11 people that were asking to be on the
12 panel, would all go first time we've
13 heard of this. We have to get back to
14 you on that, and they wouldn't have
15 the - unless you gave them the
16 information up front to figure it out.

17 I'm not sure that they would be able
18 to sort of do that level of response,
19 but I think that what we need to do is
20 based on our experiences through the
21 additional

22 site visits, knowing that this would be coming up is to try to come up
with if we specific questions that we would like them to address, giving

1 them the questions in advance so that they can
2 come prepared, or like today we had the people at
3 the table and then the back-up team.

4 So if they can bring their back-up
5 team, if they need to
6 have a back-up team for additional dialogue that
7 we may find hopeful and enlightening for what
8 we're trying to do. I think that we do have the
9 obligation to have a report in September. Not
10 everything that we identify, not everything that
11 we talk about or gather information about is
12 necessarily going to rise to the level of a
13 recommendation this year. So I think we need to
14 remember that while we're just starting down
15 asking questions and we're just starting this
16 whole process. It's clear that I think we've
17 started to start to identify things that we think
18 will rise to a level of a recommendation for this
19 year, but we're not done. So we'll have next year
20 too to continue to work on how did IDES turn out?
21 Next year, it's going to be fully implemented. So
22 you would hope that we would have very good data

1 by then as opposed to who's phasing in and phasing
2 out of legacy and how's it working, and how are
3 they balancing all of those. But they should have
4 a fairly good set of data for us next year.

5 MR. REHBEIN: One of the things that
6 occurs to me as we've done our
7 facility visits, I think we've seen in
8 the instance of the comprehensive
9 treatment plan that the way that it
10 was envisioned and the way that it's
11 working or two different things, and
12 maybe we should ask that group what
13 their vision was for IDES, and is that
14 vision the one that's being
15 implemented out there?

16 MS. DAILEY: So if I understand my guidance, and really I
17 need guidance on the Senior Oversight Committee.

18 LT. GENERAL GREEN: Hang on just a
19 minute, Denise. Let me come back to
20 this. I think there's not a good
21 reason to ask the first question. I
22 think that we as members know that
this is a hybrid in terms of decision

1 making. So if I can suggest a couple
2 of things. So on the second question,
3 how effective is the SOC at
4 facilitating collaboration between DOD
5 and VA on wounded, ill and injured
6 matters, specifically can you provide
7 your examples within information
8 transfer, the RCC and IDES systems?
9 So that gives you the specifics.
10 Then, what factors prevent - I
11 wouldn't go internal. I would just
12 say, what factors prevent greater
13 facilitation and collaboration between
14 these two departments? Then, going
15 forward, these say, what is the best
16 vehicle for continuing to facilitate
17 collaboration between DOD and VA? It
18 would be interesting to see what their
19 opinion is on that. Then, the last
20 one instead of saying, how is a SOC
21 being applied, ask them, how do you
22 identify new issues for high level

1 policy considerations? I think if you
2 do it that way, then it's basically
3 targeted towards things they control,
4 and so they can give us their opinions
5 and we can decide where to go with
6 that. Does that sound like a
7 reasonable approach that gives them
8 about four questions that they can
9 gives us that? If you want to do the
10 following piece where we say how
11 effective is the SOC at facilitating
12 collaboration between DOD and VA on
13 wounded ill and injured matters,
14 specifically can you speak to
15 information transfer, RCC and IDES,
16 and we can also say, where would you
17 go next with these three programs?
18 Which gives us what they think the
19 future is?

20 DR. GUICE: Number four, I think rather than saying best
21 vehicle, somehow we need to work into that it's really the
22 sustainability of focus. Even after we no longer
have the W - we just have ill and injured, how do

1 you maintain the sustainability of a separate
2 focus or unique focus, or how do you have the
3 governance structure? What kind of governance
4 structure for sustainability do you all envision
5 or have you discussed, and how does that play off
6 the legislative requirements to have the jack?

7 MS. DAILEY: So you want the MNRs to
8 talk about sustainability of the
9 wounded warrior programs based on
10 decreasing levels of wounded?

11 LT. GENERAL GREEN: Going forward,
12 what is the best vehicle for
13 sustaining wounded, ill and injured
14 programs, and let them tell us? Keep
15 it relatively simple?

16 MR. CONSTANTINE: Does a transfer
17 include electronic medical records?

18 DR. GUICE: I think that's part of the
19 system level transfer of information,
20 and certainly there's been some recent
21 dialogue about electronic health
22 records, so they can talk to that. I

1 think that would be a good thing for
2 us to have visibility of what they're
3 talking about and dialoguing.

4 LT. GENERAL GREEN: There's a lot of
5 internal to the department decisions
6 that have been made here in the very
7 recent past. So if we get into that,
8 that's been a subject of six different
9 working groups working for the last
10 three months. So again, I think that
11 I would keep it at information
12 transfer. My hope is that they'll
13 talk

14 about what they've done to date, and then they can always tell us where
15 they're going if they want to because we're going to ask them, where do
16 we go next. So that lets them talk to those

17 GENERAL HORST: In the area of
18 information transfer, so when you look
19 at merging the networks of each of the
20 services into a global DOD network,
21 are we making progress there? Right
22 now, we have a hard time talking to

1 each other based on which global we
2 are looking at. Global's a relative
3 term depending on where you sit. We
4 don't have that global network where
5 army physicians can talk to Air Force
6 physicians can talk to navy
7 physicians, and in the area of
8 information transfer, how about
9 effective.

10 DR. GUICE: So both within and
11 between.

12 GENERAL HORST: I believe that we've
13 got some challenges inside the DOD
14 network between the services, and
15 until we get a handle on that, I think
16 it's tough for us to get outside and
17 to be able to communicate with our VA
18 counterparts as well. So I would pose
19 maybe we better ask that question on
20 the MNRs as well.

21 LT. GENERAL GREEN: Yeah, the little
22 alarms in my head are going, "Danger

1 Will Robinson, Danger Will Robinson."
2 So the problem is that we are trying
3 to be specific, and now we're getting
4 quite broad because there's really
5 three different areas. So there's the
6 work that's been done over the last
7 four years to try and get personnel
8 records and medical records all to the
9 VA electronically so they can manage
10 them and some issues to overcome in
11 terms of the VA's reception of those
12 records especially on the medical side
13 we're mandating. I'm
14 not sure that's still true, a printout of all the medical records in
15 order to do the exam. I think because of they've gone to a single exam,
16 that's superfluous now, but then there's the issue
17 of (inaudible), which is the virtual lifetime
18 electronic record, which was to try the VA and DOD
19 systems together, and then there's the issue of
20 the medical record, Alta and Vista, and they're
21 really going to communicate in the future of that
22 particular record, and then finally there's a
discussion that's been going on within DOD about

1 how to get a single network, which is in the sixth
2 community.

3 GENERAL HORST: JMED.

4 LT. GENERAL GREEN: Well, JMED is a
5 whole different, oh my God. You
6 understand why I'm Danger Will
7 Robinson here. I (inaudible) all three
8 SGs on some of these committees, so I
9 know too much. Oh my God.

10 GENERAL HORST: Okay, sir, take a deep
11 breath.

12 LT. GENERAL GREEN: The JMED is a
13 whole separate issue, trust me. The
14 different issue that's more
15 interesting at the MNR level is that
16 there is a discussion between the
17 sixes about trying to get to a DOD
18 network, but there's pros and cons.
19 There's a way ahead, and it's a fairly
20 lengthy, but it's not anything that's
21 been part of the SOC discussions. So I
22 think that if we talk about info

1 transfer, then there's several venues
2 that they can go to. They can talk to
3 VA. They can talk the electronic
4 health record. They can talk the
5 consolidation of records to get them
6 to VA in a single package. All of
7 those things are things that have been
8 dealt with by the SOC, and so by
9 talking info transfer, we're okay. If
10 we specify to the health record or
11 specify to
12 VLR, then we'll get a much narrower focus, but we'll also hear more
13 about plans rather than if you say info transfer. Then, we can
14 basically get them to talk about what's actually
15 been done today, not what's been planned for
16 tomorrow, if that makes sense.

16 GENERAL HORST: I think it's probably
17 more helpful to focus on what's been
18 done than what they're planning.

19 LT. GENERAL GREEN: I'll be happy to
20 talk about JMED anytime, but offline.

21 DR. GUICE: I think if we keep it
22 general, too, we're offering them the

1 opportunity to tell us where their
2 success been, and tell us where it's
3 worked really well, and hopefully to
4 give us some ideas of how it could
5 have been done better, given what
6 they've learned over the time that the
7 SOC has been in existent. I think
8 keeping it broad and letting them
9 address it would be fine.

10 GENERAL HORST: I withdraw my previous
11 suggestion.

12 LT. GENERAL GREEN: So Denise, did we
13 give you a way forward that you can
14 live with, and you can have my page
15 here.

16 MS. DAILEY: To wrap up, we want to do
17 a panel with the MNRs, VA
18 representation and joint staff. We're
19 going to ask them a series of
20 questions, and we do not want to talk
21 about one. We'll give them three
22 specific areas we'd like to get

1 feedback on instead of question two.

2 Question three is what would

3 facilitate greater. I think that was

4 the word you used, what would enhance

5 or take out internal and external

6 factors.

7 GENERAL HORST: (Inaudible)

8 MS. DAILEY: Yes, that was it. Number - question number
9 four going forward, we did some wordsmithing there, and how do you
10 identify in question five - how do you identify

11 for MNRAs. Now, following on to that is do we

12 then want to use this to develop questions to go

13 to the deputy secretaries? Or do we want to use

14 this panel for our source? Or would you like to

15 take it to the deputy secretaries in another year,

16 or not take it there at all?

17 LT. GENERAL GREEN: I think we should

18 validate - I mean, basically we're

19 going to get input now from people who

20 have been on a SOC, and I think we

21 should go talk to the leadership, and

22 talk about the input that we've

received and see what their opinion

1 is.

2 MS. DAILEY: Okay.

3 LT. GENERAL GREEN: Okay?

4 MS. DAILEY: Okay. And that pushes
5 out into the summer. So we're going
6 to be compressed a little bit to pull
7 it all together for the report. We'll
8 use that panel to help craft a set of
9 follow on questions for the two
10 deputies and if the members would
11 think and collaborate among
12 yourselves, who then once we get that
13 information would like to - wants to
14 volunteer to go into the lions' dens
15 and take our what the feedback we got.
16 I really - you can't be my two co-
17 chairs.
18 The term in legislation is independent
19 of the SOC. So we need someone
20 who would be in - oh, okay. So we'll
21 follow on with some - with the one on
22 one interviews. Good, that's

1 excellent. Hang on a second.

2 LT. GENERAL GREEN: My suggestion is -

3 actually I was going to suggest that

4 Mack might be a good second, and then

5 we really should have one civilian

6 member of the board. So I don't know,

7 would you like

8 to go Suzanne? That would be great. So let the three of them represent
9 us if that would work. Okay?

9 MS. DAILEY: Okay, good.

10 GENERAL HORST: Colonel Keane would be

11 a qualified first alternate.

12 MS. DAILEY: That's true. Suzanne,

13 your question was?

14 DR. LEDERER: I would just like to

15 point out respectfully that the last

16 two questions of the four, I notice

17 that they don't really refer to the

18 SOC per se. They're much more

19 general. We have something like going

20 forward, what is the best vehicle for

21 sustaining wounded, ill and injured

22 programs. That's the third question

1 now.

2 LT. GENERAL GREEN: So you can
3 basically make that is the SOC the
4 best venue for continuing to work
5 these programs.

6 DR. LEDERER: Okay, and then the next
7 one, how do you identify new issues
8 for high level policy consideration?
9 Do you want to tailor that also a bit
10 more toward the SOC?

11 MS. DAILEY: I think it is how do you
12 - at your level, identify problems
13 that need to come to the SOC for
14 resolution or recommendation or
15 collaboration and facilitation.

16 DR. LEDERER: Thanks.

17 LT. GENERAL GREEN: I say to the SOC
18 or higher level for resolution.

19 DR. LEDERER: Thank you.

20 MS. DAILEY: Good, thank you. Thank
21 you very much. Can I now - let's see
22 what we got in tab D; that would take

1 us to tab D, ladies and gentlemen,
2 which is next month's agenda. So, we
3 have added a
4 panel, which means we might have to take something out. I know it seems
5 like it's moving fast, ladies and gentlemen. Eighteen to nineteen May
6 information meeting.

7 DR. GUICE: We do have one day one, we
8 have the four-fifteen to five-thirty
9 timeframe.

10 MS. DAILEY: I need a copy.

11 DR. GUICE: That we could use for an
12 additional panel.

13 MS. DAILEY: Okay, without taking
14 something out, I am a little concerned
15 that we are - here you go, sir - your
16 time to kind of collaborate. I do have
17 blocks of time in there, and it's a
18 trade off on the time that you don't
19 have them do kind of collaborate.

20 MS. CROCKETT-JONES: Can I ask?

21 MS. DAILEY: Yes, yes.

22 MS. CROCKETT-JONES: What happened to

1 getting a briefing
2 from the VA? Was that ever on the schedule? Did
3 it get lost, or

4 MS. DAILEY: Okay, briefing from - I
5 have the RCP briefing from the VA here
6 is in the May time frame.

7 MS. CROCKETT-JONES: All right, that's
8 - I didn't see it.

9 MS. DAILEY: I'm sure it's in there
10 somewhere.

11 DR. LEDERER: Three-fifteen, day one.

12 MS. DAILEY: Three-fifteen, day one.

13 DR. GUICE: Since the interagency
14 program office is part of the
15 information transfer that we'll be
16 talking about, should that be part of
17 the panel - part of the new panel that
18 we add then the IPO because that was
19 the information transfer part of that
20 question, and just move them into the
21 participation on the panel.

22 MS. DAILEY: Interagency program office is a discrete line
 item of our legislation. They've got a set of questions, research

1 questions that we are asking them to brief. So my
2 first thought would be no. I need them to give me
3 a data download, and I think the members kind of
4 need it, too. It seems like when we talked with
5 the SASC last time, the first things out of their
6 mouths was the SOC and the IPO office.

7 LT. GENERAL GREEN: My recommendation
8 is that we adjust the calendar a
9 little bit. I'm not sure that it's
10 imperative that we get the panels for
11 Center of Excellence in on that day.
12 So you could drop the panel for the
13 Center of Excellence, and reschedule
14 it for another time.

15 I also think that we need to think
16 about the timing if we're going to
17 have the MNRs come over and talk on
18 the same day that the PNR is going to
19 be over here and talk, or the wounded
20 warrior care and transition policy.

21 Are they the ones that actually bring
22 the SOC together?

1 MS. DAILEY: Yes, sir they are the
2 executive agent for the SOC.

3 LT. GENERAL GREEN: So the question is
4 do we want to talk to the MNRs at the
5 same time frame as we're going to be
6 talking to the people that bring the
7 SOC together.

8 MS. DAILEY: Well, they will not be
9 talking about the SOC. They'll be
10 talking about their programs, PNR. My
11 mental picture is PNR would be talking
12 about their programs under their
13 portfolio.

14 LT. GENERAL GREEN: And the
15 interagency program office, the
16 stuff that they're going to present, is that - I guess the other
17 question is could you move the interagency program office towards the
18 end of the day, and bring the MNRs in at nine-
thirty or ten.

19 MS. DAILEY: Yes, sir, not a problem.

20 LT. GENERAL GREEN: That way we can
21 hear from the MNRs before we talk to
22 the people who organize the SOC so we

1 can ask better questions of the SOC,
2 and then we get to the program, or the
3 interagency program office towards the
4 end of the day to kind of verify that
5 the MNRs, what they say has happened
6 is actually what the program office is
7 telling us, and just kind of push the
8 Center of Excellence either to another
9 day or another session.

10 MS. DAILEY: Okay, good, good.

11 LT. GENERAL GREEN: Will that work for
12 everybody?

13 MS. DAILEY: Yes, it works for me. I
14 can make that happen.

15 LT COLONEL KEANE: Sir, if we did move
16 that, I would suggest still having the
17 review of the installations. We can
18 put that at the end of the day. I'm
19 talking about the beginning of day
20 one, we had that scheduled from nine
21 to ten.

22 LT. GENERAL GREEN: I wasn't cutting

1 that out. I agree we need to do that
2 first thing, and then I think we can
3 do the MNRs immediately following. So
4 yeah, I just don't know - so the
5 timing would be that you're going to
6 bring the MNRs over at ten-fifteen or
7 do you start them at ten and have us
8 basically take our break at nine-
9 forty-five? So that way the MNRs,
10 since it's a fairly high powered
11 panel, we'd like to give them a solid
12 time, and then we'll be here
13 starting at ten o'clock say?
14 MS. DAILEY: Yeah, that's easy.
15 LT. GENERAL GREEN: So we do a nine-
16 forty-five. So we give up fifteen
17 minutes, and we still an hour and
18 forty-five that we talk about the
19 trips.
20 MS. DAILEY: I've actually just cut
21 your times to talk about trips down to
22 an hour.
 LT COLONEL KEANE: That was my second

1 point. Today, we took almost two
2 hours to talk about three trips.
3 We're going to have four more trips on
4 the rope by then. If we push that to
5 the end of the day, kind of leave it
6 open, to the end of the day when we're
7 talking about the trips.

8 LT. GENERAL GREEN: I'm trying to get
9 the MNRs before we talk with the folks
10 who actually pulled the SOC together.
11 So I think we could forego the eight
12 o'clock discussion and go straight
13 into the trip reports. So we can
14 start by talking about the trips, talk
15 for an hour and forty-five minutes,
16 and then if we find that we still need
17 to time, then we've got the time at
18 the end of the day that we could
19 continue the discussion regarding the
20 trips, if that works? There's a
21 little bit of an order thing here.
22 I'd really kind of like to hear from

1 the MNRs so our questions are better
2 when we talk with the people who are
3 basically pulling the SOC together.

4 MS. DAILEY: Yes, we can start the
5 discussion of the installation visits
6 at eight, and do it for an hour. If
7 there's more than we don't get to, we
8 can cover at the end of the day is
9 pretty much what you're thinking?

10 LT. GENERAL GREEN: We'll actually go
11 for - let's see. Let's go for an hour
12 and forty-five minutes, and at nine-
13 forty-five, we'll take the break, and
14 at ten o'clock, we'll bring in the
15 MNRs, and talk from ten o'clock until
16 eleven-fifteen, and we'll take our
17 next break.

18 MS. DAILEY: Okay, very good.

19 LT. GENERAL GREEN: I'm like you,
20 Sean. I think we'll find with five
21 visits, we're probably going to end up
22 using the end of the day to talk about

1 the remainder of the visits. So
2 that's okay?MS. DAILEY: Okay, I did
3 want to bring in -- and I see that you
4 picked it up, so I did want to bring
5 in what's called, "The Recovering --
6 The Wounded Warrior Can Transition
7 Policy Office". You all have been
8 getting briefings from the services.
9 If you're not aware, there is a single
10 DOD policy office that brings together
11 and writes policy for your non-
12 clinical care. And you all have not
13 had a chance to talk to them; and I
14 thought I'd bring them in in a panel
15 format. Also, they don't -- won't
16 have much to brief you on; because
17 quite frankly you will have heard all
18 of it from the bottom up versus the
19 top down. So, you're going to hear the
20 top at the last point for our
21 information gathering. And you can
22 tell them what you've heard out in the

1 field and see if -- essentially, what
2 they tell and what you've see in the
3 field matches up. But these won't be
4 real detailed briefings. Lesser
5 mandate is -- I got to bring in the
6 hearing, vision and traumatic injury
7 via the legislation. We got to get
8 them up and get to talk to them. And
9 then, Ma'am, you've got the recovery
10 coordinator program coming in. Is
11 that going to be you briefing, or at
12 3:15?

13 DR. GUICE: It can either be me; or it
14 can be one of my deputies, either one
15 doesn't matter.

16 MS. DAILEY: Okay.

17 DR. GUICE: And the other thing we can
18 do is see if FRCs will actually be
19 here as well. We could use a panel of
20 FRCs and people can brief the actual
21 people who do the work.

22 MS. DAILEY: Good. A panel, okay,

1 that's good. Ma'am, you've got
2 training going on that week, is that,
3 or they're in town?

4 DR. GUICE: This effort is part of
5 their training.

6 MS. DAILEY: Part of their training.
7 Okay, okay. It's a busy day, ladies
8 and gentlemen. Okay. Yes?

9 LT. GENERAL GREEN: Yes, looking at
10 the next day.

11 MS. DAILEY: Good.

12 LT. GENERAL GREEN: So, can we bring
13 the Centers of Excellence over. I'm
14 trying to look in the afternoon. I
15 don't know what the task force time
16 training Assessing Effectiveness,
17 what's that?

18 MS. DAILEY: It's how -- it's a
19 methodology that we want to reinforce
20 with the members on how we are going
21 to ultimately assess effectiveness.
22 It's the language of the legislation.

1 What's a model for assessing
2 effectiveness? We talked a little bit
3 about it in January. I've had it as a
4 tab in last month's book, but sooner
5 or later we have to go through a
6 process for assessing effectiveness.
7 What is our strategy for assessing
8 effectiveness, what models are we
9 going to use. So, I wanted to
10 introduce there, but it is optional.

11 Quite frankly, it's optional.

12 LT. GENERAL GREEN: Well, what I'm
13 thinking is, you know, doing that at
14 the end of the day, we'll all be brain
15 dead. And if you want us to actually
16 take something away from that, perhaps
17 the way to do it is simply move that
18 up and let's do that at lunch. Make
19 the lunch a little longer, we can do
20 the two hour session and then have
21 people come in after that. Have them
22 carry these discussions later. Okay,

1 that way we're doing the internal work
2 over lunch; so, less problematic for
3 us to be eating while we are doing
4 internal work.

5 MS. DAILEY: Okay, all right.

6 LT. GENERAL GREEN: And then we can,
7 perhaps, sneak the Centers of
8 Excellency in that afternoon.

9 MS. DAILEY: Okay.

10 LT. GENERAL GREEN: Okay.

11 DR. GUICE: We also have three things
12 on that second day that the members
13 have requested; and those are moveable
14 as well, because we -- as Denise has
15 wisely pointed out, we do have a
16 legislated mandate to cover for this
17 first year. So, these are things that
18 we are interested in and would like to
19 learn more about; but we don't
20 necessarily have to have them. Since
21 we have been in -- this is the main
22 meeting; and then the next meeting is

1 all about the reports. So, you know,
2 what are the key pieces of information
3 that we really do need to have before
4 that next meeting which is all about
5 the report? So, are there these, one
6 or two or all three of these, the task
7 force members would be comfortable
8 putting off that you don't feel are
9 critical for this year's
10 recommendation report.

11 MR. CONSTANTINE: Okay, you're asking
12 about the second day here or the
13 first?

14 DR. GUICE: The three things, panel on
15 Cognitive Rehab Therapy, panel on TBIPSD, Army
16 Pain Management Task Force briefing. Those are
17 all add ons.

18 MS. CROCKETT-JONES: I have a
19 question, just
20 are we getting some overlap in having panel -
21 (inaudible). I feel like we are having, that
22 there is a little bit of overlap in having the

1 Rehab Therapy panel and a TBIPSD panel. I mean,
2 I would think that some, it sort of falls under,
3 one falls under the other. At the same time, I
4 don't want to nix, nix something that is
5 important; but they seem to have overlap. And we
6 should maybe stream line the one panel on TBIPSD
7 that's such a broad topic. It's huge, and I don't
8 think that we're going to get anything in an hour.
9 If it's post, if's that generally -- if that's
10 generally stated I'm not sure what we can get in
11 an hour with such a broad heading.

12 LT. GENERAL GREEN: Suzanne, I
13 actually agree. When I looked at it,
14 I wondered why we didn't just combine
15 the TBI and the Cognitive Rehab
16 Therapy into a single session. And if
17 we want something else on PTSD, we can
18 always ask for that later. So, it
19 looks like I'm seeing a lot of head
20 nods. So, why don't we do that, make
21 the panel its covering Rehab Therapy
22 and TBI. And then, basically, we drop

1 off the PTSD for right now. And then,
2 if somebody wants to see more on that,
3 we can always request that again
4 later.

5 MS. DAILEY: Okay, so we'll focus --
6 we'll combine the TBI and Cognitive
7 Rehabilitation Therapy; and we're
8 looking, basically, for some panel of
9 experts to come in and talk about
10 these therapies, and okay -- okay.

11 MASTER SERGEANT MACKENZIE: I think
12 you will find as these folks come in
13 to talk that there will be some
14 overlap in the PTSD realm; because
15 those who are actually doing Cognitive
16 Therapy, Cognitive Rehabilitation
17 that's all part of it. So, I think we
18 will still get a good taste of the
19 PTSD part, while they're briefing.

20 MS. DAILEY: Okay, good. We got an
21 hour in there we freed up.

22 LT. GENERAL GREEN: That should take

1 care of your Centers of Excellency to
2 get them back on the schedule; and
3 then, does everybody agree with doing
4 this training that's over the lunch
5 time period? So, I think that would
6 make, we could still make that change,
7 just make it a little easier for us.

8 MS. DAILEY: Good, good.

9 LT. GENERAL GREEN: Okay?

10 MS. DAILEY: And there are two things
11 that you all have asked for that I
12 didn't put on there. Go ahead, yes?

13 MR. CONSTANTINE: I just have a
14 question. You know we just found time
15 for the Centers of Excellency, but the
16 Employment panel on here, talking
17 about the employability of military
18 members. If it was Alexander Hamilton
19 at corporate grade, they are going to
20 say without military members, you
21 know, we have a lot of military
22 members already, we can't say enough

1 good things about it. That's our 15
2 minutes there for that. I'm not
3 saying there's more to it, it just is
4 we kind of know what they're going to
5 say.

6 MS. DAILEY: Okay. The person who was
7 advocating for this was Jonah Stone, and he's not
8 here to defend his -- this. This had been a
9 recommendation at our last meeting that we
10 understand where, what employers are thinking,
11 what might not be being done for members. Now, I'm
12 happy for members leaving the military. I put
13 those in there. I can use any company's -- I mean
14 I'm just kind of filling in the blanks here so
15 it's not a, generating thoughts on your part. The
16 employment issue is important, and you all have
17 expressed a consistent interest in it. I've got
18 data, I've run the data down that you asked for.
19 We're -- you know, how do want me to go after the
20 employment issue for you?

21 MR. CONSTANTINE: Okay, okay. Iris, I
22 wasn't here last time; so, that's why

1 I didn't recognize this for what it
2 is. I think, this sounds like we're
3 trying to have some time to talk to
4 people in the private industry. We
5 need to talk about method of work and
6 gains. Some of these win awards to
7 employment; and what hasn't worked
8 directly, issues they may have or
9 something along those lines. That
10 makes sense then.

11 LT. GENERAL GREEN: We also have
12 someone from the -- in the public
13 session, or that presented, that was
14 talking about making certain that
15 people were aware of job opportunities
16 in the outside. And so, I think it
17 was kind of an expansion of that, if
18 I'm not mistaken.

19 MS. DAILEY: Correct. Yes, I was
20 responding to a number of requests on,
21 you know, where are we going wrong
22 with the employment issues,

1 essentially. Why aren't we able to
2 employ more people?

3 MASTER SERGEANT MACKENZIE: And that's
4 what was brought up in the last
5 meeting, was getting their perspective
6 of how the military DOD, VA, whatever,
7 is preparing these, or not preparing
8 these folks to come out into the
9 sector. That's one of those things we
10 were looking at as if we want to
11 measure the effectiveness of how we're
12 doing, of how the DOD is doing what
13 better than to get it from the
14 receiving end to tell us what they're
15 seeing is coming out of the pipeline.

16 MS. DAILEY: Right.

17 MASTER SERGEANT MACKENZIE: So, that
18 was the -- I believe it firmly for me
19 that was the concept we were looking
20 for.

21 MS. DAILEY. Correct. That was one
22 way to go after the employment issue;

1 and the other one was the basic
2 research, who's employed who's not
3 employed. How much fidelity can we
4 give to that visibility into the
5 population? No, I mean, that's, kind
6 of, the easy part for us; because
7 we've gotten fabulous new reports out
8 on Wounded Warrior employment at the
9 Department of Labor website, which we
10 have gone after; and I have a paper I
11 can give it to you. But I think, in
12 another method to kind of get at this
13 is what was, what isn't working, why
14 are these numbers so high? And one
15 way to do it was to go after a panel.
16 LT. GENERAL GREEN: Yes. The only
17 other question I have on that was do
18 we want to actually invite, and I'm
19 sorry I don't remember off hand who
20 the person was --
21 MS. DAILEY: It's Able Forces.
22 LT. GENERAL GREEN: But the, somebody

1 like Able Forces to basically be part
2 of that panel; because they were
3 talking about how they counsel members
4 to make certain that they have
5 knowledge of other opportunities; so,
6 not just the employers, but perhaps
7 somebody who helps people find
8 employment. It would not be a bad
9 thing. We gave them two minutes, but
10 do we want to hear a little bit more?
11 MR. REHBEIN: Another possibility too,
12 rather than specific employers is the
13 US Chamber of Commerce. You might get
14 a broader view of what's going on out
15 there in the business community rather
16 than one or two or three employer's
17 specific focus. So, that's just
18 another -- that's just another
19 possibility for the panel.
20 MASTER SERGEANT MACKENZIE: What are
21 the other programs out there to
22 Sentinels of Freedom? That what they

1 specialize in is finding those
2 donations and finding, within a local
3 community, to actually get guys
4 educated and employed. And although a
5 selective process, I'm sure that they
6 have challenges they've seen in
7 selecting these military members and
8 what is it about them that makes it
9 challenging to select them to go
10 through these programs.

11 MS. DAILEY: And the name of that
12 organization was?

13 MASTER SERGEANT MACKENZIE: Sentinels
14 of Freedom.

15 LT. GENERAL GREEN: And so if we prep
16 something like Sentinels of Freedom, and Able
17 Forces and then the Chamber of Commerce together,
18 rather than having specific employers who tend to
19 do a lot of business DOD or VA, I think we get a
20 broader picture; because that's what we're really
21 looking for is not so much how do we get people
22 employed with companies that already do a lot of

1 work with DOD and VA, but how do we basically help
2 our wounded warriors, ill and injured to find
3 other opportunities that they may not be aware of
4 at the time they are going through this process,
5 so.

6 MS. DAILEY: Good, good, good. Thank
7 you. Yes, see all those things I just
8 throw out generate a lot of good
9 ideas.

10 MS. CROCKETT-JONES: Denise?

11 MS. DAILEY: Yes, yes Suzanne?

12 MS. CROCKETT-JONES: The Army Wounded
13 Warrior
14 program, AW two, has a dedicated job development
15 cell; and they recruit corporations to develop
16 jobs and opportunities. They could also talk
17 about their experiences interacting and soliciting
18 the cooperation of the private sector. In fact,
19 they came and spoke to us at ICF for that purpose.

20 MS. DAILEY: Okay, good.

21 LT. GENERAL GREEN: That's great. So,
22 we'll make it a four member panel and

1 that'll give us a broad spectrum.

2 MS. DAILEY: Okay. I just want to

3 bring up two things that you have

4 talked about that are not on here at

5 all. And one of them is we had to get

6 an advocate through these topics areas

7 aren't here today. So, one of them

8 was, if you remember, the articles in

9 February, by the Pittsburg Post, Mr.

10 Klein, was generating a lot of

11 interest among you; and you had

12 discussed bringing him in and bringing

13 in a panel of individuals who -- who

14 have some serious concerns about the

15 effectiveness of our Warrior

16 Transition units, battalions and

17 programs. So, it would be the

18 counterpoint view. I'm at a loss,

19 right now, to find time for it. I

20 don't want you to think I've forgotten

21 it. Do you want me to make time for

22 it? Where do we stand with bringing

1 the counter voice in?

2 DR. GUICE: To me, if we were going to
3 do it, this would be a good time given
4 who's already on the agenda. Since
5 you have the policy shop, we've heard
6 from the services. We're going to
7 have the discussion with the M and
8 RAs; so, if we wanted to do it and
9 have it rolled up in this so that the
10 thing that I'm looking at is, is the
11 Army Pain Management briefing
12 important enough for what we're trying
13 to achieve for this first round or can
14 we put that off and use that time for
15 something like this?

16 GENERAL HORST: And I don't recall
17 exactly why we asked for the Army Pain
18 Management, but it seems, to me, one
19 that can defer to next round of work
20 if we prioritize the more, the more
21 relevant issues and I think that
22 counterpoint that we talked about is

1 probably important. So, I -- as an
2 Army guy, I recommend we move Army
3 Pain Management to the next, next
4 trunch of work.
5 LT. GENERAL GREEN: And the other
6 thing I know about the Pain Management
7 is that the report came out in the
8 fall; and so, a lot of the efforts has
9 gotten started across the Department.
10 And so, if we do push it into the next
11 session, there will be a lot more in
12 terms of credible work that we'll be
13 able to look at and see how they're
14 implementing some of the things
15 they're doing. So, I'd love to hear
16 the counter point. I think it would
17 be useful for us to hear, you know;
18 and find out what others are thinking
19 of the process; because we're hearing
20 mostly internal, the people who put it
21 together and then going out and
22 visiting. And so, if we could make

1 that substitution, it would fit my
2 needs nicely.

3 MS. DAILEY: Good, okay. Now that
4 was, I'd like to follow up on Mr.
5 Constantine's comment in the same kind
6 of body of the counter point exists
7 out there in the DES system; and we've
8 heard from Mr. Parker who kindly leads
9 that -- twice. He will be here again
10 tomorrow. And Justin, you said you
11 had someone from the DES experience
12 who wants to talk to the panel. So,
13 that would be a counterpoint. Can I
14 roll, do you want me to bring the DES
15 counter points, roll it on the same
16 panel?

17 LT. GENERAL GREEN: Maybe bring,
18 perhaps bring a couple for each. A
19 couple on the DES, a couple on the
20 overarching Warrior Program --

21 MS. DAILEY: Okay.

22 LT. GENERAL GREEN: to share their

1 concerns and we can listen to all
2 that.

3 MS. DAILEY: Okay.

4 LT. GENERAL GREEN: that later, you
5 know, if we put that just before the
6 end, my guess is that that might
7 actually go a little longer and so, I
8 think that if you can keep that
9 towards the end of the day that might
10 be good.

11 MS. DAILEY: Okay.

12 LT. GENERAL GREEN: Okay.

13 MS. DAILEY: Okay, good, good.

14 Mr. Constantine: I'll have to e-mail
15 my

16 friend, make sure he's available that day. I'll
17 do that tonight -- right now.

18 MS. DAILEY: Okay, that'd be great.

19 Well, I'll get in contact with Mr.
20 Parker.

21 MR. CONSTANTINE: He's still here.

22 UNKNOWN WOMAN: I think he said yes.

1 MS. DAILEY: His thumb just went up,
2 very good.
3 Okay, so we've got a counter point
4 panel coming in; and I appreciate you
5 making time for that. Any other
6 questions on what our May agenda would
7 look like? Again, it's an important
8 time; we need to kind of wrap up. So,
9 anything you think we've missed?
10 Okay, can I get everyone to look at
11 Tab E? If you're here, I'd like you to
12 take a look at your -- what you've
13 committed to on the Insulation Visits
14 and the dates. And I realize, again,
15 I'm missing a certain number of my, my
16 members. But if you, if you have any,
17 if I have the X in the wrong spot, and
18 I realize those of us over 50 are
19 going to be really tough to tell if
20 that X is in the wrong spot, make your
21 best crack. If, if I've got it wrong,
22 let me know. If you want to be added,

1 let me know. If you are sure at this
2 point you aren't going to be able to
3 go to these events, I need to know.
4 MASTER SERGEANT MACKENZIE: I'm good
5 with my schedule.
6 MS. DAILEY: Okay.
7 MASTER SERGEANT MACKENZIE: Thank you.
8 GENERAL HORST: Likewise.
9 MS. DAILEY: Okay, good.
10 MR. CROAKLEY: Same.
11 MS. DAILEY: Okay.
12 MR. REHBEIN: Okay here.
13 MR. BERTHOLD: Steve will get back to
14 you.
15 MS. DAILEY: Okay, right.
16 MR. CONSTANTINE: Works for me.
17 MS. DAILEY: Okay, all right.
18 LT. GENERAL GREEN: I'd really like to
19 join one, but I'm still looking for
20 calendar time, so --
21 MS. DAILEY: Okay, sir.
22 MASTER SERGEANT MACKENZIE: Don't

1 worry about it, sir, we got you.

2 MS. DAILEY: I do have, you know and
3 you can make the call here, I do have
4 the module. I put it in every one of
5 your books. I do have the module for
6 assessing effectiveness and the logic
7 model that we could look at now, if
8 you wanted to. Or if there are other
9 topics that we need to bring to the
10 table, I'm open.

11 DR. GUICE: Denise, you had on the
12 sort of the agenda here, reports cycle
13 completion; but there's nothing --

14 MS. DAILEY: Correct.

15 DR. GUICE: Behind Tab F. So, is that
16 something you wanted to address briefly?

17 DR. DAILEY: Very briefly, I just want
18 to emphasize the last three day of
19 July are a day in which -- three days
20 in which we will be working on your
21 findings recommendations.

22 Conceptually speaking. My thought was

1 that we would be giving you the report
2 in mid July. And those three days
3 would be dedicated to you reading --
4 having read the report now sucking out
5 your recommendations and voting on
6 them, which can be a complex process
7 -- wordsmithing them, crafting them.
8 I wouldn't be giving you any more
9 information briefings. Want to lock
10 in, sir, you said a report of about 50
11 pages? Is that where our heads still
12 are?

13 DR. GUICE: To me it's sufficient to
14 explain the thought and the rational
15 for the recommendations, and that's an
16 essence of what I think we need to
17 have as a report. I don't think there
18 needs to be a certain page target. It
19 has to be just what is sufficient and
20 succinct to explain it.

21 LT. GENERAL GREEN: And from my
22 perspective, I mean, we're not trying

1 to write a novel here; so that the
2 real secret is not how long the report
3 is. I mean, I think there -- the
4 magic is going to be how we can boil
5 this down into things that we think
6 are meaningful that are actionable
7 without a laundry list. I'd love to
8 have ten really important
9 recommendations than have 150 that,
10 you know, are all over the map, if
11 there's a way to do that. But we'll
12 have to look and see as we get there;
13 because I'm not trying to limit us to
14 ten. I'm not trying to drive us to
15 150. Somewhere in there, I'm hoping
16 we'll be able to consolidate things
17 and come to agreement that these are
18 things that are really important that
19 departments should go after. So, if
20 the report is 50 or a 100 or 200 pages
21 doesn't really matter. I think it's
22 more important how we boil down what

1 our recommendations are going to be.

2 MS. DAILEY: Okay, all right.

3 MS. CROCKETT-JONES: I do have a
4 question.

5 MS. DAILEY: Yes? MS. CROCKETT-JONES:

6 Our report that has the
7 big important recommendations, I get the goal; but
8 there are a lot of little things that we're seeing
9 on installation visits that make a difference.

10 And are we just going to -- I mean, don't we want
11 some of those things, even if they're not big, to
12 be known throughout installations. So, I'm sort
13 of wondering if there is some method for taking
14 the little ideas and sharing them.

15 Not necessarily to say everyone should be doing
16 this;

17 but if this, if you haven't considered this, will
18 this improve your four-year transition unit, or
19 your providing services or, you know, like when we
20 were talking about at Ft. Benning and cutting off
21 roads to create a walkway, to create a pedestrian,
22 sort of, village feel. It's not that I'm saying

1 that everybody should have to do that, but I'm
2 saying that if someone hasn't thought, "Hey, you
3 know, we can actually just shut off these roads".
4 It's a simple -- do you see what I'm saying; and
5 I'm wondering if there is some, going to be some
6 venue for us to provide some sort of little
7 information pool. Of course, that could be one of
8 our big recommendations to say there should be
9 some information pool where installations share
10 small measures taken that have shown to increase
11 quality of care or facilitate access to services.

12 MS. DAILEY: Steven, microphones
13 please. Here you go sir.

14 LT. GENERAL GREEN: What I was going
15 to say is, I think we have some
16 opportunities. So, for instance, if
17 we find that we want one of our major
18 recommendations to be about the design
19 of Warrior Transition Units or Warrior
20 Regiment Facilities that I think we
21 have the ability to make it an
22 overarching. Or we can basically not

1 make that a major recommendation and
2 say that some of our observations were
3 such that and we're going to look at
4 that, because it's the five year task
5 force that we think that these things
6 have merit. And basically we will
7 continue to look at those things as we
8 go out to see whether we can get a
9 broader perspective. And so there may
10 be the opportunity here to have things
11 that are truly findings and things we
12 recommend be acted upon and then
13 things we identify as things best
14 practice -- best practice may be to
15 strong yet, but basically saying
16 things that we think have merit; and
17 we want to continue to evaluate in
18 future reports. So, if you see what
19 I'm saying, we can capture a lot of
20 little things; but then, we can, when
21 we go out to other places, talk to and
22 share the things that we're seeing are

1 working for others and actually be
2 part of the growth in terms of an
3 improvement of the concepts that are
4 currently in the Wounded Warrior
5 Units.
6 DR. GUICE: So, I'm sensing an
7 appendix or a -- some sort of document
8 that we just start cataloguing good
9 ideas; and we just continue to add to
10 those and just continue to put those
11 in the reports. They're things we
12 really want to follow up on, when we
13 come back during the second or third
14 year to a certain installation, say,
15 "You know you told us about that,
16 blank, which we thought was a really
17 good idea. Did it pan out to be a
18 really good idea; and have other
19 people come to you and cloned your
20 idea and then recrafted it; and where
21 is it, you know, fit into another
22 development of maybe something

1 different"? But, you know kind of a
2 cactus, if we just maintain a
3 catalogue of good ideas, what we have
4 to do is we have to start doing it
5 now. Because, otherwise we will all
6 forget what we thought were good
7 ideas; and, you know, what's the best
8 way then, Denise, for us to capture
9 that information and feed it into you
10 all so you can just develop that
11 format.

12 MR. REHBEIN: One of the, one of the
13 things, though -- and I think that's a
14 good idea I can see an appendix of --
15 General Horst down there in the out
16 brief at Benning, you wrote the out
17 brief into categories. Not categories
18 based on our legislative, but
19 categories of importance. And I could
20 see us doing it in a separate appendix
21 of observations like that. But one
22 thing we have to, we have to keep

1 track of is where does this report go.

2 Does this report go back out to the

3 WTUs

4 where they would be able to read that

5 appendix? Or does it simply go up to

6 Congress where they may never see it

7 again?

8 DR. GUICE: Once it goes to the

9 Department of Defense, it's a public

10 document.

11 MR. REHBEIN: But we want the WTUs to

12 see those observations, because Bragg

13 doesn't know about that sidewalk at

14 Benning. So it -- somehow we have to

15 figure out how to get it distributed

16 to those WTUs so they would look at

17 it. But as we talk about the central

18 site for best practices and gathering

19 of information, if that recommendation

20 is what we end up putting in the

21 report and it is accepted, that would

22 be one of those responsibilities of

1 that manager of that location to go
2 get that information we have already
3 put in our report. So basically,
4 creating a recommendation and stuff to
5 put in there when they, when they
6 acknowledge that recommendation
7 simultaneously. I mean --
8 LT. GENERAL GREEN: Perhaps, it
9 depends on what we're saying here so
10 the other way is to have an annex that
11 is basically geared towards the
12 reports with observations from the
13 task force on visits. And so, in
14 essence, we simply write up each visit
15 with things that we think are, you
16 know, that we identified as things
17 that had merit, you know, that we --
18 that we think that need further
19 observation or think, you know, if
20 it's truly something we think is the
21 best practice, I think it will come in
22 to the body of the report. But in an

1 annex, you could basically put a lot
2 of small things that you think were
3 nice touches, okay, at various
4 facilities to basically give them feed
5 back, if you weren't able to give it
6 immediately when you were there. So,
7 I -- it kind of depends on where you
8 want to go with this thing; but there
9 is a way that I think we could do this
10 so that essentially you're taught to
11 the various sites. If it's something
12 we want to roll up and make something
13 bigger, we ought to bring it forward.
14 So, what you mentioned in terms of the
15 sidewalks may well be something that
16 we want to, we think that the concept
17 of design to make certain that this is
18 a campus and a community for mutual
19 support is important.
20 Now, do we still need the annex that
21 says we like the sidewalk at-Was it
22 Benning? I'm -- yes. Don't want to

1 cut out those kinds of feedback loops
2 in terms of things that we think that
3 was mentioned and somebody can see
4 what we saw on different visits. It
5 might be acted upon, and that's why I
6 say an annex that talked about
7 observations from visits might not be
8 a bad thing. MS. CROCKETT-JONES:
9 Well, that's what I'm
10 saying is some things might lead to a bigger
11 recommendation; but do we want to create a little
12 clearing house for the little ideas?
13 Whether they go on to other things or
14 not, that specifically whether it's an
15 appendix to the -- you know, to the
16 report or not; but that we can, I mean
17 because at this point our information
18 is going in a particular direction.
19 Is it, would it be useful to have
20 something that goes out to the
21 existing units? You know, in the
22 other direction, I mean we do it as an

1 out-briefing; but only the person,
2 only the folks right there at that
3 out-briefing get the benefit of
4 saying, you know, we noticed this
5 little thing you're, you guys are
6 doing right and getting good response
7 from your soldiers. Wouldn't that be
8 helpful at every -- if every
9 installation found out that these
10 little things can, you know, sometimes
11 they turn into -- they might make a
12 difference for a soldier, and I just
13 -- it just seems to me that there
14 should be a way to disseminate it and
15 I know we could make it electronic and
16 just send it to them. But we'd have
17 to determine that we want to make that
18 little clearing house of, that little
19 list of small things regardless of
20 whether they turn into big things.
21 Even if they're just sent out there
22 and if, for people to do with what

1 they will.

2 MS. DAILEY: We've done this before on
3 other reports and we've got a page a
4 page in there. They're very, they're
5 quick, they're one-liners, you know,
6 at such and such installation did
7 this. I've done this before, so this
8 is not -- this is not undoable. It's
9 very easy. The other thing that helps
10 is, you know, you can also -- we can
11 also create some, you know, if the
12 press picks up something like that.
13 Those one-liners are always good for
14 the press to disseminate gets it out
15 in the broader population and it gets
16 a lot more visibility.

17 So, those are very easy things to do.

18 MASTER SERGEANT MACKENZIE: And that
19 would be one of those things, as we
20 did all of our out briefs, at least we
21 did on the visits we were on, we kind
22 of mentioned to those, that leadership

1 in other facilities it's always, you
2 know, the reports coming out on this
3 date, check the website, it could just
4 that section of the website that goes,
5 "hey, these -- the facilities that
6 were interested in our out-brief and
7 what we found would be looking for the
8 concept". And so, that would be one
9 of those things, too, where versus,
10 versus being the responsible agency to
11 send out to every WTB or every Patient
12 Squadron or every Wounded Warrior
13 Battalion or that, that's a huge
14 responsibility, I think, for us to
15 take on to be the responsible party to
16 pass on this information. We created
17 a resource for them to them to capture
18 that information; and also, when we
19 brief the services the following year.
20 DR. GUICE: I do believe that the age
21 of electronic dissimulation of
22 information makes it, the burden, a

1 lot less; and I think that as a matter
2 of recourse and a matter of just
3 courtesy we would provide a copy of
4 the report to all the installations
5 that we did visit in that calendar
6 year. Just as a matter of we can do
7 that. That's easy; and once it's made
8 into an electronic format, it's easy
9 to do after the presentation to the
10 deputy, the Secretary of Defense.

11 MASTER SERGEANT MACKENZIE: I really
12 think it's just a formatting question.

13 You don't want drive work, so, I'm
14 not trying -- we don't want to drive a
15 trip report on each side necessarily.
16 On the other side of that, if we can
17 find a way to aggregate these things
18 into practices, you know, that we
19 thought had merit. I mean, all those
20 kinds of things could easily be tapped
21 into, you know, some part of the
22 report. So, it would serve us well,

1 honestly.

2 LT. GENERAL GREEN: So, how about a
3 compromise? Since, it's about four o'clock right
4 now, so that we don't have to spend two hours in
5 May doing this effectiveness, why don't we have
6 them introduce the concept and then we'll cut out
7 in about 45 minutes to an hour?

8 MS. DAILEY: Good, good.

9 LT. GENERAL GREEN: And we can take a
10 break if you need a break. Okay Carl,
11 a break is will do. So, how about,
12 everybody we take a ten minute break.
13 We'll start at ten after and go until
14 five, okay?

15 Whereupon a short break was taken off
16 the
17 record.MS. DAILEY: We're looking for
18 effective and efficient ways to assess
19 program effectiveness and how to
20 assess it. And when we talk to
21 Congress about how we came to certain
22 conclusions and we can use current

1 terminology, current models, accepted
2 parameters that civilian industry uses
3 or that the scientific or educational
4 industry uses to assess effectiveness
5 of program's industries.
6 And a lot of these programs that we
7 have here, in the Department of
8 Defense, are capable and should have
9 some sort of disciplined assessment
10 applied to them. And I think Congress
11 kind of gave you that mandate. So, we
12 want to give you a structure that
13 helps look at that. And we're -- the
14 terminology in industry is a logic
15 model, and let's, we'll walk through
16 that a little bit with you and then
17 give you some background. So, I just
18 wanted to like get the language out
19 there again. We talked a little bit
20 about it in the January meeting. I
21 put it in the February meeting, but
22 let's touch it one more time. Again,

1 here's a mandate, Assess the
2 Effectiveness, and now that's --
3 you've got 16 topics to assess
4 effectiveness of; and even then, you
5 may want to group them as Doctor
6 Lieutenant General Green talked about
7 in to our four categories. So, a
8 mandate assessing effectiveness -- so
9 let's look at when you're looking at a
10 program some of the things you want to
11 consider. One of the things you want
12 to consider and which will confound
13 you to a degree is, you know, what's
14 the maturity of a program? Are we
15 talking here about very mature
16 programs where we've had a lot of
17 data; and we're looking at a lot of
18 data; and we've got lots of resources
19 going in; and so we can really look at
20 outcomes. Or, and in your own heads
21 you're going to have to sort out, are
22 we looking at very immature programs,

1 new programs that we're only able to
2 assess, you know -- you know how --
3 how much is happening in those
4 programs. Not so much what the
5 outcome of that program is, we can
6 just kind of assess the activities
7 going on inside of it. So, you're
8 going to have to, one of the judgments
9 you're going to end up coming to is,
10 is are these programs mature; or are
11 they immature? And if they're mature,
12 there's, kind of, a number of things
13 that we will look at and have access
14 to; and you will be able to evaluate a
15 larger amount of data. And if they're
16 immature, you're going to have to
17 assess their effectiveness, you know,
18 pretty much based on, you know,
19 activity and churn and you'll really
20 only be able to look at -- really be
21 able to look at activities and
22 resources.

1 So, here are some of the steps that
2 people use in going into program
3 assessment. Wrong way. So, this is
4 kind of how the -- we're going to kind
5 of build this model for you. As much
6 of the data as we're getting, we're
7 going to be able to put in some bins
8 for you we call them. We'll be able
9 to give you some rough idea about the
10 resources going in to these -- these
11 programs. We'll be able to talk -- we
12 get a lot of activity data, don't we?
13 I mean, we were -- we were at Ft.
14 Benning; and at the ASFAC they had
15 this list of activities this long.
16 So, we get a lot of activity data.
17 We are getting, we're getting some
18 output data from some
19 of these programs. We really want to
20 look for in most programs, even if we
21 don't have it now, some day we want to
22 see outputs. And, I think, you've all

1 pretty much defined in your own heads
2 what an output is. It's -- it's the
3 accomplished recovered service member
4 with a job, with a healthy family
5 life, secured finances and an
6 individual kind of reaching their
7 goals. And, what's that?
8 MRS. CROCKETT-JONES: Outcome.
9 MS. DAILEY: Outcome, I'm sorry, the
10 outcome. The real outcome is that
11 model recovered service member
12 whose life is full and they're not
13 just surviving, they are thriving.
14 And do we really know if we've got
15 those outcomes yet? Now, I don't want
16 to put words in your mouth; but, you
17 know, it ultimately might be the
18 outcome we're looking for. For all
19 these programs, how does it contribute
20 to that vision? So, real quick, we
21 did this a couple of months ago. We
22 used IDES as kind of a model, because

1 believe it or not, we are getting a
2 lot of data on the Integrated
3 Disability Evaluations System. It's
4 being measured in significant ways.
5 So, we thought it would make a good
6 example for -- for us to kind of
7 demonstrate a product we're going to
8 give to you that will kind of help you
9 get your head around the effectiveness
10 of a program. And we had a lot of
11 data then in January, February and
12 when we do this we have a lot more
13 now. So, but as an example, so, I
14 have not updated this. We'll give you
15 a document that will have this type
16 of, of data on it. You'll have
17 legislated mandate for IDES; a
18 mission, you know, kind of a -- the
19 maturity of the program for example is
20 year old, two year old, what? What,
21 when it was kind of got off the
22 ground. A maturity self assessment,

1 and -- Suzanne I don't
2 remember self assessment. How are we
3 looking at self assessment?

4 MRS. CROCKETT-JONES: At the time, we
5 thought we would ask the program
6 representatives. I don't know if
7 that's actually going to materialize
8 that piece.

9 MS. DAILEY: Okay, all right. So, if
10 we have a self assessment from the
11 program, we would put what they think
12 their maturity is. And then the logic
13 model, fill in the logic model with
14 the answers to some of the research
15 questions that you've seen embedded in
16 the agendas and embedded in the
17 requests for information; and what
18 that would look like, and then an
19 information summary.

20 So, for example IDES -- here's our
21 legislative mandates for IDES. The
22 effectiveness of pilot programs and

1 the support provided to individuals in
2 the IDES two in fact that we were
3 trying to be, you know, access the
4 effectiveness of the support,
5 assessing the effectiveness of the
6 pilot programs. So, here's a Mission
7 Statements that we've, that they've
8 probably provided us or we understand
9 these programs to try and achieve, you
10 know, simplify it; reduce time; single
11 medical evaluations; seamless
12 transition; continuity of care. So,
13 these are the missions we're trying to
14 assess the effectiveness of. And
15 here's kind of an example where we
16 might be able to show you the maturity
17 of the program, some of the, some of
18 the bullets in their life cycle, so to
19 speak. Again, whatever information we
20 get on a self assessment. And then,
21 you'd see something like this, these
22 are the research questions that apply

1 to each one of the -- that applies to
2 each one of the logic model bins.
3 We'd put, you know, here the questions
4 that kind of represent an out, we'll
5 say an output. So, for IDES an output
6 would be what forms of support and
7 assistance are provided to recovering
8 warriors as they progress through
9 IDES. That's kind of an output
10 question. We, it's just a list of
11 things that support individuals, in
12 legal support, PEBLO support. So, an
13 outputer (phonetic spelling), that
14 where you capture all that. It's an
15 output question for our research
16 questions. An outcome question, which
17 is kind of where we want all these
18 programs to be, and what we really
19 want to measure, their effectiveness
20 against their outcomes. And we kind
21 of, and some of this is being sort of
22 jiggered a little bit; and you know

1 it's a subjective approach on what
2 research questions would go in what
3 bin. But in this last one here, when
4 outcome measure, how do you define
5 success; what is, how do you measure
6 success; or how do you measure DES;
7 how do you benchmark? These are
8 better outcome questions.
9 So, the next would be what, what are
10 kind of the answers to these questions
11 in the logic model. So, we've
12 collected this much data so far, this
13 is where we're kind of gathering data
14 that answers each one of those
15 research questions in each one of
16 those bins. And at the time, this is
17 -- this is what we could fill into
18 that bins, those bins, based on the
19 answers to those research questions.
20 So, we didn't have that much
21 information on resourcing going into
22 IDES. I think we have a lot more

1 resource information now if we talk
2 about number of PEBLOS. I'm not sure,
3 but I think by now I have a little
4 more resource information. We're not
5 -- in that resource information.
6 We're not counting, we're not counting
7 dollars. We haven't gone down the
8 budget road; but I think that, for
9 example, if we were to talk about
10 legal support. We had -- we got a lot
11 of feedback that legal support might
12 be insufficient, is that not what we
13 heard for example? So, in a resource
14 category we would, that probably get
15 plugged in, plugged in here for legal
16 support. So, here are the findings
17 that come out of each one of those
18 research questions plugged into each
19 one of those bins. Just for example,
20 outputs -- outcomes.
21 Let's talk outcomes. We know to a
22 degree based on the research data we

1 have that there's still
2 dissatisfaction with the MEB portion
3 of the IDES. So, we kind of start
4 getting in this program some outcomes
5 that give us a, give us a look at the
6 effectiveness. What are the other
7 ones here? Success measured in days
8 to compensate other administrative
9 data, as well as customer
10 satisfaction. Customer satisfaction
11 findings are coming from several
12 different sources that are
13 representing this outcome data as not
14 satisfactory. And today we saw some
15 of it from the Marine Corp. as they
16 talked about -- we call this an
17 outcome. Their data was showing that
18 the outcome is not a high level of
19 satisfaction with the MEB process.
20 So, that's the end.
21 Don't have a real strong wrap up for
22 you, but just want to familiarize you

1 with a product we want to help you,
2 give to you to kind of help you get
3 your heads around the assessing
4 effectiveness piece of your mission.
5 So, it's a whole lot of pages going
6 back and forth. And

7 I got Suzanne's hand up there, so, Suzanne?

8 MRS. CROCKETT-JONES: I was just going
9 to explain that this came about
10 through a meeting we had with Dr.
11 Guice several months ago; and the plan
12 at this point is to -- for each topic
13 to give you two documents. One will be
14 a detailed set of results organized
15 according to these bins; and then, the
16 second will be more of a top line
17 summary. And that way those of you
18 who want to drill down and deal with
19 that minutiae, will have that
20 available; and those of you who don't
21 want to, or perhaps not for each
22 topic, will be able to pay attention

1 to the summary document and use that
2 as the springboard for your
3 recommendations.

4 MS. DAILEY: And Dr. Guice also
5 provided us some pretty good training
6 modules coming out of the University
7 of Wisconsin, ma'am? And we have,
8 we've put that up on our website. It
9 takes you through the whole logic
10 model process, what they're used for,
11 background; and it is in your book, by
12 the way. So those of you flipping
13 past, this last one it's in your book,
14 it's a training module. Just want to
15 keep everyone's finger in that pie
16 that -- that's how we hope to kind of
17 structure the assessing effectiveness
18 task.

19 LT. GENERAL GREEN: The complexities
20 in the things that we're dealing with
21 is that, you know, the normal things
22 in term of the process that you look

1 at in terms of time and dollars are
2 not as important to us as the outcome.
3 And the outcome that we're really
4 trying to
5 look for is right time, right dollars
6 spent for the right condition. And,
7 you know, we are going to find
8 ourselves in, in kind of a fledgling
9 environment here, I think, because, at
10 least from what we've heard from
11 everyone that has briefed us so far,
12 they're only beginning to think about
13 collecting data on some of this.
14 And so it'll -- the other piece that I
15 still think we may want to go after,
16 and maybe the researchers have looked
17 at this; but if Walther Reed,
18 Bethesda, and the Warrior Transition
19 Unit up here has actual data on that
20 they've used to try and establish how
21 long it takes to treat different
22 injuries at least gets us to where we

1 have a ballpark to think about, well,
2 probably the right time for a single
3 amputee is roughly X; or it's going to
4 be very hard to get to dollars. But,
5 I mean, if you think about what we're
6 really trying to get to is we want to
7 is we want a high satisfaction with,
8 I'll say the right number of dollars
9 that have been spent to get somebody
10 to where they either are back to duty
11 or out to the VA system in something
12 that shows relative stability so that
13 they can move on with their lives.
14 And so, getting to that kind of
15 outcome is going to be complex.
16 DR. GUICE: Actually, Denise, do you
17 happen to have that URL that I sent to
18 you earlier this week when we were
19 talking on the phone. It's the one
20 that refers to the lower back pain
21 information. If you -- if we could
22 bring that up, let me show you a

1 resource that actually I understand
2 DOD has provided. I'm not sure about
3 the penetration of this particular
4 resource; but it does go through in
5 very lovely way -- including costs in
6 the private sector, in the public
7 sector for certain kinds of events
8 related to kind of Workers'
9 Compensation kind of thing. So it
10 goes through, you know, the, what low
11 back pain should be and how long it
12 should take to recovery, depending on
13 low usage of someone's back to barely
14 high strenuous usage of back; but it
15 goes through all the various
16 conditions that you can think of. And
17 it actually tells you about how long
18 it should take a recovery process and
19 how much it's going to cost. So, it
20 is one -- it's an additional resource.
21 I was totally unaware that it was
22 available and provided by DOD; but

1 again, I think it's a penetration
2 problem. We tend to provide a lot of
3 resources; and then we sort of forgot
4 where they are and maybe don't use
5 them to the full extent possible. But
6 this was a lovely one, I thought, and
7 particularly after the Army had just
8 presented to us about, you know, the
9 low back pain focus that they had done
10 -- started to work on.

11 MS. DAILEY: I don't have it; and
12 that's not wire capable, so I can't
13 get to the net. But I can send it
14 out, ma'am.

15 LT. GENERAL GREEN: But the other
16 problem you have is that you have two
17 physicians that are sitting up on this
18 end of the table, okay? And so, we're
19 thinking, you know, more medical in
20 evident space as to how we approach
21 this. And so for some of you who have
22 different, the question would be, "How

1 would you word an outcome"? And so,
2 perhaps individually, okay; because we
3 do this group thing, go get, we should
4 try and think about what are the
5 outcomes that we're really looking
6 for; and how would you put it into
7 words so that when we get together in
8 a future session, you know, in the
9 next three or four months, we could
10 actually be thinking about well what
11 are the outcomes that we really are
12 looking for? You know, everybody
13 comes from a different perspective and
14 so, you know, it's not necessarily how
15 rapidly you can get them to the end
16 game. It's really about getting to
17 the end game when they're ready to be
18 at the end game. And for some people,
19 that's even harder because they may
20 not want the end game to occur. And
21 so -- anyway, so think about it and
22 rather than do it as a group exercise

1 I'll ask each of you to kind of see if
2 you can write out what you think the
3 outcomes are that are really important
4 from a Wounded Warrior perspective,
5 okay, because we should be patient
6 centered here. What is it that if you
7 are a Wounded Warrior, that you really
8 -- I shouldn't not narrow it that far.
9 But Wounded, Ill or Injured what is
10 it that you feel is the outcome of
11 this process? And then, we can sit
12 down and now sometime we'll do with
13 the little yellow stickies with a
14 board and see if we can't come to a
15 compact consensus on the outcomes.
16 But, I think it's one of those things
17 that we probably would have been nice
18 to have even as with the end in mind.
19 So, don't put it off too long. Just
20 in your own mind, think about it, and
21 then we will work through it at one of
22 these sessions.

1 MS. DAILEY: That's pretty much all I
2 have ladies and gentlemen.

3 LT. GENERAL GREEN: Just for
4 everybody, I will not be here
5 tomorrow. Originally, it was because
6 I was going to be going in to do a
7 commissioning ceremony for my
8 daughter. She's been delayed in that
9 process, but I've got to go out of
10 town for a death that occurred. I'm
11 going to be attending that service, so
12 Karen you have it tomorrow, okay?
13 Thank you and forgive me for not being
14 here. This will be the first session
15 I'll miss, but I apologize.
16 And I think we're adjourned. Thank
17 you everybody.

18 Whereupon, proceedings were concluded
19 at approximately 4:27 p.m.

20 CERTIFICATION OF TRANSCRIPT

21 I certify that the attached transcript
22 of the

1 DEPARTMENT OF DEFENSE TASK FORCE took
2 place on March 30 in the year of 2011
3 in Maryland.
4 I, the undersigned, do certify that
5 this is a true, accurate and complete
6 transcript prepared from the
7 electronic recording taken by Mark
8 Mahoney of Beta Court Reporting on the
9 aforementioned date and that I have
10 verified the accuracy of the
11 transcript by comparing the
12 typewritten transcript against the
13 verbal recording.

14 Mark Mahoney
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