1 U.S. DEPARTMENT OF DEFENSE
2 DEPARTMENT OF DEFENSE TASK FORCE
3 ON THE CARE, MANAGEMENT AND TRANSITION
OF RECOVERING WOUNDED, ILL AND INJURED
4 MEMBERS OF THE ARMED FORCES
(the Task Force)
5 Washington, D.C.
6 Thursday,
7 March 31, 2011

8 U.S. Department of Defense

9 Gaylord National Resort and Convention

10 Center

11 201 Waterford Street

12 National Harbor, Maryland 20745

13
APPEARANCES:
14
Non-DoD Task Force Members Present:
15
Dr. Karen S. Guice, M.D., M.P.P., Non-DoD Co-Chair
16 Mr. Justin Constantine
Mr. David K. Rehbein
17 Ms. Suzanne Crockett-Jones DoD Task Force Members

18 Present:

19 Major General Karl R. Horst
Major General Richard S. Stone, M.D.
20 Master Sergeant Christian S. MacKenzie
Commander Timothy A. Coakley, M.D.
21 Lt. Col. Sean P. Keane Staff Present: Denise F.

22 Dailey, PMP, Executive Director Larry Nisenoff,

1 MBA, PMP, Director of Operations James B. Wood,
2 Records Manager Lakia Brockenberry Philip Karash
3 Stephen Lu Bella Gonzales DeQuetta Tyree Phillip
4 Karash Heather Moore John Booton
5 * * * * *
6 P R O C E E D I N G S
7 MS. DAILEY: Good morning, ladies and
8 gentleman. Can I bring the members to a table
9 please? We won't be starting the Navy briefings
10 until 9:15 so you guys don't have to sit there if
11 you don't want to. We are going to be -- I don't
12 want you to feel like you are in the spotlight or
13 anything, but we are going to be -- you are going
14 to be kind of the guys behind the curtain back
15 there, okay? We are going to start with some what
16 I would consider committee business. We would
17 like to spend this hour or at least twenty minutes
18 of it depending on your level of interest, talking
19 about the upcoming report and recommended report
20 outline. And we also have the report timeline
21 which we want to start discussing and to put
22 before you for your comment and guidance. So do I

1 have everyone that I am supposed to have? I know
2 that at times I don't have some and other times I
3 do have some, so --
4 UNKNOWN FEMALE: Suzanne is here.
5 MS. DAILEY: So she is here. Okay, well we
6 are going to just kind of warm up here I guess
7 that is what we call these time periods, a warm
8 up. Suzanne is going to talk with us about
9 recommended report outlines, so I am going to put
10 her up in front of the podium there for you and we
11 will go from there.
12 DR. LEDERER: Good morning. You all had
13 some discussion -- began a discussion yesterday
14 about how to structure the report and what it
15 should include. This proposed outline, this
16 structure for the report, has been in the works
17 for several months actually. There have been
18 several iterations of it, and it's based -- it
19 doesn't come from thin air. It's based on several
20 preexisting reports that have come recommended to
21 us such as the Dole-Shalala report, the report of
22 the Task Force on Mental Health, and several

1 years' worth of DACOWITS reports so it is sort of
2 a hybrid but formed by those reports; also
3 informed by the requirements spelled out in the
4 legislation. So that is how we came up with this
5 structure and since you don't have hard copies
6 perhaps I could walk you through this. We provide
7 it as a basis -- as a springboard for discussion.
8 Hopefully it will help you to decide how you want
9 to structure your report. I should mention though
10 that because of a constrained work time table this
11 year for all of us, we also have a constrained
12 report generation time line. The staff, we would
13 like to get started on drafting some of this front
14 matter soon. Okay, so there is the usual
15 preliminary material -- transmittal letters if you
16 choose to include them, signature page, obviously
17 table of contents and then the first three
18 chapters are front matter. They are build-ups,
19 some context. The first talks about the task
20 force, the genesis, the structure of the task
21 force. The second is more substantive about the
22 continuum of Recovering Warrior Programs at DOD

1 that the military departments have stood up,
2 particularly since 2007. The third chapter is an
3 overview of how the task force this year has gone
4 about executing its mission, you know, how you
5 have gathered information and then from whom, and
6 how you are using this to assess effectiveness.
7 Then chapter four is where it is -- where the
8 substance is introduced. If you would scroll down,
9 Steven? That is great. Chapter four would be
10 summaries of the integrated results for each of
11 the mandated topics that you are looking at, and
12 we would be providing you these in the draft
13 report. You in turn would then use those as well
14 as your recollections and your impressions and
15 your notes to generate chapter five. Chapter five
16 is where the rubber meets the road. If you will
17 scroll again, Steven? Chapter five is where --
18 what is most important from those results is
19 identified and prioritized and expressed how you
20 want to express it, what you want to convey to the
21 Secretary of Defense and Congress that came out of
22 your year of research. This would be your

1 findings, your conclusions, and your
2 recommendations. It may well be that you want to
3 make this chapter 4. You may want to leave with
4 this. You may want to put the more granular
5 results for topics A through Q in an Appendix for
6 example. That would streamline your report.
7 So I thought going into this discussion is that we
8 would
9 organize this chapter, which by the way is what
10 you would be working on at the end July meeting
11 primarily. We would organize this chapter
12 according to the four focal areas that Lieutenant
13 General Green introduced a number of months ago.
14 Those would be results for B, C, D, and E. You
15 see B, C, D, and E, and under each of those
16 headers you would identify your strategic findings
17 and conclusions, your best practices and lessons
18 learned, and of course your recommendations. If
19 you will scroll up, Steven, at the beginning of
20 chapter five, we thought you would want to perhaps
21 do an overarching look at the overall
22 effectiveness across these four focal areas. And

1 particularly, that is where you could identify
2 issues that transcend these four focal areas and
3 are not focal area specific. One example might be
4 the discovery in your data gathering that there is
5 a relative scarcity of outcome assessment going
6 on. That is a finding that doesn't pertain
7 necessarily to restoring wellness, optimizing
8 ability and so forth. So that is chapter 5.
9 Scroll please, Steven? Chapter six is a
10 requirement of the legislation to describe the
11 plan for the subsequent research here. What are
12 you going to do the same or different next year as
13 compared to this year? We will draft that for you
14 and you will hopefully, I am sure, tweak it and
15 make it your own. Our thought was that we would
16 call upon what we have heard you say formally and
17 informally over the past several months at these
18 meetings and perhaps on site. We would try to use
19 what we bill as important to you going forward, as
20 well as some of our own thoughts and we would talk
21 about the methods that would be used. For
22 example, perhaps you would like to leverage Quick

1 Compass which is the Defense Manpower Data
2 Center's rapid survey methodology that would allow
3 you to gather quantitative data from a much larger
4 sample than we have been able to touch this year.
5 So this research plan in chapter six would look at
6 methodologies that you might want to pursue as
7 well as substantive areas you might want to
8 pursue. I have heard some talk of maybe we need to
9 hone in on Guard and Reserve issues, for example.
10 Issues related to being remotely located from base
11 services, perhaps gender issues, and so forth. So
12 that was our chapters one through six. We would
13 draft all by five for you. When we submit draft
14 number one, it would be fairly complete except for
15 that chapter five which is your findings,
16 conclusions, and recommendations based on the
17 results. The Appendices, those are pretty pro-
18 former. Most of them are very obvious you know
19 the legislation, the member bios, charter, a list
20 of the business meetings that took place -- you
21 may or may not want to include the reference
22 handbook -- that would be E. You may or may not

1 want to include J -- survey data tables. Those
2 are the item by item frequency tabulations for the
3 two mini surveys. We will summarize pertinent
4 results in the body of the report, but you may or
5 may not want to include that level of detail in
6 the Appendix. So, I am sorry that you don't have a
7 hard copy in front of you.
8 GENERAL STONE: Could you please scroll back
9 up to four, please?
10 DR. GUICE: My first impression in looking
11 at this is that it is a very task force commission
12 outline and very concrete. I think that to me the
13 entire thing that we are focusing on is chapter 5,
14 and I would like the report to be chapter 5. The
15 rest of this stuff is supporting documentation
16 which can live on our website and be added to. I
17 don't think it adds a lot of value to a report. In
18 fact, what it does is it increases the poundage of
19 the report and in my experience, the fatter the
20 report the less likely it is going to get any kind
21 of 'umph' -- people aren't going to read it. You
22 know a 500 page report, people are going to look

1 at and go "Oh, I don't want to read this". If we
2 make it 20 to 30 pages of meat, this chapter 5.
3 What if we find -- and keep the rest of the
4 administrative kind of information very thin and
5 at the minimum necessary to put in a report like
6 this. I think that that is going to be the best
7 strategy for getting one, attention and two,
8 letting people read it and digest it knowing that
9 they can go find the documentation, the back-up,
10 the -- I don't think that any of us feel like our
11 bio's need to be in the report. They are on the
12 website so you know -- using our electronic
13 capability of providing that ancillary information
14 to me is makes some of this written report totally
15 irrelevant anymore. But I would like to hear what
16 the rest of the members think.
17 MASTER SERGEANT MACKENZIE: I concur with
18 that idea. The fact that -- let's give them
19 something they are going to read, are willing to
20 read, and are energized to read. Not something
21 that is going to sit on a bookshelf somewhere or
22 "I'll get to it later" or maybe one of my staffers

1 can read me about it and give me cliffs notes.
2 GENERAL STONE: It comes for example, I
3 think we all agree with the fact that we need to
4 go -- everybody will go to the findings
5 recommendations anyway and our bio's they will not
6 spend a lot of time with I am quite sure. I think
7 the question we have is we have looked at delivery
8 systems from each of the services. Clearly we
9 opened with the Defense Center of Excellence, and
10 what the Defense Center of Excellence's attempt I
11 think to get at was "How do you move basic
12 research onto clinical knowledge and get that to
13 the bedside of Wounded, Ill, and Injured?" I am
14 not sure in this structure we really apply
15 sufficient focus to how long it takes for issues
16 regarding new disease processes or newly
17 recognized disease processes to correlate into
18 adequate treatment for our Wounded, Ill, and
19 Injured and specifically some of the testimony
20 that we have heard regarding TBI, Post Traumatic
21 Stress -- the issues regarding Post Traumatic
22 Stress Disorder, how those issues are approached

1 by the different services. I think we would be
2 doing the report a disservice and those who have
3 empowered us to give this report a disservice if
4 we didn't concentrate on the front end as much as
5 we did on the issue of what is bedside care and
6 what is the reintegration processes. In my
7 initial look at this, I am concerned that we don't
8 adequately capture that.
9 DR. GUICE: Would that be something though
10 that could be worked -- if we just focus on the
11 chapter five outline, because I think that is
12 really where we want to focus our efforts here.
13 But part of that is in as you develop policies and
14 programs, that is part of that really intensive
15 end front, up front part that people don't
16 necessarily pay attention to. Maybe to put it
17 into that part of the -- we don't -- I agree with
18 you. I don't see a natural home for it anywhere
19 else, but there in terms of strategic findings and
20 conclusions I think that kind of fits within that
21 framework right there.
22 GENERAL HORST: I would offer another

1 consideration. If we did the full report as is
2 proposed, that would serve as the body of work for
3 perpetuity but I think that deliverable -- I agree
4 with Dr. Guice's chapter 5, so we do the large
5 complete report with all of the chapters, all of
6 the appendices, and then what we deliver is an
7 executive summary which is chapter 5. So there is
8 long version, short version. They are going to do
9 the work, whether they hang it on the web or
10 whatever but there is the complete one -- but the
11 deliverable ends up being our executive summary to
12 the Secretary and to Congress because that is
13 really what people are going to read is the
14 executive summary. Then if there are questions
15 about -- you can either go to the web or go the
16 complete document but chapter five is the meat
17 where people ought to focus their attention and
18 where we are rightly focusing.
19 DR. GUICE: I think we are saying the same
20 thing. You know, the deliverable to me is chapter
21 5. The rest of it is supporting material, and it
22 has to exist because we have to document what we

1 did. We have to document how we were chartered.
2 We have to document who we were. We have to
3 document all of that stuff but whether that exists
4 in a -- whether this is the deliverable, and this
5 is the backup document. If this lives in paper I
6 think that would probably be a waste of paper. In
7 my own personal opinion, I think people can look
8 at it on the website but the deliverable is
9 chapter 5. There needs to be a very thin, brief,
10 this is what we were chartered to do, this is what
11 we set out to do this year, this is how we went
12 about or business, but here is what we found. The
13 other thing that I will take a lesson from the
14 Dole-Shalala report because I think the
15 interesting thing about that -- there were a lot
16 of task forces, commissions, and groups stood up
17 in a very quick time frame to do it. The one that
18 continues to be mentioned however, is Dole-
19 Shalala, and you have to kind of go back to why is
20 that? I think because the recommendations were
21 crisp, there weren't 500 recommendations, there
22 were a handful. And at the very back of that

1 document was a "who needs to do what" matrix. I
2 think that is something that we probably ought to
3 think about as well for this because I think it
4 clearly lays out where we see the accountability
5 and where we see the who needs to do what
6 checklist, and it just cuts to the chase a little
7 bit. It gives you a measurable thing to kind of
8 look at, so I would think that that was a very
9 beneficial thing out of that particular report.
10 But short, snappy, useful, something that you can
11 -- you don't need a wheelbarrow to --
12 DR. LEDERER: Sure, of course.
13 DR. GUICE: -- pull around, I think is
14 really what we need to focus on and something that
15 people are going to read, understand, get, and be
16 able to go "Yes, they are right and let's go take
17 care of it".
18 DR. LEDERER: Helpful. Thank you. What do
19 we -- what does the product that we will provide
20 you on July 15th, this draft one, what does that
21 product look like? What is the structure, if not
22 this? Just need some guidance so that we can be

1 responsive.

2 MS. DAILEY: I think what we need to do is

3 we will -- next meeting we will rejigger this and

4 we will come back with another one that looks

5 different and incorporates your guidance, puts

6 chapter five up front, and so we will put a

7 proposal in front of you then. This is just kind

8 of starting the discussion. We have -- we are

9 there in that I am going to take your guidance and

10 I am going to rejigger it and all the pieces are

11 there, ladies and gentleman. We just need to put

12 it in the format you think is going to bring your

13 salient points to the top immediately.

14 DR. GUICE: Can you scroll back up to the

15 very top. I think you can already -- it is not

16 that -- you don't need to toss this away. I think

17 what you have here is you have captured buckets of

18 information that I think we will need to see and

19 look at so that, you know, the introduction. You

20 know these can be part of that backup document.

21 So to go ahead and develop those and what we would

22 do is we would take out the pieces that are

1 relevant for that shorter document and move them
2 up front like you would in a -- I see this as a
3 little bit more than an executive summary -- but a
4 little bit more meaty executive summary. So those
5 things could already be developed and passed
6 around to us even certainly I would think chapter
7 one, we could see that by the next meeting, and
8 chapter two that is pretty straight forward as
9 well, and chapter three -- we could already have
10 those provided to us by the next meeting for
11 looking at, reading and agreeing with. I think
12 that would help you to go ahead and get what you
13 need to get done -- done.
14 DR. LEDERER: Sure.
15 DR. GUICE: And in a way where we can help
16 you with getting the easy stuff out of the way
17 quickly.
18 DR. LEDERER: Yes.
19 DR. GUICE: Does that help?
20 DR. LEDERER: Yes, and well we did intend to
21 get the front matter, whatever that may be, out of
22 the way early to allow time to deal with the hard

1 stuff in July. Do we have time to take a quick
2 look at the time table?
3 MS. DAILEY: Yes, but Suzanne?
4 DR. LEDERER: I'm sorry. MS. CROCKETT-JONES: I
5 just wanted to say that I think the only thing we
6 are asking that is going to be extra to all of
7 this work is a summary of it to put with the
8 deliverable. You know a summary -- a short
9 version of this supporting information. The only
10 thing that is going to require extra -- you know
11 everything is here; it is really worth talking
12 about taking something out of it as a deliverable.
13 DR. LEDERER: Yes. Yes. MS. CROCKETT-
14 JONES: So that the only thing that will be in
15 addition will be a summary of the supporting stuff
16 to go with the deliverable. So I think that you
17 are right, this can -- you can begin on this
18 assuming this is a reasonable start. I don't
19 think you need to rework it much. You know, I
20 don't think that's -- at least that's the way it
21 seems to me.
22 MS. DAILEY: Our development of chapter five as an

1 outline for you is important and where it goes
2 versus one, two, and three, where it goes versus
3 one, two, and three should be defined a little
4 better for you, so and remembering will also help
5 you get your head around what it is going to look
6 like. In creating the outline for you based on
7 your guidance by May, will be helpful for you in
8 July. You will know -- be able to step right into
9 findings and recommendations versus trying to
10 wonder about "Well should one go here, and two go
11 back here".
12 DR. LEDERER: May we move on to time table?
13 Steven, we will go ahead. Okay. As I mentioned
14 earlier, it is a very ambitious time table. There
15 are external factors that are driving this that
16 are compressing all of us. So, at the next meeting
17 we will provide you -- and this is just look and
18 feel -- we will provide you two styles, two
19 layouts to consider and select. On July 15th is
20 when we will generate this first draft -- Dr.
21 Guice, you look --
22 DR. GUICE: No, I am just looking at the --

1 sorry, I will turn my mic on -- the time between
2 July 15th and July 26th is 10 days. So for us to
3 get the entire first C draft and get back
4 substantial edits, concerns, comments in 10 days
5 -- I would like the rest of the task to -- to me
6 that is a tall order and I wonder if there is a
7 way we can one bite at a time a little bit more,
8 and maybe we want to go back to our structure with
9 the members identified and associated with one
10 topic area and have a little bit more of a -- let
11 them take a first -- but I am not sure that is
12 going to fit within that time frame. I am like
13 you, it is an aggressive time line but I am a
14 little worried about the compression of it.
15 DR. LEDERER: And that is why we are
16 presenting it, because as I say there are
17 considerations that are out of our control. The
18 report is due September 2nd. Our understanding is
19 that we need to have the camera ready by August
20 19th and so we are working between July 15th and
21 August 19th. I believe Ms. Dailey's plan, and as
22 we talked about it together, was to circulate the

1 draft -- and again, you will already have seen as
2 we have just talked about -- you will already have
3 seen the front matter. But what will be new to
4 you hopefully will be the meat. So we will
5 circulate that on July 15th and encourage you to
6 become very intimately familiar with it and to
7 individually and perhaps collaboratively, perhaps
8 in the four groups, work up your edits and your
9 findings and your recommendations so that when you
10 come together for the July 26th-28th meeting a lot
11 of that work would have been completed. But Dr.
12 Guice I hear what you are saying which is "that
13 there's just not enough time".
14 DR. GUICE: I'd ask everybody else to
15 comment on that. That is my own, I looked at that
16 and went "Whoa"! But how do you guys feel and
17 what is going to be the best way to approach this
18 knowing that we actually have to have final
19 product by the 19th and a lot of stuff has to
20 happen that gives the team what about three maybe
21 four weeks and print, final print.
22 DR. LEDERER: Between the July meeting and

1 August 19th, there is an interim draft at least as
2 currently envisioned. There is draft two which is
3 to be complete on August 10th. Ms. Dailey, do you
4 want to talk about what you had in mind to do with
5 that particular version?
6 MS. DAILEY: Yes. We do need to float it
7 among our various services. I need to get a copy
8 of your findings and recommendations, we need to
9 see it, the services -- I can, one way to compress
10 this time frame is during your deliberations,
11 during your findings and recommendations, they are
12 here, we invite them, they can provide input. So
13 that helps us get feedback from them. Keeping
14 them in mind, you are an independent body and if a
15 service says "we don't agree with that", you get
16 to say "that's okay that you don't agree with
17 that, this is our finding and this is our
18 recommendation". So we do need to have them in
19 the mix with you, but by mid-August, earlier than
20 that, they need to have what you are going to go
21 to the DOD with. So we have to informally staff
22 it.

1 GENERAL STONE: As a member of the DA staff,
2 I am sure none of the services are like this --
3 once we begin staffing things, it is extraordinary
4 what comes back. Not sure that the staffing
5 process will provide substantial value to our
6 deliberations. I am extraordinarily respectful of
7 all of the services staffs, but we have had a
8 chance to hear from the services for six to eight
9 hour briefings on their approach to Wounded, Ill,
10 and Injured care. They will have a long time to
11 respond to this after we release our report. I am
12 not sure how additional staffing and input back on
13 proposed recommendations would inform us in a
14 broader manner. I don't know if anybody else
15 feels different about that but I think that our
16 independence from staffing processes would allow
17 us to be informed in a better manner.
18 DR. GUICE: For me, the only value of asking
19 the services to look at it would be to make sure
20 that we have our facts correct. It would be a
21 fact thing, not as a comment back on our
22 recommendation because we do have that

1 independence. I think once you start trying to
2 staff it with the services, I mean, that is a
3 whole chunk of time that it is just really not
4 built into your schedule either. I think to do
5 that would strike me as being a step away from our
6 independence, and I think that is not what
7 Congress intended. So, if what we want to do is
8 invite them to review our findings, our basic
9 findings, to make sure our facts are correct then
10 I think that is a level of input that I would
11 value just because we don't want to be wrong. If
12 we have misspoken or misunderstood something we
13 would want that clarified, because that might have
14 an impact on a recommendation and we would want to
15 know that I would think. So it is our due
16 diligence kind of part of it, but in terms of
17 having them concur on the recommendations before
18 they are actually recommendations or to say that
19 they don't agree with them, their chance to do
20 that is once the recommendations are done. That
21 is a more typical approach anyway in my
22 experience.

1 MS. DAILEY: You all just made my day. I
2 have had people come in and say "you know you
3 really need 60 days to go in and talk to the
4 services about this and massage it with them", and
5 I am going "Oh my gosh", but if that is really not
6 where you want to go I am -- we will put it out
7 there and then like you said they get their three
8 months afterwards.
9 LIEUTENANT COLONEL KEANE: There seems to be
10 a lot of work that needs to be done between now
11 and September. Is there any reason why we
12 couldn't meet in June? Roll up our sleeves and
13 knock it out?
14 MS. DAILEY: We will not be -- we are going
15 to be in the process of analyzing the data in
16 June. I don't know how much rolling up of your
17 sleeves you really are going to have product to do
18 that on in June. I will not be in the gathering
19 data mode. I mean we can do a meeting in June
20 which would get us ready for next year, but as far
21 as doing work on this year because of the
22 shortened time frame, we need that time to write

1 it, to analyze the data, to synthesize it.

2 DR. LEDERER: Could I chime in on that? It

3 would be helpful. I don't know that a whole

4 meeting is necessary, but it certainly would be

5 helpful for you all to have the opportunity to

6 talk about what you want to do next year. So, that

7 is one good reason to me to --

8 GENERAL HORST: I think we have got to get

9 through this year before we lay the ground work

10 for next year. I mean why --

11 DR. LEDERER: Except that Congress, sir, would be

12 addressed in the report.

13 GENERAL HORST: Well I would recommend that

14 we meet maybe in August to do that. I just have

15 to tell you June is a really bad month for

16 everybody, because the music starts and the chairs

17 get vacant, and moving vans come and yes, there is

18 --

19 DR. LEDERER: PCS season.

20 GENERAL HORST: -- June is not a good time.

21 DR. LEDERER: Okay.

22 GENERAL HORST: But if we want to meet a

1 second time in July or in early August that would
2 probably be a little bit better, but I think that,
3 I mean, we can develop where we want to go next
4 year but our priority needs to be the body of the
5 report.
6 GENERAL STONE: I am not sure I agree with
7 that approach.
8 I think the difficulty is until you begin to put
9 this
10 report together with some strong recommendations,
11 it will be difficult to inform our future work to
12 see where our data gathering left some holes for
13 year two, and secondly, where with the complexity
14 of the recommendations, how quickly can the
15 services and DOD respond to that and then to begin
16 to gather additional data to see what kind of
17 progress has been made. And so to do an informed
18 approach to year two, I think you have to begin to
19 see what the recommendations are from year one and
20 I think all of us have some opinion of where we
21 think parts of this are going to go. But I don't
22 think we are at the point until the end of July to

1 really begin to define year two work.
2 MASTER SEARGENT MACKENZIE: One of the
3 things I see, obviously, it is nice to have a
4 forum like this but as we have already started to
5 change things as we are talking about getting some
6 of the supporting documents out by the May
7 meeting. The timelines that are listed in here,
8 if stuff is ready to go before this timeline we
9 ought to be more flexible to say "hey, let's
10 release -- you know we have chapters one, two, and
11 three, or chapters A, B, C, and D completed", we
12 should get it out to you guys.
13 DR. LEDERER: Yes, this is already obsolete.
14 MASTER SEARGENT MACKENZIE: Yes, the
15 schedule itself is already obsolete until we get
16 our hands on it, as we found with the focus group
17 guidelines. We are not going to know exactly
18 where this is going to go but I want to say that
19 whatever we come up with it needs to have some of
20 that flexibility that we don't need big chunks.
21 Small chunks is going to effectively help us as we
22 are getting closer to those timelines. What we

1 can get our hands on will help us. I mean, if we
2 start receiving stuff in the first of July, we are
3 not getting 100 pages on July 15th.
4 DR. LEDERER: Sure.
5 MASTER SEARGENT MACKENZIE: We are getting
6 25 pages every week with a due date of the July
7 26th-28th meeting, so that will help us with that
8 I think.
9 MS. DAILEY: So for example, if you had IPO
10 on chapter four. Yes, let's use Defense Center of
11 Excellence. If you had Defense Center of
12 Excellence topic done, from chapter four in May
13 let's say or the end of May, could you push that
14 out and send it out to the members?
15 DR. LEDERER: Yes, as a matter of fact there
16 are some topics that don't involve focus group
17 data. They are not addressed on site like that.
18 So those topics I think we can wrap up the
19 integrated results earlier, and we can plan on
20 delivering those sooner.
21 MS. DAILEY: So that kind of takes big
22 chunks out of -- it would be great if I could

1 deliver like all of "Optimizing the Future" or all
2 of "Restoring Abilities", but you may only get two
3 out of Restoring Abilities and -- but based on
4 that you can start wrapping your head around what
5 is in there and pulling recommendations together
6 as you get them.
7 DR. LEDERER: This is helpful to us. Thank you.
8 MS. DAILEY: I just want to wrap up your
9 findings and your recommendation. Chapters one,
10 two, and three in your estimation really kind of
11 need to be pretty minimal?
12 They might just be only an introduction, so we are
13 really only talking about an introduction before
14 we hit what would be a chapter four which is a lay
15 down of each topic and then chapter five which is
16 synthesizing it into the four groups.
17 DR. GUICE: Can you -- do you mind -- can
18 you switch back to our outline and go down to
19 chapter 4? So chapter four to me, you know 30
20 pages of results, I would want -- I think for this
21 particular report to try to put the capsule the
22 results. We obviously will have more results but

1 they should all support our recommendations. So I
2 almost think that it is a blend of four and five
3 instead of two distinct things that you -- the
4 recommendation to do blank is based on the
5 following results and observations so that we use
6 the results as supporting our conclusions and not
7 separate them like that. I think if you separate
8 them, to me it is easier as a reader if I can see
9 the recommendation and the rational, and the data
10 that drove that recommendation in one place. I
11 don't have to remember, oh and because we bend
12 them a little differently in chapter five, then I
13 know you are -- the need to kind of do it this way
14 is probably based on the legislation, but those
15 can all be the supporting -- the Appendix or the
16 backup pieces of it. But, I would really like to
17 see the results woven in to chapter five and make
18 it just the report.
19 DR. LEDERER: Yes, yes. When we present
20 chapter five to you presumably in July, parts of
21 it -- we will present what we have already
22 provided to you earlier because some of these

1 items DCOE, IPO, we may be able to provide you
2 with the results earlier and if so we will, but in
3 July when we present chapter five to you, we will
4 include the ones we have already presented to you
5 as well as anything new and they will be embedded.
6 The results now instead of being presented
7 separately will be embedded under the respective
8 four topics. Sure.
9 DR. GUICE: Is there any way for you all --
10 I am sure you have probably already started this
11 because the results -- we have already started to
12 accrue results and findings. Are you starting to
13 develop the data tables already based on the
14 preliminary findings that we have and the
15 preliminary results and if so, would there be a
16 way for you to just continuously feed us that
17 information and update as we -- you know they are
18 all going to be draft documents but building
19 information. I think that might help us as we
20 start to think about are we seeing consistencies,
21 are we seeing -- you know, and developing our
22 little compendium of good ideas -- that we have

1 those documents started now and start to circulate
2 those even as a rudimentary draft just for us to
3 see that.
4 DR. LEDERER: We are beginning to gather the
5 results from different sources in one location for
6 each topic and we actually are gathering them
7 under the logic model bins, but it's very messy
8 quite honestly. It is not something that at this
9 stage would be useful to share with you. When
10 those get to a more coherent stage, we could share
11 those. What we also can do is I would say toward
12 the end of May, we can provide you the
13 consolidated, analyzed focus group data which I
14 think will be very helpful to you. It will all be
15 very familiar but it will have all been
16 systematically analyzed across all of the focus
17 groups and the best practices will be called out
18 in the strong themes and even the lesser themes
19 with supporting quotations. That would be
20 helpful, yes.
21 DR. GUICE: I think that would be
22 extraordinarily helpful and I hate to push you,

1 but again going back to that time schedule, could
2 you have a significant chunk of that for us in
3 May?
4 DR. LEDERER: Are you talking about the
5 focus group? Yes.
6 DR. GUICE: Yes.
7 DR. LEDERER: Yes, that would be our plan.
8 The focus groups in at the end of April and yes, I
9 would say that toward the end of May we should
10 have that available to you. We will make it a
11 goal.
12 DR. GUICE: Perhaps even by the May meeting?
13 DR. LEDERER: You are negotiating with me?
14 DR. GUICE: I am.
15 DR. LEDERER: Yes. We will make that a goal.
16 DR. GUICE: Excellent. I think that --
17 MS. DAILEY: Suzanne, you just committed
18 yourself to having the focus groups done by the
19 May meeting.
20 DR. LEDERER: That is May 25th.
21 MS. DAILEY: That is May 18th and 19th.
22 DR. LEDERER: I thought it was May 25th.

1 MS. GUICE: You can get it as far as you can and
2 hopefully it will be done, but it would be great
3 if it could be.
4 DR. LEDERER: Yes, we will have something
5 that will be of use to you. It may not be the
6 finished product. Okay?
7 DR. GUICE: I think most of us would
8 appreciate even a narrative complete draft.
9 DR. LEDERER: Okay. This is not -- ma'am,
10 this is not narrative. This is a very detailed
11 outline of results, okay?
12 DR. GUICE: Anybody else have any other
13 comments or --
14 MR. REHBEIN: Let me clarify something in my
15 own mind if I could. Chapter five, when we come
16 to the July meeting, each of the four groups, what
17 do you anticipate a group bringing to that
18 meeting? A set of bullet points on our
19 recommendations that we've worked out between
20 ourselves, or will there be time at the July
21 meeting to do that then, or as a third alternative
22 and this one requires a lot of work, an actual

1 draft of our three or four page recommendation.
2 What is the anticipation there? Because if that
3 last alternative is what we are really looking for
4 for each of the groups to bring in a draft, I am
5 not sure that the 15th provides enough time. I
6 have worked on those kinds of projects before with
7 people spread all over the country and circulating
8 materials and finding time in work schedules in
9 those kinds of things. So if a draft is what you
10 are anticipating, I think we need to massage that
11 date a little.
12 DR. GUICE: Denise and Suzanne, between the
13 May meeting and the July meeting, would there be
14 opportunities -- because you will, by the May
15 meeting, have a fair amount of preliminary stuff
16 pulled together.
17 DR. LEDERER: It will be the focus group
18 data as opposed to the many other sources of
19 information.
20 DR. GUICE: But it will be a start.
21 DR. LEDERER: Yes.
22 DR. GUICE: So between May and July, is

1 there a way to have the four groups meet by
2 conference call two or three times to kind of
3 start to really pull together the information so
4 that we can have a written product by July with at
5 least some specs out there? But I think that
6 there needs to be a significant commitment of time
7 from the task members between May and July in that
8 format there that we've divided into those four
9 groups to really focus on the areas in there based
10 on the data that we have and the data that we will
11 have the analysis ongoing.
12 But still certainly by the 1st of June -- into
13 June,
14 your team should have a pretty good idea of what
15 the analysis is starting to deliver and feeding
16 that back into sort of a subcommittee structure
17 before that July meeting I think would probably be
18 a useful thing. I agree, I think it is hard to do
19 but if we don't have sort of a strategy and a plan
20 and a focused effort of two to three or whatever
21 it takes of the subgroups before July, we won't --
22 we will get to July and go "Hmmm".

1 GENERAL STONE: I think you are right. I
2 think if we can get all of the data together in
3 May, spend June working in our subcommittees --
4 Dave, unfortunately I think we are going to have
5 to bring a draft back. I mean if we leave this as
6 bullets, it will be open to interpretation by our
7 professional writers that I am sure will come back
8 and say "Oh you didn't capture what I was really
9 thinking". So I think you have got to come back
10 with a draft from a June work that then begins
11 coming out of the subcommittees in July, so that
12 the whole committee can really begin to chop on
13 it. I know that that is the most intensive work
14 product, but if this is in fact going to reflect
15 our thought process I think it has to be generated
16 from us.
17 DR. REHBEIN: And I agree with you General,
18 I think just amongst the three of us it will take
19 several iterations to get agreement between the
20 three of us before we submit to the full task
21 force. I agree. I believe that the draft is
22 required. I just want to make sure that there is

1 enough time to fit it into everyone's schedules
2 and get a good draft agreed on before then to
3 bring with us.
4 DR. GUICE: And I think between May and the
5 July meeting -- okay, I am going to ask you to
6 flip back now to the schedule, sorry. So between
7 May 18th, between the 20th when we leave because
8 that is really when we would start -- so between
9 the 20th and the 26th -- two to three subcommittee
10 meetings to develop those recommendation out of
11 each of the subgroups? Is that what we would be
12 committing to do? As task force members as well,
13 and our research team will be there with us. So
14 it will be sort of push and pull to get it done,
15 but you know this is -- we are time bound and we
16 all know why. So, we need to make a real focused
17 effort during then to make it happen.
18 So Denise, I think you've got a commitment from
19 the task
20 force members as frequently as needed on
21 conference calls between May and July to focus on
22 each of the four subgroups to come back with a

1 pretty good set of recommendations out of the
2 subgroups to the full committee at the end of that
3 July meeting, and actually some work product.
4 MS. DAILEY: So on the 15th, we will provide
5 you a draft of the other portion of the report and
6 between 15 July and 26 July, you will basically
7 re-tweak your draft any to ensure that what is in
8 the report is sinking up with your
9 recommendations, sinking up with your drafts, and
10 we would vote -- we would rejigger basically 25,
11 27, 28 July and vote. When you walk out of the
12 report on the 28th of July, a three day meeting,
13 you will have a voted on draft. The draft may
14 change, but the recommendations do not change
15 after you all raise your hands.
16 DR. GUICE: Everybody agree with that?
17 MASTER SEARGENT MACKENZIE: Yes.
18 MR. CONSTANTINE: Yes.
19 DR. GUICE: Okay, excellent. Thank you.
20 Suzanne, thank you and thank your team for all of
21 the hard work that you are going to do here for
22 us.

1 DR. LEDERER: It is an honor.

2 DR. GUICE: Okay, it is almost nine o'clock.

3 MS. DAILEY: Let me give everyone a break. We have to do
some updates to your book for the meeting -- for the Safe
4 Harbor briefing -- and then we will do public forum at
nine, I believe. Yes, public forum at nine and then
5 maybe Safe Harbor we will start at 9:15. So we have ten
till. We are going to re-stuff your books. Please be
6 back at nine.MS. DAILEY: Ladies and gentlemen, I would
like to bring the members to the table please? Ladies
7 and gentlemen, we are now going to do what is our public
forum portion of the task force. As a federal advisory
8 committee, we are allowed to open our microphone

9 to members of the public who have topics that they

10 would like the task force to address, information

11 they would like the task force to hear, and today

12 with us is Mr. Michael Parker who will be

13 addressing the disability evaluation system.

14 MR. PARKER: Thank you and good morning. In

15 this week's meeting, the task force is exploring

16 the Department of the Navy's Disability Evaluation

17 System, or DES. To be blunt, the Navy's DES is

18 disingenuous and dishonest. The Navy has created

19 several ways to cheat sailors and marines out of

20 their DOD disability benefits. You can read the

21 details of these disgraceful practices in my DES

22 Outrage Series which is posted on PEBFORM.com.

1 Perhaps the most dishonest Navy technique is when
2 the Physical Evaluation Board or PEB finds an
3 individual fit for duty and then the Navy or
4 Marine Corp deems the member unsuitable for
5 service and discharges them without DOD disability
6 benefits. After I wrote about the fit but
7 unsuitable practice in
8 DES Outrage number three, Congress took action and passed section 534 of the 2011 National Defense Authorization
9 Act. This law prevents the services from administratively discharging members due to a condition
10 that the PEB deems fitting. In response to this law, the Navy simply adjusted tactics. They are continuing and
11 expanding a similar technique that bars reenlistment due to the same condition a PEB has deemed fitting. This
12 lead to separation without DOD Disability benefits due to a service connected condition.
13 In addition, since the Fit but Unsuitable law went
14 into effect on 7 January, I have seen several
15 cases where the Navy is simply refusing to submit
16 Wounded Warriors to the DES as required by law and
17 regulation. They are avoiding the Fit but
18 Unsuitable discharge prohibition by simply
19 avoiding fit findings. You must ask the Navy and
20 Marine Corp their positions on the Fit but
21 Unsuitable issue, specifically will they continue
22 to deny reenlistment due to the same condition

1 that PEB found to be fitting; will they continue
2 to deny evaluations to members required to undergo
3 such evaluations; and under what circumstances do
4 they believe they can deny disability evaluations
5 under the DES? I ask that the task force take a
6 deep look into the Navy's dishonesty DES practices
7 by exploring the details of Sergeant Roy Sanchez's
8 disability case. This Marine's disability case
9 clearly points out the many techniques the Navy
10 uses to cheat sailors and marines out of DOD
11 Disability benefits. You can find the details of
12 Sergeant Sanchez's case in DES Outrage number 14
13 and 16.
14 Thank you.
MS. DAILEY: Thank you, Mr. Parker. Mr. Parker's
15 comments are in Tab H. Are there any questions? We have
one minute for questions of Mr. Parker.
16 GENERAL STONE: Mr. Parker, I wonder if you could comment
on whether you believe that the DES system is connected
17 between Department of Defense and the Veteran's
Administration from your work over these last numbers of
18 months.
MR. PARKER: Well more so under the ideas for sure,
19 because the VA and the IDS are the ones that is
20 running the medical evaluations by and large and
21 that helps make sure that all of the data gets in
22 that needs to get into the MEB. The big issue in

1 the Legacy DES is that the MEB's are not covering
2 -- the conditions are not covering in sufficient
3 detail and that leads to a bad PEB. So, I believe
4 that it is better on the IDS. It is broken under
5 the Legacy, which still covers about 40 percent of
6 the military force at this point. There are still
7 issues in terms of medical transfer and all that
8 other things. One of the issues that is out there
9 though is under TDRL review. My understanding is
10 that that will not work under the IDS process, so
11 if someone gets put on TDRL, 18 months later they
12 are going to be reevaluated. It appears as though
13 that is going to fall back into a legacy model
14 where the VA is not going to be involved. So you
15 are going to have a situation where folks are
16 going to get it done right on the initial one only
17 to fall victim to the practices of the legacy
18 system on TDRL review.
19 GENERAL STONE: Thank you.
MS. DAILEY: Are there any other questions for Mr.
20 Parker? Mr. Parker, thank you.
MR. PARKER: Thank you.
21 MS. DAILEY: Okay, we will go into the Navy briefing.
And ladies and gentlemen, this puts us at Tab I.
22 CAPTAIN CARTER: Good morning, members of the Recovery
Wounded Warriors task force. I am Captain Bernie Carter.

1 I am the Director of the Navy and Coastguards Wounded Warrior Program which you commonly refer to as Safe
2 Harbor. No, it is not a safe haven for ships as
3 some of the -- when I inquire about what Safe
4 Harbor is sometimes I will get that reply from
5 people. So you know we have got a massive
6 communication effort ahead of us to try to get
7 everybody into the know of what the Navy and
8 Coastguards Wounded Warrior Program is all about.
9 You have a daunting task in front of you and we
10 will try to answer as much as we can about as much
11 of what we know and have learned in the past of
12 doing this job and the formation of the Navy and
13 Coastguard's Wounded Warrior Program. Let me tell
14 you a little about myself. I am a surface warfare
15 guy, CREWDES that is my background. Mostly all
16 ships, frigates, destroyers, cruisers. I have
17 done a lot OPNAV staff as far as the acquisition
18 piece. I had my first stint in the N1 World in
19 the last three years doing Manpower acquisition
20 and so forth, so I have had a chance to watch the
21 Navy Safe Harbor piece grow from one person in
22 2005 to the 42 that we have right now. I want to

1 introduce my panel. I have got Commander Mike
2 Darius over here who is my Deputy; Ms. Marissa Larson, my Strategic Support Officer; and Lieutenant David Noriega,
3 my Operations guy. I'll talk maybe just ten percent of the time today since I have been here a little over three
4 months, but they will do the majority of the talking. They are kind of like my brains within the outfit and
5 they do a lot of the legwork on that, and I just do a lot of the -- as they run it through me I approve and
6 disapprove on where we want to go and take the direction of this program. In the back here I have Dr. David
7 Shapiro, my Medical Officer assigned to the staff;
8 and Commander Bill Bailey, my JAG. Let me set a
9 little bit of the ground rules. We are not a
10 command, okay, that is one thing about Safe
11 Harbor. There is no command. We don't own any of
12 our enrollees; they are all tied into their
13 commands or an MTF that they are associated with
14 or so forth. We don't garrison anyone either, so
15 we don't have that setup like the marine's do at
16 Camp Pendleton and Camp Regime where they have
17 barracks and so forth set up for these guys.
18 These guys are still tied to their parent commands
19 if they are not in an MTF or not tied to a VA poly
20 trauma. Like I said, we are 42 bullets -- really
21 just 40. I say 42 because I have a Department of
22 Labor liaison person which I have just recently

1 lost and I am getting a VA FRC from Dr. Guice here
2 on 11 April. So that will put me at 41. But that
3 stuff ebbs and floods as far as our men, but we
4 are small. We are small compared to that 456 or
5 so number you heard from the Marine Corp which is
6 a command, yesterday. Our structure is a little
7 bit
8 different. Since we are not a command and I am branch,
what we have is -- we have the CNO in our structure, the
9 Vice Chief, the Chief of Naval Personnel, 3 star; my boss
Admiral Covell, and then you have Safe Harbor. So it is
10 pretty tiered down there, okay, and why I want to mention
that is because when you are fighting for resources and
11 you are not a command you have to fight amongst all of
the other branches within the N1. There is like four or
12 five directors within one and there is like four or five
branches within there. So we are all fighting for that
13 piece of money as we move forward. In my
14 headquarters command, like I said I have my
15 Strategic Support side and I have my Ops side.
16 But within those 42 people, 18 of them are out
17 there in the field at the 12 military treatment
18 facilities and the four VA poly traumas that I
19 talked about earlier. They are out there in the
20 field and the remaining are here at the
21 headquarters staff working it. We are doing some
22 internal reorganization even as we speak because I

1 am the new guy on the block and I want to make
2 sure that we have got our people postured in the
3 best position to get the most work out of them
4 since we are a very small organization. Our budget
5 is small. This year on the FY11, we are looking
6 at 4.5 million dollar range, but because of the
7 continuing resolution we are operating under FY10
8 controls which puts us back around 2.5, 2.6
9 million dollars which I think, Marissa, we spent
10 maybe what, 1.6 million out of that? So, it is
11 not a whole lot. Not a lot. Next slide. Oh,
12 that's me? Do I do that?
13 Like I said, Lieutenant Noriega and Ms. Larson will do
most of the discussion this morning. We are going to
14 cover all of the topics that you asked us to cover in
your requests; the effectiveness, the training, best
15 practice information, support, and that transition piece.
Here is our mission statement. Our mission statement
16 and our guiding principle -- the bottom line is we want
to provide the best care that we can to our service
17 members, our sailors, and our Coastguard members the best
we possibly can with what we have available. I am an
18 outgoing guy. I am pretty much a people person
19 and you have got to be a people person to do this
20 job well, so my doors are always open. I am
21 always willing to talk to service members about
22 their concerns, about their needs and where we can

1 help better. We are all about that and my whole
2 staff -- all 42 of them are about that, plus or
3 minus -- are all about that. Like I said, Safe
4 Harbor had humble beginnings in '05. They have
5 grown up to 42 people. Some of the things that I
6 am proud of is that we have a serve support that
7 we will talk about a little bit later in the
8 brief. We have got our anchor program off of the
9 ground, we have got some direct sailor videos and
10 I think Ms. Larson is going to show you one of
11 those this morning in her presentation, we
12 successfully jumped in well with that
13 rehabilitation piece with that Wounded Warrior
14 games and the whole adaptive athletics piece, and
15 like I said we have assigned the MOA with the
16 Veterans this year with the FRC liaison in our
17 program. One thing I want to talk about that I
18 came in on is this
19 adaptive athletic program. Right now -- last year we had
a Warrior Game out in Colorado Springs and afterwards you
20 know, OSD started shooting a lot of money out to kind of
tell all of the services "yeah let's get involved with
21 this adaptive athletic piece, and let's get that in
everybody's workings and part of their program". But the
22 only hard part about that, it wasn't mandated anywhere.
So it makes it really tough to go procure funding by that

1 so we really somehow need to get that into a NDAA in the future to say "hey, these Warrior Programs are mandated
2 to have that, and you are mandated to have this
3 many people in to do the job, because right now I
4 am living off of the goodness of OSD and the funds
5 that they transferred to us for this adaptive
6 athletics program. So if they were to cut it off
7 tomorrow, that would be crucial for me in the
8 execution of that program. I am going to
9 transition here a little bit now. I am going to
10 have Mr. Noriega come up, and we are going to talk
11 a little bit more about the program and some of
12 the things that goes on in the Operations
13 Department with the Nonmedical Care Managers and
14 the RCC's.
15 DR. GUICE: Commander, before you leave
16 could you go back to that slide there. There was
17 a number discrepancy that I noticed and I just --
18 if you could explain that under the 2010 yellow
19 line, where you say total case load seating 1,000
20 service members but on your bubbles on the far
21 right, the bottom -- it looks like it would be
22 somewhere between 600 and 625.

1 CAPTAIN CARTER: That is the enrolled.

2 Those are the enrollees, and the case load is all

3 of the assessed. We

4 will talk more about that in the brief too to help you capture that.

5 DR. GUICE: So that's -- those are the number enrolled in Safe Harbor, then what is the discrepancy with the 375 in

6 the 2010?

CAPTAIN CARTER: 375?

7 DR. GUICE: You said the total case load exceeded 1000?

CAPTAIN CARTER: Right. That other 375 would be

8 assessed.

DR. GUICE: They are not enrolled in your program but

9 those are individuals that received some sort of

10 support, assistance --

11 CAPTAIN CARTER: Support, some kind of

12 medical care, right.

13 DR. GUICE: -- from the program. And where

14 are those 375?

15 CAPTAIN CARTER: Those are all ones that we

16 assessed. We keep them in our database, correct

17 Dave?

18 LIEUTENANT NORIEGA: Yes ma'am, so we have --

19 CAPTAIN CARTER: Do you have a mic? Well

20 just come on up Dave, because you are going to be

21 coming up here anyway.

22 LIEUTENANT NORIEGA: So our total case load

1 is really made up of two different numbers. We
2 have our enrollees, those are the ones we consider
3 seriously Wounded, Ill, and Injured. Then we have
4 a category that we categorize as assessed, so
5 those are folks who are not seriously Wounded,
6 Ill, and Injured but however may require some
7 assistance from us whether that be legal,
8 financial, family services. It runs a gamut, so
9 it is a service that we provide but it is a way
10 for us to capture that in
11 our database and show what our Care Managers are doing and if that case somewhere along the line becomes an
12 enrolled case, something serious, then we have that data to pull out through our database.
13 DR. GUICE: Will you be explaining to us the enrollment criteria?
14 LIEUTENANT NORIEGA: Yes ma'am, I will.
MASTER SERGEANT MACKENZIE: Sir, a question for you. You
15 mentioned in the very beginning about your challenges with the Navy. So being a program that is supposed to be
16 taking care of the Navy's seriously Wounded, Ill,
17 and Injured, are you saying that the Navy doesn't
18 support well enough to give you priority when
19 looking for funding?
20 CAPTAIN CARTER: No, no, no, not at all. We are
21 supporting, but like I said we are just competing
22 because of the way we are aligned right now we are

1 just competing with all of the other requirements
2 within. Just because of the way we are aligned
3 right now it just makes it tougher. I mean, the
4 Navy is very supportive. But like I said, the
5 emphasis is that we have to compete with all of
6 the other interests within the organization.
7 MASTER SERGEANT MACKENZIE: Thank you, sir.
8 That was a clarification, because there is a
9 difference between being interested with a
10 handshake and being interested with a checkbook.
11 CAPTAIN CARTER: Absolutely.
12 GENERAL STONE: You are going to come to a
13 slide in your future that shows that 50 percent of
14 your spouses and families are either dissatisfied
15 or neutral regarding the
16 program. I wonder if you will be able to comment on that data.
17 LIEUTENANT NORIEGA: Yes when we get to our measures, we will. Yes, sir. So, I am Lieutenant David Noriega. I
18 am the Operations Officer for Navy Safe Harbor. If you haven't heard yet, we are a very small program. Small,
19 42 people, and this chart here really illustrates where we fall within big Navy. Currently, we are a program not
20 a command. We fall within a branch of N12 which is the Manpower requirements divisions, and our Director,
21 Captain Carter, has a direct report to the Vice
22 Chief. So, just so you know we fall very low

1 within Navy structure. We are a program embedded
2 within N12, which belongs to N1. So I just want
3 to make that clear, and we have 42 people total
4 with 18 of those being out in the field. On this
5 side here, as you see here N1 is broken up into
6 two different regions. You have OPNAV Navy which
7 is headquartered here at the Navy Annex, and then
8 you have the Navy personnel command which is at
9 Millington, Tennessee. What we do at Navy Safe
10 Harbor is we work with our internal processes with
11 N135 and PERS95. I wanted to point that out
12 because we as Navy Safe Harbor do not own the
13 Casualty Assistance like I think the Air Force
14 brief; I think the Casualty Assistance kind of
15 falls within your Wounded Warrior program, and our
16 Reserve MEDHOLD and LOD falls under PERS95. So we
17 have a liaison over at DPERS who coordinates and
18 works our efforts with these two different
19 organizations. So this program, the MEDHOLD
20 program, is owned by PERS95 and the Casualty is
21 owned by
22 N135C. So I just wanted to make that clear is what we really do is we coordinate with those folks but we don't

1 necessarily own any of those processes. Any questions with that slide?
2 Okay, I am going to go over some demographics and maybe I can answer some of the questions regarding our assessed.
3 So our current case load is 1276 and that case load comprises of our enrollees 625 as of 30 March, and our
4 assessed cases which we talked about earlier. So, these are seriously Wounded, Ill, and Injured, 625 and our
5 assessed are 651. Again, those assessed are those
6 who are not necessarily seriously Wounded, Ill, or
7 Injured, however may require some assistance.
8 Some legal assistance, some family programs
9 assistance, or maybe it is just calling to enquire
10 about our program. So we keep track of that, and
11 we track them as assessed. We have different
12 categories that we track our cases, and that would
13 be considered an assessed. Do you have any
14 questions, ma'am?
15 DR. GUICE: I do. The definition of
16 seriously Wounded, Ill, or Injured -- I see you
17 have got your book out on the right with the very
18 specifically, and I am sure that some of those
19 people have more than one of those --
20 LIEUTENANT NORIEGA: Yes. Yes, ma'am.
21 DR. GUICE: There is some cross counting.
22 But how do you define seriously ill and injured to

1 the extent that it would get you enrolled into

2 Navy Safe Harbor?

3 LIEUTENANT NORIEGA: Primarily through our

4 personnel casualty report. So we get a message

5 that is either SI, Seriously Injured, or VSI, Very

6 Seriously Injured. So

7 when we see those two PCR's come through, that is when
our folks will engage. However, we do get these messages
8 that are NSI's, not seriously injured. And if we read
that if it is a battle casualty, someone who may have
9 been injured in theater, or if we see that maybe Safe
Harbor should engage and at least conduct the needs
10 assessment initially to screen that person for
enrollment, we will do that. So it is really based on
11 the seriousness, the acuity of the injury.
DR. GUICE: But that is based on the casualty.
12 LIEUTENANT NORIEGA: Casualty, yes.

13 DR. GUICE: So it is whatever gets put on

14 the casualty list.

15 LIEUTENANT NORIEGA: Absolutely.

16 MR. REHBEIN: Real world --

17 LIEUTENANT NORIEGA: But that is just one

18 source -- I am sorry. That is just one source.

19 We also get referrals from Medical Case Managers,

20 from the hospital staff, or we get self referrals.

21 We get chaplains to call in. So that is one

22 source of a referral. Yes, sir?

1 MR. REHBEIN: Real world situation.

2 Yesterday there was an incident/accident on a

3 carrier deck. You now have four sailors that were

4 off the ship into the hospital. How quickly will

5 you receive information on them as to whether or

6 not they need to be enrolled or assisted? How

7 fast will that move down the chain?

8 LIEUTENANT NORIEGA: One of the things we

9 are trying to put out is that it is really the

10 command's responsibility to put these PCR's out.

11 In many instances we find out before the PCR

12 through just word of mouth, Navy -- I mean

13 Navy Safe Harbor, they understand what we do so we may
get a call and say "hey there has been an incident here,
14 you should be aware of it". But quite honestly it is the
command's responsibility to put these PCR's through so
15 that we are made aware of it. In theater, they are
great. Typically before they are in Landstuhl, we
16 already know about them. So our combat wounded I think
we are capturing very well. It is the liberty accidents.
17 It's the someone who may be PCS-ing (phonetic spelling)
from one command to another and ends up in a
18 motor-vehicle accident and ends up in a civilian

19 hospital, where we may not be aware of that until

20 the Tri-Care bill comes up or maybe BUMED would

21 let us know about that and refer them to us. So

22 it is not a perfect system. We do use folks

1 occasionally when that type of incidence occurs.

2 GENERAL STONE: So who is your final

3 adjudicator of admission and definition of

4 serious?

5 LIEUTENANT NORIEGA: We are at Safe Harbor,

6 and we have our Medical Officer and we work

7 closely with our Medical Case Managers, so it is

8 really a multidisciplinary effort to decide

9 whether this person is seriously Wounded, Ill, and

10 Injured. But quite honestly we are on the side of

11 caution. So, you know we pretty much know when

12 someone is going to need our assistance. If there

13 is a serious motor-vehicle accident, we know more

14 than likely this guy is going to get enrolled.

15 Now, if someone breaks their leg while running,

16 doing PT, physical fitness -- that is the type of

17 person we will probably assist but not necessarily

18 enroll. So we will provide guidance, we will

19 provide information on what we do, maybe some support services, but that is not what we would include in our

20 625.

CAPTAIN CARTER: I think going back to your question, I

21 think the data spell out to the type of -- everything that Dave said but also the other tools of whether or not

22 we also look at it from a point of "Is this guy more than likely or highly unlikely to return back to active duty

1 within 180 days or so." That is a lot of the criteria
that we use in that decision making process too, and it
2 is spelled out in the DODI on how you are going to
3 do that. So that is a lot of -- that is another
4 one of those steps we use to go into that
5 enrollment process.
6 DR. GUICE: Let me ask the question in a
7 different way.
8 LIEUTENANT NORIEGA: Sure.
9 DR. GUICE: How many people have been
10 referred either through the reports on the
11 casualty list, through your standard referrals
12 through the MTF system, your word of mouth, your
13 command referral, whatever, however they get to
14 you; how many have been referred that you have not
15 enrolled and you have sent somewhere else?
16 LIEUTENANT NORIEGA: I would say that number
17 is very small. Quite honestly a lot of our PCR's
18 that come through from the get go, they are
19 enrolled in our program. We begin our
20 comprehensive needs assessment almost immediately.
21 And a lot of our referrals through the medical
22 case managers, they know what Navy Safe Harbor

1 does. So we have our Nonmedical Care Managers at
2 many of these MTF's so they work with the MTF's
3 and our Nonmedical Care Managers at the MTF, they
4 understand our
5 enrollment criteria, and when they refer those folks more than likely they are going to be enrolled.
6 GENERAL STONE: Your largest population is Post-Traumatic Stress and TBI --
7 LIEUTENANT NORIEGA: Yes, sir.
GENERAL STONE: -- with late arising symptoms, with a
8 geographically dispersed force with 20 percent of your force is Guard and Reserve. How do you capture those?
9 LIEUTENANT NORIEGA: We work closely with -- really through referrals is the only way we can capture them.
10 We work closely with PERS95 who owns the LOD
11 process. So we have a liaison over at Millington
12 who advocates for those members. So say a
13 reservist is demobilized and then symptoms of Post
14 Traumatic Stress Disorder manifest six months down
15 the line, we have our hotline; this is another
16 source I failed to mention. So we get a lot of
17 calls from the hotline, and I have got to tell you
18 if they call and it is Post Traumatic Stress
19 Disorder or something like that, we will engage.
20 Again, we have our liaison at our PERS95 -- or at
21 Millington who works closely with PERS95 and that
22 is when we will start tracking the line of duty

1 process. Again, we don't own that process but we
2 work closely with PERS95 to follow these sailors.
3 GENERAL STONE: You are using a DODI and
4 informed 180 day decision process. The Army
5 briefed that they are using a 365 day medical
6 decision process. What is the right number?
7 LIEUTENANT NORIEGA: That is a good
8 question, sir. We use 180 days --
9 MR. REHBEIN: I think the Marine Corp was using 90 days, weren't they?
10 LIEUTENANT NORIEGA: Yes. There is no standardization of that. I think 180 days is what we have been using,
11 again, Army may be -- Marine Corp may be lower. So but we -- what we try to look at is not only 180 days, but is
12 this member likely to be retired, medically retired.
MR. REHBEIN: So at 180 days, what percentage of your
13 enrollees is extended because they haven't reached the medical decision process?
14 LIEUTENANT NORIEGA: The medical decision
15 for MEB?
16 MR. REHBEIN: No, because your physicians or
17 your senior physician believes that there is
18 potential for future recovery, that the sailor
19 should be observed for additional period of time.
20 LIEUTENANT NORIEGA: In those cases, as I
21 said, we error on the side of caution so if we --
22 MR. REHBEIN: But do you have data?

1 LIEUTENANT NORIEGA: No, we do not have that data.

2 DR. GUICE: I think I can probably rephrase

3 that. If the criteria are 180 days expected to be

4 out of work, off of their MOS, at the 180 day

5 point from their injury or their illness

6 diagnosis, how many from your enrollees have

7 actually gone back to work either within those 180

8 days or within the next 180 days?

9 LIEUTENANT NORIEGA: Okay, we do have that.

10 DR. GUICE: Can you figure that out? That

11 would be helpful for us I think.

12 LIEUTENANT NORIEGA: We do have 21 percent of our

13 enrolling population returns to duty. So we are

14 looking

15 at about 85 or so of our 625 have returned to duty. So I hope that helps. That -- so these are folks that we

16 screened, we thought possibly they were going to be medically separated from military. However, they

17 recovered and returned to duty. So we are looking at 21 percent, so about 85 or so folks who are enrolled in our

18 program are currently on active duty.
DR. GUICE: And for the rest, the others -- 79 to 80

19 percent -- when do they enter the MEB process? Are you tracking that?

20 LIEUTENANT NORIEGA: You know, we are not.

21 But that varies depending on treatment. You could

22 initially be in Bethesda for a month, month and a

1 half, and then transfer over to the VA poly trauma
2 center in Tampa for rehabilitation, then back for
3 additional surgeries. So it is really tough to
4 really put a number on that -- on an average.
5 DR. GUICE: Do you capture that though, that
6 when someone becomes enrolled in the MEB so you
7 could probably through your data give us an
8 average time to enter into an MEB and then the
9 average amount in a range, and then the average
10 amount of time that they are in the MEB/PEB
11 process. Could you do that for us?
12 LIEUTENANT NORIEGA: We have currently
13 enhanced our database to actually -- so that we
14 can capture that date when they enter the MEB
15 process, so maybe looking forward we can do that.
16 But, looking back we will not be able to do that.
17 DR. COAKLEY: Lieutenant, I have a question
18 for you.
19 LIEUTENANT NORIEGA: Yes, sir?
20 DR. COAKLEY: Walk me through if you can, just like a
typical scenario. For instance, one of my Seabees in
21 TYCOM NECC is wounded -- injured I should say, in
Afghanistan. They are doing work and they either hurt
22 their leg or whatever. I am just confused or I need some
clarification on the process, how does that Seabee who

1 has returned to the states to one of my commands, how
does the communication go between N135 Charlie and PERS95
2 and you? Is that an automatic kind of system for that
classification?
3 LIEUTENANT NORIEGA: So let me run a
4 scenario. By the way, this 61 -- let me go back.
5 This 61 combat wounded is primarily our Seabees
6 and our hospital Corp men embedded with the
7 marines, so just wanting to clarify that. So let
8 me run you through a scenario. So you have a
9 battle casualty in Iraq or Afghanistan, now that
10 command submits a PCR to N135 and that message
11 comes to us at Navy Safe Harbor. At that point,
12 they will probably be medivac'd to Landstuhl.
13 While at Landstuhl, we will track the medivac'd
14 coming to Bethesda. Our Care Mangers will be
15 working with N135 and our liaison at Millington
16 for the invitational travel orders for the family
17 to be bed side. We will start coordinating
18 housing, and all of the families' immediate needs
19 upon their arrival to the states. From that point
20 on, once they arrive at Bethesda, our Nonmedical
21 Care Managers as well as the medical staff will
22 greet them and that is where our Nonmedical Care

35d3e2fa-d345-46de-b608-dda506fb6452

1 Managers introduce themselves to the families and
2 really explain what our program is all about.
3 From that point on we will conduct our needs
4 assessment, comprehensive needs assessment -- so legal, financial, it runs a gamut -- and then what we do upon
5 that is we develop the comprehensive recovery plan to address those needs identified in the CNA, the
6 Comprehensive Needs Assessment.
DR. COAKLEY: Thank you.
7 LIEUTENANT NORIEGA: Yes, sir.
MR. CONSTANTINE: Lieutenant Noriega, let's try -- the
8 circle in the middle -- is that the percentage of the total number or of the enrollees?
9 LIEUTENANT NORIEGA: No, these are the
10 enrollees.
11 MR. CONSTANTINE: Okay, so it looks like you
12 have 61 combat wounded, but about over 200 falls
13 in the TBI and PTSD category. So you are saying
14 that over 200 sailors have been diagnosed and they
15 are not going to go back to work ever again?
16 LIEUTENANT NORIEGA: Right. So we will look
17 at that here for our combat wounded is our purple
18 hearts. That is how we account for our combat
19 wounded.
20 MR. CONSTANTINE: Okay, but that 32 percent
21 have PTSD or TBI?
22 LIEUTENANT NORIEGA: Right and TBI can be

1 from motor vehicle accidents and other injuries

2 other than --

3 MR. CONSTANTINE: Sure, I understand with PTSD.

4 Obviously it is not all happening in theater, but

5 the point is that 200 sailors are not going back

6 to work -- your criteria are out of work for 180

7 days?

8 LIEUTENANT NORIEGA: Typically.

9 MR. CONSTANTINE: Right?

10 CAPTAIN CARTER: But I think your question

11 is -- at that

12 180 days, does it stop? Because I think during that whole process, you know there is still medical

13 involvement, our involvement, that guy is still being -- that individual is still being evaluated. Because he

14 could necessarily go back and as the evaluation takes form, maybe not, but they have to constantly reevaluate

15 it. But we have to give ourselves a number to say "Okay, at this point we need to say 'make a decision'". Then

16 again, he could come back to life and go back in the service. It all depends.

17 MR. CONSTANTINE: It just seems really high

18 to me, that so few are wounded in theater -- which

19 they are out of work for a long period of time due

20 to PTSD or TBI. So half a year is a long time to

21 me, and then you have 25 percent which is a little

22 over 150 due to whatever illnesses, and 92 percent

1 due to other. So 76 percent or so are for reasons
2 that fall in categories that I would think the
3 other things, gunshot wounds, paralysis, I could
4 easily see 180 days, but the vast majority to me
5 is -- I am just surprised to hear that.
6 LIEUTENANT NORIEGA: I think we are getting
7 stuck on the 180 days. We don't necessarily start
8 the clock and then at 180 days make a decision.
9 We make that decision on the officer right from
10 the get go, so it is more than likely "is this
11 service member going to likely be out of work for
12 over 180 days"? We make that decision at the
13 front end. So we don't necessarily make that
14 decision six months down the line. So if you are
15 seriously injured and more than likely not going
16 to return to duty within the next 180 days, you
17 are enrolled. We don't
18 change that. Once you are enrolled we don't unenroll you, so those folks remain within our program.
19 MR. CONSTANTINE: So once someone -- someone could, for lack of a better word, recover, from their injury but
20 they are still on your --
LIEUTENANT NORIEGA: Absolutely. That is why we have
21 that 21 percent return to duty.
MR. CONSTANTINE: And what does it take -- what kind of
22 VA rating for PTSD is consistent with missing work for such a significant amount of time?

1 LIEUTENANT NORIEGA: I think the standard is
2 50 percent. Don't they give a PTSD, 50 percent?
3 That is at the VA level. I don't think we track
4 that here.
5 MR. CONSTANTINE: Okay.
6 DR. SHAPIRO: Just one quick comment. I
7 mean, so every service defines "work" and "out of
8 work" differently, but some of this often has to
9 do with somebody say being on "limited duty". So
10 that is an administrative term, basically meaning
11 if you are seeing psychologist, psychiatrists, and
12 going to all of the different groups, I really
13 can't put you on a ship and send you to sea for
14 six months so you are put in a DD status, or for
15 you post folks, the 105 status -- it keeps you
16 assigned to either a local unit or the military
17 treatment facility so that you can get care. You
18 may actually -- during your treatment, depending
19 upon how intense it is, you may be working locally
20 at a command but you are not worldwide deployable.
21 I need to keep you in the proximity of the
22 facility that can provide the level of treatment

1 that you need. So the 180 days and all of that,

2 that doesn't

3 necessarily mean that you are sitting in the hospital getting care, but what that means is you are assigned to
4 the area of the hospital getting the level of care that that hospital can provide. Because if we have a guy with
5 PTSD, I don't want him on a surface ship that is about to get under way. I need to know that he is getting care,
6 and also so that we can see what happens. Some of these guys recover and return to duty, but they need a fair
7 amount of time to get care and what not and then as time progresses we can look and see how they are doing, etc.
8 MR. CONSTANTINE: Okay, I understand. I

9 just have a couple of points. One, PTSD obviously

10 has a wide sector and so your mentality shouldn't

11 be "if someone has PTSD I don't want them on a

12 ship" because I think that you would be surprised

13 how many of your sailors probably have it,

14 worldwide deployable. And somehow I think when

15 you hear of a presentation like this, you actually

16 make sure that what it means to go back to work is

17 -- I can understand a lot easier than just out of

18 work for 180 days. So I would encourage you to

19 use that kind of language. It makes it into

20 something I can understand, not being worldwide

21 deployable.

22 LIEUTENANT NORIEGA: People with PTSD do get

1 -- go back to work and go back to sea. A lot of
2 it just generically in the Navy, just has to do
3 with DD status is, can you get the level and
4 intensity of care in their current status. I
5 mean, I have worked with small ships like the
6 Captain did for a while, although small is a
7 relative term in the Navy -- and so we need to
8 know that if the specialists are right, they are
9 good to go, and they have
10 PTSD but it is under control and if they are fully functional then they go back to sea with that diagnosis.
11 A lot of it has to do with the time requirements and the access to the specialists as they are getting care. But
12 like I said, at the same time that doesn't mean that they are not working at what we refer to as a shore duty
13 command you know when they have the time.
MR. CONSTANTINE: I understand that. What of the 19
14 percent of other and the 25 percent illnesses -- what kind of (inaudible) is involved in that?
15 LIEUTENANT NORIEGA: We have actually had
16 our folks crunch those numbers. Again, when the
17 program was stood up in 2005 there was another
18 database, and when that information crossed over
19 to our current database some of that information
20 did not cross over into the fields. So what we
21 are finding is of that 19 percent, over half of
22 them are Cancer patients. So different variations

1 of Cancer, and the other half we are still trying
2 to scrub the database to ascertain the primary
3 diagnosis or injury.
4 MR. CONSTANTINE: So what kind of illnesses
5 do you have? Cancers and other -- what makes up
6 the illnesses?
7 LIEUTENANT NORIEGA: So we started off --
8 the 25 percent illnesses, those are the ones that
9 our database was actually able to pull and show
10 that these members had Cancer. This other did not
11 show, so we weren't sure. We weren't clear. So
12 we had our folks scrub that database and find that
13 over half of those folks should have been in the
14 illness category for Cancer. So, it was not
15 showing. So when that data transferred, that
16 field for
17 injury or illness did not populate.
MR. CONSTANTINE: So you have enrollees, but you don't
18 know what is wrong with them?
LIEUTENANT NORIEGA: Some of those were from the 2005 and
19 before the Safe Harbor Program was established, but you
are correct. It is not pulling it. It may be in the
20 notes, because our Care Managers take notes and there is
a section there for that. So it is not something that we
21 can pull the data essentially and give you those numbers.
We will have to read through the notes to pull that
22 information and then populate the field.

1 DR. GUICE: It is an artifact of the way you
2 capture the data --
3 LIEUTENANT NORIEGA: Absolutely.
4 DR. GUICE: -- in that initial data set, and
5 now you have to go back and identify. So a lot of
6 the illnesses were captured in another category
7 because you didn't have a way to put it into one
8 of these other categories.
9 LIEUTENANT NORIEGA: Absolutely. That is correct.
10 CAPTAIN CARTER: Now we have to go back and
11 find out what the primary diagnosis, even they may
12 probably have two or three illnesses, but what is
13 the primary diagnosis? Get it categorized in the
14 right spot.
15 DR. GUICE: And then someone behind you has
16 got his hand up.
17 CAPTAIN CARTER: Talk to the doc. So in
18 discussing with the CO and Lieutenant Noriega
19 about these cases before we had the database --
20 they are in the database now, but none of the
21 details are necessary for them because they were
22 enrolled before we were using our current

1 database.

2 I am actually going back -- I can't go back forever -- but I am pretty fascinated with the electronic medical
3 record, so I am going back and identifying to try to chop that 19 percent down. We started to make progress. I
4 really suspect that in about six months or so that that number is going to be significantly smaller. But I have
5 to go through each individual medical record and search and search and search sometimes to really figure out what
6 was wrong with these individuals. I mean, I actually spend -- I spend a few hours every week doing it.
7 I will tell you and the answer to your other

8 question about what are some of the other

9 diagnoses that we see -- this motorcycle stuff.

10 Liberty motorcycle accidents, I have seen a number

11 of those and you know they are some pretty

12 significant accidents that are definitely

13 enrollees, a fair amount of malignancies where

14 patients have one whether it is a poor prognosis

15 and they are needing chemotherapy and surgery and

16 that there prognosis is poor, and occasionally

17 some other odd ball things, and they are not

18 really -- they are not really odd ball, but like

19 neurological conditions where they patients have a

20 chronic neurological condition, they get

21 treatment, but it is not something that they are

22 truly going to ever recover from so they will end

35d3e2fa-d345-46de-b608-dda506fb6452

1 up getting medical boards. I have seen a few of
2 those, sort of neurological conditions,
3 inflammatory bowel disease, things that
4 individuals get treatment and depending upon how
5 bad that disease is -- that disease state -- they
6 may not eventually return to duty. So, I am going
7 back through
8 case by case and part of the problem that I have been talking to Lieutenant Noriega is in their notes there may
9 be documentation by it is in -- the ability to do the data poll isn't there. So what we are going through now
10 is we are going and filling in that diagnosis so that we can get a data poll. Occasionally, if I can get some
11 other information on an old case, like I read something; I am also feeding that to Lieutenant Noriega to fill in
12 any blanks for stuff going back to say 2006. Occasionally, maybe we will figure out something else and
13 we can fill that in also.
14 GENERAL STONE: Your largest group is PTSD
15 and TBI at 32 percent, but yet your combat wounds
16 are at 61? Could we assume then that the
17 breakdown is not blast exposure and more Post
18 Traumatic Stress in that population?
19 LIEUTENANT NORIEGA: Yes, sir.
20 GENERAL STONE: How do you capture blast exposure?
21 LIEUTENANT NORIEGA: Again, our database --
22 MS. DAILEY: May I help? Maybe in the TBI

1 in the medical portion we will be able to talk
2 about that. Would that be a better question for
3 the -- I see the Doc's head going up and down.
4 LIEUTENANT NORIEGA: It may be. What we are
5 doing is, based on the diagnosis of a sailor or a
6 Coastguardsman, so when our Nonmedical Care
7 Manager meets the family, becomes part of the
8 multidisciplinary team, they are told "well this
9 member has PTSD". So this is what we capture in
10 our database. So it is not a decision that we are
11 making in terms of "what category should we put
12 this service member in". It is simply we are
13 trying to
14 capture our primary diagnosis for our members.
DR. SHAPIRO: Sir, remember we are a nonmedical entity.
15 So stuff like that triggers my curiosity meaning I have
seen people who have TBI that weren't injured in a blast.
16 I mean some of them when you look at their record you
can tell they were involved in an IED blast. Sometimes
17 that is not like the first thing people notice, but
remember I am sort of doing forensic stuff now, but
18 eventually they will end up getting diagnosed with TBI.
That is one of the reasons why it is taking me -- it is
19 not like a quick look at their record, because I
20 am looking for "oh well they were wounded, but as
21 time goes on were they diagnosed with TBI or PTSD
22 say a year later", and we do have cases where

1 people were in theater and have TBI from another
2 reason. An example would be a guy who was working
3 underneath a vehicle -- I know someone mentioned
4 Seabees -- and the vehicle collapsed and pinned
5 his head to the deck. He has TBI now. So, from
6 the Safe Harbor, it is a nonmedical entity. It is
7 a nonmedical thing, but it is still important that
8 we know what their primary diagnosis is but we are
9 not doing hardcore medical data collection as to
10 was this guy injured in a blast. It may be in the
11 notes, but it is not something that we are
12 hardcore focused on in a sense that we are not
13 trying to collect data for that sort of medical
14 purpose as opposed to we should still know what is
15 wrong with them generically.
16 MR. CONSTANTINE: It seems like if you are combat
17 wounded, it is the people who have gotten purple
18 hearts. If it were any of us and I were not to
19 receive a purple
20 heart, that number could be TBI from one of us. Not to
beat a dead horse, but it sounds like you are having a
21 lot of trouble finding out what makes that 19 percent.
Are some of the people who are your enrollees no longer
22 in the Navy?
LIEUTENANT NORIEGA: That is correct. Yes. So of that

1 625 -- and I think that is on one or two slides later -- of that 625, 300 or so have transitioned and are now in
2 Veteran status. So of that 625, our active cases, folks who are still in the Navy are about 200 or so. That is
3 not including those who have gone through Safe
4 Harbor and returned to duty. So that is excluding
5 that 21 percent. We are talking about folks who
6 haven't been transitioned yet, 225 or so folks.
7 So the vast majority of that number has
8 transitioned.
9 CAPTAIN CARTER: But I wouldn't categorize
10 the 19 percent as we are in trouble. I think we
11 will get to the bottom line to find out what the
12 primary diagnosis is and what other ailments they
13 had, but I just want to get it correct for the
14 database. As far as some of the other questions,
15 as far as some of the medical diagnoses, you will
16 probably hit on that with some of the
17 psychiatrists and psychologists when they do the
18 medical piece from BUMED this afternoon. I am
19 just looking at that Nonmedical Case Manager and
20 how to provide that nonmedical support. But I do
21 want to capture what is wrong with them. So if
22 someone asked me why do I have them in my database

1 and why do I have them as an enrollee, "well
2 something is wrong with his head" okay. He fell
3 down. It doesn't necessarily have to be an ORF
4 and OEF, because a majority of our guys are just guys that are hurt aboard ship, hurt in a squadron, hurt
5 driving a car, hurt driving a motorcycle, okay, fell off the roof trying to play batman, all kind of crazy stuff
6 -- but it happens.
MASTER SERGEANT MACKENZIE: Sir, let me elaborate on some
7 of this frustration I think that the panel may be feeling right now, and that is 626 enrollees is basically what
8 you are telling me is you don't know who half or a portion of your enrollees are because you are not
9 communicating with them. You are now using a
10 medical officer to do forensics because you can't
11 communicate with the individuals that are enrolled
12 with you. So, I think that is a level of
13 frustration here is that it is about communication
14 for getting to these individuals and knowing why
15 they are on your books. You did touch on it
16 Captain, and I appreciate that, but that is -- it
17 is coming across that we have a log book of 625
18 slots but you are not coming right out and saying
19 that we haven't reached all of these slots yet to
20 validate this database shift. That is kind of the
21 appearance I think we are getting.
22 CAPTAIN CARTER: Well I think, remember it

1 is just 19 percent of that 625 enrolled. We are
2 just trying to go back through and say "this is a
3 concern of mine". This 19 percent, are they
4 properly categorized within the database. Because
5 we are moving to a new database, and that was an
6 old database so they were put in there for a
7 reason, but now I want to go back and capture what
8 the primary reason -- what is the primary
9 diagnosis of the
10 individual. I don't think it is a problem, I just think
I want to make sure I categorize it right.
11 DR. GUICE: I don't think it is a frustration, at least
not for me. To me it is very clear what happened. You
12 have an artifact based on the way you collected data and
the way you are currently collecting data, and now you
13 are going back through and scrubbing the data and binning
them in the right categories. It is important for the
14 Nonclinical Case Managers to understand the complexity of
the injury and illness diagnoses because we all know that
15 based on those little things over there in your
16 little laundry list, those turn benefits on or
17 turn benefits off in a variety of very interesting
18 ways. So, for the managers to understand the
19 types of medical problems that people are dealing
20 with, it allows them then to match up things. So,
21 I don't think it is a confusion, I think this is
22 just simple an artifact and we have probably spent

1 way too much time on it. The one thing I would
2 ask you to do while we do have this tendency and
3 because of our data you have collected these, so
4 many of your guys and gals will actually have more
5 than one. So I think one way of looking at your
6 information and probably getting to that severity
7 of illness or injury, is how many of your
8 individuals have two or more of these? That 32
9 percent is a collection of -- 32 percent of your
10 entire client population has PTSD or TBI. They
11 may well have one, two, three, four, or five of
12 those other things.
13 LIEUTENANT NORIEGA: Absolutely.
14 DR. GUICE: So it's not just that you have
15 got 32 percent
16 that all they have is PTSD. You may have a subset that
yes that is true and is probably the more moderate to
17 severe, but you are going to have several individuals who
not only have PTSD but have an amputation or two, have a
18 burn of some percentage, and may have an illness as a
comarbidity as well. So, I think that our databases are
19 good in how they give us data. I think a lot of it is in
how we present the information to kind of paint the
20 picture that I think the Captain is trying to get at,
which is how do I show the world who is on this program
21 and how that matches up to my entry criteria which
22 is what we are trying to understand. All of the

1 programs seem to have a little bit of a different
2 entry criteria, which is what we are trying to
3 understand. Because all of the programs seem to
4 have a little bit of an entry criteria -- what
5 gets you into a Wounded Warrior Program, what gets
6 you not in, how long do you stay. So we are
7 trying to put what you do in context with what all
8 of these other programs do. We are sorry if we
9 seem a little nitpicky this morning, but I think
10 we are just trying to understand what you are
11 presenting us. Thank you very much for your
12 patience.
13 CAPTAIN CARTER: You bring up some very good
14 points. Thank you.
15 LIEUTENANT NORIEGA: Alright, so we will
16 just continue with the demographics. As you can
17 see, about two thirds of our population is married
18 and the median age for our soldiers is about 32.
19 It is a little older than some of the other
20 services, 87 percent male, 13 percent female which
21 is pretty consistent with the Navy numbers in
22 terms

1 of male and female. Any questions on that slide? It is
just -- okay, here we go back to some of the break outs
2 in terms of our officer enlisted ranks and active duty
and reserve. So as I mentioned earlier, 21 percent of
3 our enrollment is from a Reserve component. We also
captured here some of the home of records. We thought it
4 would be important to capture that because some of these
folks will be returning when they transition out back
5 home. So, we want to know if we are adequately resourced
in California. Virginia seems to be the vast majority of
6 home of record for our enrollment population. Any

7 questions on this slide here? Okay. Alright, I

8 think we talked about our enrollment and the

9 assessed. What this bar graph here is showing is

10 a break out of 625. I mentioned earlier that of

11 that 625 most are in transition in Veteran status

12 or return to duty. So, of this 404, 85 -- 21

13 percent of our total enrollment population has

14 returned to duty. Really we are looking at about

15 300 or so Veterans who have gone from active duty,

16 through the PEB process, and out of the military.

17 So this transition number makes up our return to

18 duty and our veterans. I mentioned earlier that we

19 have an assist category. We actually have five

20 categories that we place a service member in. So,

21 we have deceased, assist, and then one of these

22 three categories: transition, progress, and

1 maintenance. Again, transition would be those who
2 have separated from service or returned to duty.
3 This end progress and maintenance category is
4 something that we use to balance our case load
5 among our Care Managers.
6 So, when a service member enters the MTF, this is where
our Care Managers work where they are dealing with the
7 families and to ensure that the invitation of travel
orders are here, when ensuring that they have lodging,
8 when ensuring that when there is childcare needs those
are addressed. So the work load for our Nonmedical Care
9 Managers, throughout the first two or three weeks of
initial injury, it is pretty high. So, we look at this
10 in progress category as someone who has just arrived to
the hospital and our Care Managers are trying to meet all
11 of their immediate needs in the family. So the
12 work load is essentially high at that point. When
13 they go into the rehabilitation stage, we put them
14 in a maintenance status. So what that does for me
15 as the Operations Officer, is I will see a case
16 and I will see a Care Manager with cases in
17 maintenance, five cases in maintenance. So that
18 tells me that I need to balance the work load at
19 that location. I need to shift in progress cases
20 to the Care Manager who has most of them in rehab.
21 So that is just a tool for us to balance that case
22 load. Currently if we look at just our active duty

1 cases, which is the combination of these two here,
2 the case load is about 13 per Care Manager on
3 average. If we take into account the transition
4 cases, we are looking at about 35.
5 So, that helps us at the Operations side to
6 balance the
7 work load and ensure that our Care Managers have
8 enough time to spend with these families, that
9 they are not overwhelmed with four or five cases.
10 MS. CROCKETT-JONES: I have a question for you.
11 LIEUTENANT NORIEGA: Absolutely.
12 MS. CROCKETT-JONES: When you say they are in transition, is that 404 mean they have separated, it is done? Or
13 does that mean the MEB process has started? That is a -- LIEUTENANT NORIEGA: No. It is the latter, ma'am. This
14 404 are folks who have gone through the PEB process, are veterans, or have returned to duty. So, it is a
15 combination of things. MS. CROCKETT-JONES: So the number -- that 98 maintenance
16 -- might include people who -- LIEUTENANT NORIEGA: Yes. Absolutely.
17 MS. CROCKETT-JONES: -- have started.
18 LIEUTENANT NORIEGA: So these are folks who
19 may be in the rehabilitation phase going to the
20 MEB or awaiting the PEB. So this 98 here -- MS.
21 CROCKETT-JONES: Okay.
22 LIEUTENANT NORIEGA: And this 123 would be

1 those who are in acute phase of treatment more or
2 less.
3 DR. GUICE: So your orange, what you say "in
4 transition", those are really individuals who have
5 "transitioned"?
6 LIEUTENANT NORIEGA: Out. Yes. MS. CROCKETT-
7 JONES: Past tense.
8 LIEUTENANT NORIEGA: Yes. MS. CROCKETT-JONES:
9 Does Safe Harbor provide services to them once
10 they are separated and --
11 LIEUTENANT NORIEGA: Yes we do ma'am. MS.
12 CROCKETT-JONES: You continue to follow? So they
13 are a part of the case load?
14 LIEUTENANT NORIEGA: Yes ma'am.
15 CAPTAIN CARTER: And we will talk about some
16 of the programs we use to stay in contact with
17 those individuals
18 too.
MS. DAILEY: Dr. Guice, I have to say I think this is the
19 first time anyone has ever broken out intensity which
goes back to your question of one -- one to 40, one to
20 ten ratios, this is the first time I have heard anyone
say "here is the highest intensity cases, here is what it
21 looks like when you are managing them, here is what it
looks like when you are not having those types of cases
22 in your portfolio.
DR. GUICE: Correct, and it would be interesting to have

1 that to understand that just a little bit better.
2 LIEUTENANT NORIEGA: Absolutely.
3 DR. GUICE: The thing that is striking to me
4 and as I am starting to puzzle through it -- I
5 mean really what you are -- the recovery care
6 coordination is really a nonclinical case
7 management program, so it may be a -- we probably
8 have to think about the differences between what
9 is case management and what is coordination,
10 because their probably is a little bit of a nuance
11 difference. But that is why you are seeing the
12 intensity of within that initial hospitalization
13 and why it is so high. For the Federal Recovery
14 Coordination Program, because we have a little bit
15 of a different function we see it quite
16 differently. We see that inpatient time as
17 actually not requiring a lot of the FRC time
18 because of programs like Navy Safe Harbor where
19 the FRC's have their intensity go up during those
20 transitions making sure that the knowledge and
21 information moves and that the family has one
22 point to kind of go to to resolve any of those

1 transitioning issues that we all know are in part

2 partial

3 of our headaches. So I think that is a very interesting observation and I like the way you have started to drill
4 down onto "how do we actually balance the caseload in a more rational way than just random assignment. So thank
5 you, kudos for that.
LIEUTENANT NORIEGA: Thank you. It really does help us
6 with our work load composites when we look at assigning a Care Manager at a case, so it is very helpful for us.
7 Any other questions on this slide here? Alright we will talk a little bit about how we are organized.
8 Again, I am the Operations Officer. I am

9 essentially the Recovery Care Program Manager. I

10 have an Operations Officer East and West who

11 handles all of our cases in those two areas. What

12 those two Operations Officers do is they

13 coordinate with our liaison in Millington and they

14 receive these PCR's and these referrals. So they

15 receive a referral from someone say in Bremerton,

16 Washington so our Ops West will contact our

17 Nonmedical Care Manager over at Bremerton and

18 assign that case to that member. So they will

19 start the needs assessment, they will start the

20 Comprehensive Recovery Plan. So that coordination

21 is done by Operations West and East, but primarily

22 what they do is they oversee the execution of the

1 Comprehensive Recovery Plan. So we have 18
2 Nonmedical Care Managers in the field. They
3 conduct the Comprehensive Needs Assessment, they
4 develop the Comprehensive Recovery Plan, and
5 however, Operation East and West oversee the
6 execution of it. So it is a QA function. So our
7 Care Managers in the field conduct the needs
8 assessment, identify certain needs, develop a
9 comprehensive plan to address those needs, and our
Operations -- Assistant Operations East and West will
10 oversee the execution of that. So that is the QA
function that we conduct and we do that mainly through
11 case reviews -- weekly case reviews.
DR. GUICE: Can you just walk us through an example, say
12 you have -- one of your case managers has done the
assessment and they have developed a plan. Alright now,
13 so you see the plan. Now as the QA function and the
execution, what are you actually doing?
14 LIEUTENANT NORIEGA: Right. So when they
15 develop the Comprehensive Recovery Plan, there is
16 a date attached to it. So you identified a need
17 October 1st. It is now middle of November. Where
18 are we with that stuff? Has it been completed and
19 if so then annotate that in the Comprehensive
20 Recovery Plan, because it is a breathing, living
21 document. It never remains static. It is always
22 being updated -- it is always changing.

1 DR. GUICE: But your Nonmedical Case Manager
2 actually implementing the plan as well. They are
3 just providing that oversight to make sure that
4 things are running on time?
5 LIEUTENANT NORIEGA: Absolutely.
6 CAPTAIN CARTER: And that's how I kind of
7 began that piece, as I was taking over and reading
8 the NDA from 2000 -- that Nonmedical Care Manager
9 would be at that level at the MTF's and that
10 Recovery Care Coordinator would be that guy
11 providing that oversight in the QA piece, and that
12 is how come we are redoing it right now.
13 LIEUTENANT NORIEGA: This graph really shows
14 where our
15 Nonmedical Care Mangers are located. Again, we have 18
Nonmedical Care Managers. They are located at all the
16 major Navy MTF's. We have two at Brook Army Medical
Center. We have at the VA poly trauma center, and we
17 also have as you can see here, this is where our liaison
-- this is a staff member embedded within a Naval
18 Personnel Command in Millington who is our liaison with
PERS95 and N135 for our Reservist, Reserve issues as well
19 as our invitational travel orders.
This break out here -- these graphical break outs --
20 these are essentially partners within our anchor
21 programs. So for every triangle you see within
22 these regions, those are our Naval Operations

1 Support Center. So those are reserve centers, Navy
2 Reserve Centers. What we have done with all of
3 these Naval Reserve Centers to address a very
4 important part of our transition piece which is
5 our mentorship. So, a member transitions out of
6 the Navy -- and I will talk a little bit more
7 about the anchor program -- but the idea is to
8 find a peer mentor within one of these regions.
9 This member is transitioning to Kansas say, and it
10 is not a fleet concentrated area, so we will find
11 a local Naval Operational Support Center and find
12 this member a peer mentor to really shadow him and
13 really provide that feedback to us and it will be
14 reported to our Anchor Program Coordinator and
15 essentially just keep tabs on this guy. So, does
16 he have any financial needs currently? Is there
17 something medically going on with this service
18 member that we should be aware of? So really it
19 is our conduit and how we reach out to all of
20 our folks who are in transition. So through this
mentorship and we currently have about 46 people who have
21 entered this program. It is a voluntary mentorship
program. I don't think we have found anybody to turn in
22 down or not.
CAPTAIN CARTER: And all of this is on volunteering,

1 because we can't make a service member do anything. Okay? Once they transition out, we can reach out to them
2 and say "hey do you want to get involved with this? I think this is something good for you to have a junior
3 mentor and a senior mentor okay, back in your
4 hometown or back in your home record of town --
5 get you matriculated back into your home town if
6 you want that". But it is completely voluntary
7 and it is just a small piece of the transition,
8 because I have got a long way to go with the
9 transition piece. But that is just one small
10 piece of it.
11 LIEUTENANT NORIEGA: Again we have 18 Navy
12 Safe Harbor Nonmedical Care Mangers. 9 of the 18
13 have gone through the OSDRCC Certification. The
14 plan is to send the remaining 9 through the RCC
15 training by the end of this fiscal year. Our
16 headquarters components -- so we have 18
17 Nonmedical Care Managers in the field. The
18 remainder is at headquarters with one liaison in
19 Millington, and that is Ms. Larson's department,
20 the Strategic Support Department and really that
21 is where all of our subject matter experts are.
22 We have two -- today we have our medical advisor

35d3e2fa-d345-46de-b608-dda506fb6452

1 and our legal advisor. We have a family services

2 coordinator, our anchor program coordinator, the

3 program we just mentioned, an adaptive sports

4 coordinator

5 we just recently acquired, and the Department of Labor
who we are hoping we can get back soon. So we are
6 tracking on that hopefully.
I want to put this slide in here just to kind of show the
7 model of how our Recovery Program operates. So here we
have our Nonmedical Care Mangers in the field. All
8 right, the RCC function, the oversee and assessed is done
by Operations East and West. Then we have our partners
9 here, our medical case managers and our primary care
physicians down below. So this really makes up that
10 multidisciplinary team that we were talking about

11 earlier. We work obviously closely with the chain

12 of command. Again, we don't own any of our

13 sailors. So they are either attached to an MTF or

14 attached to their units with some of the support

15 personnel that our care managers deal with on a

16 day to day basis.

17 DR. COAKLEY: Lieutenant, I have a question.

18 So the members that are attached to the MTF --

19 LIEUTENANT NORIEGA: Yes.

20 DR. COAKLEY: -- they are PCS for their care?

21 LIEUTENANT NORIEGA: They could be, yes.

22 They could be PCS to the MTF or put on some sort

1 of inpatient status.

2 DR. COAKLEY: Okay. Once that cure is

3 complete then they are transferred or just

4 transported back to their current command?

5 LIEUTENANT NORIEGA: Yes, if they are

6 returned back to duty.

7 DR. REHBEIN: Let me follow up for just a

8 minute on what the Commander was saying. Once

9 they go back to their parent command that

10 Nonmedical Case Manager remains with them through

11 long distance?

12 LIEUTENANT NORIEGA: Yes. Absolutely.

13 DR. REHBEIN: They never see each other face

14 to face beyond that.

15 LIEUTENANT NORIEGA: They may have a mentor

16 at that time if they so choose, so if they return

17 back to duty and they require further assistance

18 they are rogue for life. So any assistance that

19 they need, we will provide. But in many cases,

20 they are like "Okay, thank you. We are good to

21 go. We are back with our units". They may not

22 require anything from Safe Harbor.

1 DR. COAKLEY: Just to clarify, so the
2 individual member goes back to their command and
3 then the Operational Commander, ship driver,
4 Seabee Commander or whatever, they have that
5 individual on their books and what happens to them
6 then? For instance, you have a division getting
7 ready to go down to ranch battalion of DOD or
8 Seabees in my scenario. Does that individual get
9 transferred to a temporary holding unit or how
10 does the Operational Commander recoup that?
11 Because in the other Warrior Transition Units,
12 they are off their books so they could recoup
13 those bullets.
14 LIEUTENANT NORIEGA: They may in fact get
15 different orders. They may not go back to their
16 original plan. In many cases, if the treatment
17 was long enough where they have lost them in the
18 books, they may recover and then get a new set of
19 PCS orders. So they may not necessarily
20 go back to their original command.DR. GUICE:
21 I have a different question. You have 18 field
22 staff, but a total program staff of 42.

35d3e2fa-d345-46de-b608-dda506fb6452

1 CAPTAIN CARTER: Correct, with liaisons, right.
2 DR. GUICE: And can you kind of give us that
3 entire, the rest of that, just in writing -- you
4 don't have to do it right now but just provide us
5 that entire -- you have 40 -- 40 to 42 staff
6 depending on any given day, right?
7 CAPTAIN CARTER: Exactly.
8 DR. GUICE: But you have 18 full staff
9 performing the job of the non-medical case
10 manager, so what are the other people doing?
11 MASTER SERGEANT MACKENZIE: Lieutenant, one
12 thing on one of the comments you made was
13 individual returns to duty, goes back in the unit,
14 I don't need anything from Safe Harbor so I'm good
15 to go.
16 LIEUTENANT NORIEGA: We still follow up.
17 MASTER SERGEANT MACKENZIE: What is the
18 frequency of contact required by Safe Harbor non-
19 medical care managers on those individuals who
20 have been returned to duty and/or the veteran
21 status?
22 LIEUTENANT NORIEGA: Initially we contact

1 them monthly, until maybe six months down the
2 line, and at that point we may contact them every
3 six months or so. Initially a lot more, so again,
4 many of them may not want a mentor or maybe, thank
5 you, I'm fine, I just want to go back to my unit,
6 go back to work. Occasionally that happens and
7 then we'll get a call, say, hey, you know, my
8 wife's looking for employment, or are there any
9 family service centers in this location here. So
10 there's always some relationship there and they
11 know who to call. So it may not be us at
12 headquarters, but they'll call their non-medical
13 care manager.
14 CAPTAIN CARTER: But keep in mind though,
15 like anything else, you know, happenstance, people
16 tend to get lost because they'll move and they
17 won't inform you where they've moved to, or the
18 care manager doesn't know that, or they change
19 email addresses sometimes and you try to email
20 them to find out where they are. It's a constant
21 battle to say where is the individual, I want to
22 keep tabs on him, so what's the best way to find

1 out if he's changed. Is he trying to tell me
2 don't contact me because I've moved, changed my
3 email address? There are lots of signals out
4 there, but we are constantly having to try to get
5 back in the database to see where that individual
6 has moved to or what's its status, which is a
7 constant battle.
8 MASTER SERGEANT MACKENZIE: That's the
9 reason I asked that question is that's how you fix
10 that issue and get additional support necessary to
11 resolve that issue.
12 CAPTAIN CARTER: Yes.
13 MASTER SERGEANT MACKENZIE: If you have
14 numbers where you can say we call every six months
15 and here is our success, here is our challenges --
16 CAPTAIN CARTER: And we have some of that,
17 with the Anchor Program, that's a little bit of
18 what I have my Anchor Program doing, but I need to
19 do more on that. But that's a piece -- like I
20 said, the transition piece is a piece I need to
21 grow a little bit on, because you saw my bar
22 graph. Most of them are transitioning out now so

1 that should be a big job to keep a tab on them and
2 where they're going, especially in someplace like
3 Montana in the middle, where there's not a NOSC or
4 anything there real close. Okay. It's going to
5 be hard to fly out to his house and say, are you
6 still here?
7 LIEUTENANT NORIEGA: Thank you again. Going
8 back to our enrollment criteria where I think
9 we've beat this half to death, but again, that 180
10 days, I really don't want to get caught up on that
11 too much. It's more than likely, and it's not
12 like we set a clock and then at 180 days we say,
13 hey, we're not going to enroll you. That decision
14 is made from the onset, so again, our primary
15 referral sources are PCRs that come in through our
16 N135 and our liaison in Millington. It's important
17 to note here, and I think I talked a little bit
18 about this, is there are occasions where you may
19 not be seriously rudimentary, but you have some,
20 you know, some family dynamics, some socio-
21 economic conditions that warrant involvement or
22 interaction with our non-medical care managers.

1 So again, case by case, if we see -- and we like
2 to err on the side of caution, if we think that
3 this person can benefit from our program, we're
4 going to enroll them. So again, I don't want to
5 get caught in this 180 days and maybe that wasn't
6 a good way to put this, but we're looking at those
7 who are more than likely not going to return
8 within 180 days.
9 We're not setting a clock. MS. CROCKETT-JONES: I
10 don't think we're concerned that you're setting a
11 clock on services you're providing. I think that
12 when we see that 180 days, we want to know the
13 progress and the services, we're looking to see
14 how long it takes for someone who has a serious
15 problem to get to a decision-making process for
16 the transition or the progress of his -- where
17 he's going. And so if that's going to be leaving,
18 separating, or returning to duty, then we're
19 looking to see how much -- we need to track how
20 long it takes before someone has a determination
21 on where they're going next.
22 LIEUTENANT NORIEGA: I see. MS. CROCKETT-JONES:

1 And so that is hopefully some data you can start
2 capturing.
3 CAPTAIN CARTER: I catch what you're saying,
4 I mean, if we can get that 180 days [inaudible]
5 re-evaluation that he's still got to stay there
6 longer and so forth. Because the whole recovery --
7 whole recovery and rehabilitation and [inaudible],
8 like I tell my team all the time, it's not phases,
9 it doesn't cut off anywhere. It doesn't -- just
10 because you go out of recovery doesn't mean you go
11 back. The whole thing goes back and forth,
12 recovery, rehabilitation, reintegration. A person
13 can have a relapse and maybe at one time we have
14 to start all over with them again. That's
15 something we work amongst ourselves and the
16 medical team and the primary care managers to make
17 those decisions on. But there's no stop to those
18 phases. They just kind of, we work it as best we
19 can between the three.
20 GENERAL STONE: So just to expand on that
21 slightly, you earlier said that we inform that
22 decision based on the DODI, right, the 180 days

1 came off the DODI. Is the DODI right [inaudible].
2 CAPTAIN CARTER: I don't think the DODI can
3 say its 180 days. It says [inaudible] 180 days,
4 yes.
5 GENERAL STONE: Okay. So what systems have
6 you put in place to relook at that to see is that
7 the right number? We are respectful of the fact
8 that you are not cutting off services, but is the
9 -- either you're going to look at the definition
10 of seriously, or you have a look at the 180-day
11 number. What informs your admission criteria,
12 your continuation form, your entrance into the
13 MEB/PEB IDES process?
14 CAPTAIN CARTER: Do we have anything on that?
15 LIEUTENANT NORIEGA: I think that the
16 seriousness of the condition is really what we
17 look at. Again, that 180 days is not necessarily
18 something that we focus too much on, quite
19 frankly. What we look at is, is this member
20 likely to return to duty, or is this member -- is
21 this condition so serious that it may warrant an
22 MEB/PEB. And if the question is maybe, or we

1 don't know, we enroll. We err on the side of
2 caution. Again, I think it's very difficult to
3 come up with a timeline at 180.
4 GENERAL STONE: And I recognize the fact,
5 and one of the reasons that I'm spending so much
6 time with this is each of the services has
7 approached this --
8 CAPTAIN CARTER: Differently.
9 GENERAL STONE: -- very differently, and I
10 think the question is what's right, and when you
11 have little data to support your decision-making
12 10 years into this, it is troublesome.
13 CAPTAIN CARTER: But they are enrolled for
14 [inaudible] once we enroll them, they are enrolled
15 for life. So we're going to provide that non-
16 medical care.
17 GENERAL STONE: I'm not questioning that you're
18 continuing to provide services. The question is
19 when is the decision-making to allow the sailor to
20 begin to plan their life and future, and then as
21 you get into later and your briefings, what
22 services do you provide once you make that

1 decision?

2 CAPTAIN CARTER: Right.

3 GENERAL STONE: Or who adjudicates this so

4 that two years into this, if you still feel

5 there's a capacity to recover, where is the

6 adjudication process? You heard public testimony

7 with the frustration of where is the decision-

8 making process.

9 DR. GUICE: Having read the DODI recently,

10 as probably Captain Carter did too for another

11 event we were participating in, this is -- the

12 DODI actually says there are three categories, and

13 they are just totally administrative. They are --

14 trying to operationalize administrative terms is

15 always artful. But this tracks more with Category

16 3 under the DODI. So my question is what are you

17 doing about the Category 2s under the DODI, or

18 that sort of administrative descriptors within the

19 DODI, which were really designed to be -- make

20 sure that those had the recovery care

21 coordination, because this, to me, tracks a little

22 bit more with that Cat 3 description.

1 LIEUTENANT NORIEGA: Right. Well, when we
2 get these casualties reports, they are either SI
3 or VSI. So we don't -- you can be
4 catastrophically injured or you can be seriously
5 injured. We make no distinction between the two.
6 If you're like to go through the PEB process and
7 you're likely not to return to duty, we're going
8 to enroll you whether it's, we put it in a nice
9 Category 2 or a nice Category 3, it's really tough
10 to categorize these service members into those.
11 There's really no criteria that I'm aware of,
12 other than 180 days return to duty, or likely to
13 be -- go through the medical board. And for a
14 Category 3 is catastrophically or very seriously
15 injured and likely to be discharged. So it's --
16 the ones that we look at, is this person likely to
17 be discharged and go through the PEB process? If
18 we can't answer that question, we enroll them. So
19 we err on the side of caution.
20 CAPTAIN CARTER: I got that homework assignment.
21 LIEUTENANT NORIEGA: Yes.
22 CAPTAIN CARTER: Because when you put that

35d3e2fa-d345-46de-b608-dda506fb6452

1 definitive number, it means different things to
2 different people, okay? So maybe we need to come
3 up with, between the services, some other -- some
4 number that's similar that we all use based on the
5 whole DES and MEB DES process.
6 MS. DAILEY: And keep in mind that there's a
7 piece here now missing which we've had with other
8 presentations, which is the chain of command.
9 Your individuals are still with the chain of
10 command, whether it be a medical chain of command,
11 a MEB hold, or it be a land-based, non-ship unit.
12 So they're involved in the decision to say that he
13 is not going to be able to function, I, the
14 commander want to move him onto the next step,
15 which is the MEB board.
16 CAPTAIN CARTER: Right.
17 LIEUTENANT NORIEGA: Thank you, ma'am. That
18 is a very informed part of this and we need to
19 factor that in. And again, we don't own any of
20 these sailors, so we rely on the chain of command.
21 We work closely with them.
22 GENERAL STONE: So before you go on, does

1 the chain of command have veto authority over a
2 medical decision?
3 CAPTAIN CARTER: I don't -- no, that's not
4 true. I mean that's a -- I think what you were
5 getting at is that, in the case of a ship or squad
6 room or something like that, if the command feels
7 anybody was not up to specs to performs its
8 functions, the member ought to get him off the
9 ship or out of the squad room before we take off
10 for deployment, something like that. But he
11 doesn't have -- I think that's got to be a
12 collaborative decision between the whole multiple
13 disciplinary team.
14 GENERAL STONE: And if your
15 multidisciplinary delivery team believes that the
16 sailor needs 365 days, can the commander override
17 that?
18 LIEUTENANT NORIEGA: I can't talk to the chain of
19 command.
20 CAPTAIN CARTER: I'm not sure about that,
21 General. I can't make a comment on that. I don't
22 know -- I wouldn't be in that command's -- that

1 individual's chain of command working with his
2 ISIC or his battlement commander. I wouldn't
3 know. I cannot comment on that one.
4 DR. COAKLEY: I can speak to that, Captain. It
5 traditionally I'm in operational forces, as you
6 know - it traditionally the commanding officer
7 will not usually go against that recommendation.
8 When the recommendation is made to the chain of
9 command, that's why I wanted to elaborate that
10 since we don't have, quote, Warrior Transition
11 Units. That commander will usually side with
12 whatever the decision is, so if it's 365 days,
13 that would be fine. It does force that
14 operational commander's hand to figure out where
15 they are going to place this sailor, because now
16 they have a loss and they have no prospective
17 gain. So what they'll do is they'll place that
18 individual in what we call a transitional unit or
19 a holding unit. We have several of them at
20 different coasts. That way they can have the
21 person transferred there, it's like a PCS, and
22 they can go ahead and get a fill for that

1 operation.

2 LIEUTENANT NORIEGA: Okay. I talked a

3 little bit about the reserves and how our -- the

4 med hold and LOD program is run by a separate

5 organization, PERS 95. What we're finding, at

6 least for our calculation, is that when a

7 reservist is injured in theater or, you know,

8 while on active duty in some capacity, they remain

9 on active duty through the recovery,

10 rehabilitation, and eventually transition out of

11 the Navy. So really, for us, we make no

12 distinction between how we conduct business with

13 an active component sailor and a reserve component

14 sailor. It's transparent. So if you're a

15 mobilized reservist and you're injured in theater,

16 you'll MedEvac straight to the MTF and you will

17 remain on active duty throughout that process. So

18 the vast majority will be on active duty. Yes,

19 sir.

20 MR. REHBEIN: Yes, I was intrigued by that

21 word, most, where you leave out the second bullet,

22 because implies that there are others that --

35d3e2fa-d345-46de-b608-dda506fb6452

1 LIEUTENANT NORIEGA: There are, and we know
2 that and we all know that that's the case. PTSD,
3 for instance, you demobe a sailor, and then these
4 symptoms manifest six months down the line, and
5 this is where we have to work with our partners at
6 PERS 95 to get this LOD process in place for them.
7 MR. REHBEIN: So what you're saying is the
8 diagnosis comes after demobilization.
9 LIEUTENANT NORIEGA: In many cases, yes, sir.
10 CAPTAIN CARTER: What we've found sometimes,
11 a lot of times these guys come back and when
12 they're going through the demobe process,
13 unfortunately they are in such a hurry to get home
14 they're not really sure if they -- they might not
15 be telling the doc everything that's happening to
16 them. And them maybe four or five months down the
17 road, now I think I have something. So we'll have
18 to work back through their NOSC and work right
19 through PERS 95 to get help. And that's where
20 that coordination piece with comes into play.
21 LIEUTENANT NORIEGA: Right, and that
22 coordination piece is really our liaison over at

35d3e2fa-d345-46de-b608-dda506fb6452

1 Millington. That's a key staff member for us, is
2 that liaison over in PERS. Any questions?
3 MR. REHBEIN: It looks to me like we're
4 going to move away from people, so I'm going to
5 ask one question.
6 LIEUTENANT NORIEGA: Yes, sir.
7 MR. REHBEIN: Your non-medical case
8 managers, where do they come from? I get the
9 impression that maybe this is a permanent job for
10 them?
11 LIEUTENANT NORIEGA: You know, of the 18,
12 they are made up of civilian employees, there are
13 five civilian employees, two contractors; the
14 remainder are on active duty, active duty members.
15 Of those, seven are mobilized reservists. So we
16 have seven mobilized reservists, three active
17 component sailors who are non-medical care
18 managers, five government employees, and then two
19 contractors. So it's -- so, yeah.
20 MS. LARSON: And, sir, if I might add one
21 additional thing. When the program stood up, we
22 stood up with all mobilized reservists for non-

1 medical care managers and those five civilians.
2 During FY11, we were able to secure permanent
3 active duty billets who now we are working to
4 transfer the mobilized reservists into the active
5 duty component.
6 MR. REHBEIN: Mobilized -- mobilized for
7 what period of time? Six months, a year, two
8 years?
9 MS. LARSON: They have been mobilized on
10 annual orders.
11 MS. DAILEY: And real quick, just for my
12 clarification, are you utilizing the term non-
13 medical care manager and recovery care coordinator
14 synonymously?
15 LIEUTENANT NORIEGA: Yes, and that is the
16 intent, to have our -- we have nine of our non-
17 medical case managers gone through the RCC
18 training. So we're going to send the remaining
19 nine, and really it will be matter of semantics
20 when we refer to our RCCs and non-medical care
21 managers. MS. CROCKETT-JONES: Okay, I have a
22 question for you. How long does that training

1 take, and are you sending people who are mobilized
2 for a year to that training and then you lose that
3 from their year. So are you having -- it this
4 going to --
5 LIEUTENANT NORIEGA: Which training?
6 CAPTAIN CARTER: The RCC training.
7 LIEUTENANT NORIEGA: That's a one-week
8 training course with the OSD folks at D.C. so it
9 takes place here. It's one week long, and that's
10 in addition to our non-medical care manager
11 training that we hold annually. MS. CROCKETT-
12 JONES: But how long is the non-medical care
13 manager training?
14 LIEUTENANT NORIEGA: Initially we do two
15 weeks. So when we obtain a new non-medical case
16 manager, they'll spend a week at headquarters
17 going through some operational procedures, and
18 then a week on-the-job training with another non-
19 medical case manager. So two weeks and then they
20 are off to their assignment. MS. CROCKETT-JONES:
21 Just looking at this as a stay in field
22 continuity, so if you're mobilizing someone and

1 someone is mobilized for a year, then we subtract
2 training time, that's several weeks, we might also
3 have leave time, so you're really only getting
4 them for maybe ten, ten and a half months. Are
5 they likely to stay with you, get more orders for
6 another year, or are they then cycled and we're
7 retraining new people?
8 MS. LARSON: Ma'am, I would like to answer
9 that. Let me clarify one thing for you. In
10 regards to our mobilized reservists, we receive on
11 an annual basis mobilization authority to have
12 these non-medical care managers on for a year, but
13 what we've experienced is that we have extended --
14 we have been successful in extending that
15 mobilization authority until we've received those
16 active duty billets. So our experience has been
17 the majority of our non-medical care managers from
18 the military side, we've been successful in
19 keeping them for two to three years on these
20 mobilization orders. It just authority that we've
21 utilized to keep them. MS. CROCKETT-JONES: Thank
22 you.

1 CAPTAIN CARTER: Okay. Next we're going to
2 get into the actual questions that you guys
3 presented to us to present to you, and we're going
4 to shift over and now Ms. Larson is going to go
5 over here and start talking about the measures of
6 effectiveness.
7 MS. LARSON: Hi, good morning, and thank you
8 once again for having us here. It's such a
9 wonderful opportunity to be before you and to be
10 speaking about the Navy Safe Harbor Program. You
11 had asked us in regards to what are some of our
12 measures of effectiveness and how we define
13 success within the program. So one thing that I
14 want to talk to you today about is what we do
15 internally with regards to the measures of
16 effectiveness. What we have established
17 internally at Safe Harbor is our annual strategic
18 goals and objectives, and these goals and
19 objectives are really what drive our day-to-day
20 business here at Navy Safe Harbor. And we
21 initialized these objectives during fiscal year
22 ten, and what we do is we've reviewed these goals

1 and objectives on an annual basis and update them
2 as deemed necessary by Captain Carter and senior
3 leadership. In regards to the definitions of
4 success, we have thus far conducted two annual
5 customer satisfaction surveys, and actually what
6 you'll find in your packet of information that we
7 have for you today is the executive summary for
8 the 2009 annual customer satisfaction survey, and
9 then also too we conducted a 2010 survey, and
10 those results will actually be out in about a
11 week. So we apologize for not having those
12 results, but we're more than happy to provide
13 those to you when we receive them. But I did
14 include in your packet the actual questions we
15 asked in 2010. Furthermore, another survey that
16 we utilized is focused primarily on the awareness
17 -- fleet awareness about Navy Safe Harbor, and
18 that is actually a survey that we piggy-back off
19 of. It's a behavioral quick poll study which goes
20 out to the entire fleet, and we utilize three
21 questions off of that survey to deem the total
22 awareness of the fleet about the Navy's Wounded

1 Warrior Program. So as I mentioned, in FY10,
2 that's when we really established our vision and
3 mission statement. And as you can see here on the
4 board, we have established six strategic goals,
5 and under those goals, we have various initiatives
6 that drive our day-to-day business. And under
7 these initiatives we actually have the objectives
8 and measurable metrics. One thing that we are
9 looking to in the future is to be able to
10 encompass all of these matrix into our database so
11 that we do not have to use multiple Excel
12 spreadsheets, in fact hindering some of our
13 analysis and our data. So that's an additional
14 module that we'd like to add into our database in
15 the future so that we can send out nice reports.
16 As you can see here in regards to our goals, we
17 are focusing obviously on our core business, which
18 is the non-medical care management in goal number
19 one, all the way through to our increasing Safe
20 Harbor awareness and also on one of the lines for
21 goal number six, which is focusing on attracting
22 and sustaining the appropriate staff. One thing

1 also, too, that I'd like to mention that we're
2 excited about is we are internally developing a
3 five-year strategic plan, and that's something
4 that we'd like to have out in the street by the
5 end of this fiscal year. And what that five-year
6 strategic plan is going to do, it's going to help
7 us be able to build our annual plans into the
8 future, and also it's really good exercise to
9 allow us to envision what Safe Harbor should look
10 like in the future, where should we be aligned,
11 how should we run our business. So in regards to
12 the goals and objectives --
13 GENERAL STONE: So based on that comment, so
14 you're strictly OCO-funded today.
15 MS. LARSON: No, sir. We actually became a
16 program of record in FY10 and we are currently
17 funded though OMN, sir.
18 GENERAL STONE: And your mobilized reserve
19 component are being funded through that base
20 funding program?
21 MS. LARSON: The mobilized reservists, sir,
22 come out of the NPN pot, out of the N1

1 organization. So for our strategic goals and
2 objectives, we actually utilize the stoplight
3 chart, and what we do is on a quarterly basis and
4 actually monthly basis, we are receiving the data
5 from our field and from our headquarters staff to
6 be able to develop this stoplight matrix. And so
7 as you can see here up on the slides, here is
8 where we are rating ourselves -- and just please
9 note that we are finalizing the second quarter of
10 the fiscal year, so we are halfway through the
11 fiscal year. And this is where we are currently
12 measuring ourselves against these initiatives and
13 these strategic goals. So if I can just kind of
14 draw your attention, one thing that we feel as
15 though we are doing a good job at 1.2, which is
16 really being able to have a sound mechanism to be
17 able to receive feedback and information from our
18 end customers, those folks who are enrolled and
19 their family members. One thing that we would
20 really like to work on this year, which we are
21 working on as one of Captain Carter's initiatives,
22 is to implement that transition team. Now on a

1 caveat, we feel as though we have some of the
2 right components for the transition team, but we
3 don't have a transition team lead. So someone who
4 can be that bellybutton, who can wrap their hands
5 around all those individuals who touch the
6 transition process. So that's something that
7 we're looking at internally and that is why we
8 measured ourselves at red right now. So we have a
9 plan, we just need to move forward in the next two
10 quarters of fiscal year and get that plan
11 implemented. And one other thing I'd like to
12 mention too in regards to cultivate and
13 institutionalize external and internal
14 relationships, we've been talking a lot about the
15 Anchor Program. And so last year our goal was to
16 implement an Anchor Program. So this year it's a
17 little bit different; it's enhancing the Anchor
18 Program. So as Lieutenant Noriega had mentioned,
19 we have 46 people who are enrolled in the Anchor
20 Program, where our goal this year is to have 100.
21 So that's why we're not there yet, we're not at
22 green, but we're eventually working towards that

1 goal for ourselves. So a strategic goal as number
2 three and number four, we definitely have some
3 additional work that we would like to do by the
4 end of the fiscal year with regards to providing
5 more focused outreach opportunities for our
6 wounded and injured. There are definitely some
7 great initiatives that are out there right now
8 through the OSD and DOD world that we are trying
9 to leverage with, especially in the employment
10 area and also through the ISI initiative as well
11 we are working on those. And one thing that we've
12 been talking a lot about to do is the Adaptive
13 Athletic program, and we're very thrilled to have
14 that up and running, and also to another good news
15 story that goes along with the Adaptive Athletic
16 program is that we actually were able to hire one
17 of our Wounded Warriors in our athletes, he was
18 our coach last year at the Warrior Games and now
19 he is our Adaptive Athletic coordinator program.
20 DR. GUICE: I have a question on your 3.2,
21 develop and coordinate family-focused programs and
22 resources. There are a lot of family-focused

1 programs and resources that currently exist, so
2 are you doing kind of a gap analysis first to
3 figure out if you do need to develop something
4 unique, different, based on the needs of your
5 clientele, or are you just going to be able to
6 leverage what already exists and therefore comes
7 at a smaller cost?
8 MS. LARSON: Yes, ma'am, you're correct.
9 And one thing that we do a lot of is leverage
10 Commander Navy Installations Command, CNIC. They
11 are the ones who own all the Fleet and Family
12 Service regular centers, and so our non-medical
13 care managers who are out in the field work hand-
14 in-hand with these Fleet and Family Service
15 centers, and we've been successful at, you know,
16 the echelon two level to be able to work with
17 leadership for CNIC to actually have some of their
18 policies reviewed and revised. For example, we've
19 been successful at having the child and youth
20 programs, have our Wounded Warrior children at the
21 priority list, and also to have some additional
22 free daycare provided at the service centers for

1 our Wounded Warrior families. And then also, too,
2 we've been able to have a priority in regards to
3 housing as well. So they've expanded and adapted
4 some of their policies specifically for our
5 Wounded Warrior population and that's really based
6 upon us leveraging our partnerships with CNIC. So,
7 what we try to do is we really want to focus on
8 first, you know, what's available at the Navy
9 level, what's at DOD and the OSD level. So we
10 don't want to reinvent the wheel. We really want
11 to utilize what is out there and see how we can
12 potentially tailor it to what our family members
13 need.
14 DR. GUICE: Can you -- a similar question
15 about 3.3.
16 MS. LARSON: Yes, ma'am.
17 DR. GUICE: Your caregiver support network,
18 specifically related to external partners. Which
19 external partners are you pursuing networking
20 capabilities?
21 MS. LARSON: Well, it's really -- we have --
22 let me just back up to, and caveat, we have one

1 person on our staff who is our sole family care
2 coordinator. And so that is really her bread and
3 butter, and what she does is she goes out and she
4 vets organizations and opportunities for our
5 family members. So she's really worked closely
6 with the DOD. You know, there are specific BUMED
7 programs, such as Focus, for example, that she is
8 really working towards have some of our family
9 members and their services as well. The Military
10 One source, we utilize the Military One source
11 handbooks that are Keeping It All Together. We
12 have received information and feedback that those
13 have been very useful to our families as well.
14 Also, OSD WWCTP provides great resources. They
15 just came out with a new family journal that we
16 have provided to all of our family members as
17 well.
18 MS. DAILEY: Your revised Navy regulations
19 for priority for Wounded Warriors in the daycare
20 centers, childcare priority, can you get that to
21 us? Would you take that as a task --
22 MS. LARSON: Yes. Yes, ma'am.

1 MS. DAILEY: -- and get back to us, please?
2 MS. LARSON: Will do.
3 MS. DAILEY: Thank you.
4 DR. GUICE: Actually, before we leave that,
5 we're going to offer you the opportunity to look
6 at this book. I know the WWCTP has done a family
7 journal, but this is what was given to us the
8 other day from the Marines, and it's sort of a
9 hybrid. So if you'd like to take a look at that,
10 we'd welcome you to.
11 MS. LARSON: Thank you very much. And we
12 actually do also utilize the Keeping It All
13 Together handbook too. So thank you very much. And
14 then moving along to goal number five and goal
15 number six, we feel as though we have been
16 successful when it comes to being able to identify
17 and aligning resources, a tour program, you know,
18 DOD, POM cycles. However, everyone is operating
19 under the constraints of the continuing resolution
20 and we feel as though we are doing a good job in
21 regards to identifying external resources from
22 NGUs, from foundations that can also support our

1 service members, especially those who are retired
2 as well. In regards to goal number six, the
3 majority of our program is manpower, both from the
4 military and the civilian side of the house. So
5 we really want to make sure that we do a good job
6 in providing our staff members with the right
7 training, the right resources that they need so
8 that they can provide the optimal care to our
9 enrollees. In regards to how we define success, we
10 talked about the annual customer satisfaction
11 survey, and this, these results are coming from
12 the 2009 survey, and like I mentioned earlier, we
13 have the executive summary for you as well. And
14 these are the top-line snapshots and the questions
15 that we asked were very focused on the services
16 that are being provided by the non-medical care
17 managers, how satisfied are they with that. And
18 one thing that I want to mention, lessons learned
19 from the 2009 survey, we went out to our
20 population in 2009 and we sent about 392 surveys
21 out to the service members. And the initial
22 thought was to survey just the service members,

1 and what we noticed was that some of the service
2 members were unable to take the survey. And that
3 is why you see responses from spouse or other.
4 But the spouse was supposed to be answering the
5 survey through the eyes of their service member,
6 and so that is one thing that we've actually
7 changed from 2009 to 2010. In 2010, we actually
8 have a set of questions solely, specifically for
9 the spouses. And that's something that is in your
10 packet, because we actually really wanted to drive
11 home what do the family members need. And so
12 we're really looking forward to getting the
13 results from 2010 to be able to help craft our
14 Family Care Coordinator program a little bit
15 better so that we make sure that we're meeting the
16 needs of our family members. But what this portion
17 is telling you, the overall satisfaction with the
18 program, the blue quadrant here for the sailors,
19 65 percent in 2009 were satisfied or very
20 satisfied with the services that they were
21 receiving from the non-medical care managers. And
22 in the 17 percent was the neutral. And then as

1 you look to the right, the spouses and the others,
2 so you're right, it is 50 percent to are satisfied
3 or very satisfied, it's just that 27 percent were
4 neutral, similar to what the Marine Corps had
5 briefed yesterday. So, and the other big side of
6 the customer satisfaction survey is would you
7 recommend this program to others. And 71 percent
8 of the service members annotated that they would
9 recommend this program to other service members.
10 And the spouses were the 62 percent. So this was
11 our baseline data. This is from 2009, so we are
12 very eager to see how this correlates to our
13 survey results in 2010, so that we can really see,
14 you know, have we improved, are the things that
15 we're currently doing making impacts in people's
16 lives, how will we need to adjust. So that will
17 be telling in the next couple of months here.
18 DR. GUICE: Could I -- back to that just a
19 little bit. Your target population was your entire
20 enrollee population?
21 MS. LARSON: Well, ma'am, during 2009, we
22 sent out to the enrolled population and the

1 addresses that we had were 392. That was the
2 sample size
3 DR. GUICE: And how many were returned?
4 MS. LARSON: We had a response rate of 29.7
5 percent, which is in line with the Navy's average
6 for surveys.
7 MR. GUICE: And was the survey conducted
8 using just mail?
9 Did you do telephone follow-up or any combination.
10 MS. LARSON: Actually, ma'am, this is a
11 great question because this is a lesson learned
12 during 2009 which we changed to 2010. We actually
13 went out with our survey electronically, and we
14 sent letters of notification notifying the service
15 members that this survey was coming and that you
16 could take it electronically, because we thought
17 that our population would have more access to the
18 computer, to Internet, to take the survey. But
19 what we actually found was sometimes that wasn't
20 the case. We didn't have very good web addresses
21 -- excuse me, email addresses. And so we changed
22 that. So in 2010 when we sent the survey out, we

1 sent it out completely in paper format. We
2 actually mailed the surveys in 2010. And from the
3 initial feedback that we are receiving from NPRST,
4 which is the Naval Personnel Research and Studies
5 who conducts all of our professional surveys, that
6 our response rate is higher this year than it was
7 last year.
8 DR. GUICE: And do you know what that is?
9 MS. LARSON: I do not know the official
10 final, but we can definitely get that to you. So
11 this was also another great summary that we
12 received from NPRST for our annual customer
13 satisfaction survey in regards to what are the
14 most programs or information that our service
15 members need. And so from 2009 we were really
16 able to delineate that a lot of our service
17 members were needing information from the pay and
18 personnel side, and then also too from the
19 education and training benefits. So we feel very
20 thankful that we were able to delineate this
21 information. This helps us to have a very focused
22 effort on what services and resources we will be

1 able to provide our service members with.
2 GENERAL STONE: So help us read this.
3 MS. LARSON: Yes.
4 GENERAL STONE: What do you mean here, 40
5 percent said they need more information on pay and
6 personnel issues?
7 MS. LARSON: No, sir. I'm sorry, 40
8 percent, those are the individuals who are
9 utilizing that information the most, or that they
10 need -- that is the type of information and
11 resources that they are receiving and that they
12 are most interested in.
13 GENERAL STONE: Okay. So you got that from
14 your 2009 survey. Maybe I can get at this a
15 little differently. What actions did you take
16 based on this data that have now informed your
17 processes for 2010?
18 MS. LARSON: Right, great question. So one
19 of the first things that we did was we ran out and
20 we got -- we worked very closely with the
21 Department of Labor to get an agreement with them
22 so that we could have a Department of Labor

1 analyst in our stasis to be able to provide that
2 expertise from the education and the employment
3 side of the house. Also too, another thing that
4 we did, we were able to secure a family
5 coordinator as well, and then also too, we were
6 able to provide additional fact sheets, we were
7 able to provide information on our website via the
8 fact sheets to our service members and their
9 caregivers about some of these top issues,
10 specifically the pay and personnel.
11 GENERAL STONE: Thank you. Now if you'd go
12 back to the previous slide.
13 MS. LARSON: Yes, sir.
14 GENERAL STONE: What informs the
15 dissatisfaction and neutral processes from family
16 and sailors? What made them say I am dissatisfied
17 with this program or I am neutral or ambivalent
18 about this program.
19 MS. LARSON: Right. We were able to receive some
20 unanimous feedback in regards to, you know, the
21 written explanations or comments in the feedback
22 sessions of the surveys. And one thing that we

1 were able to delineate from that information is
2 that sometimes our non-medical care managers were
3 providing a lot more focus on the service member
4 than the family member. And so that's one thing
5 that we have incorporated into our training and
6 that's, you know, additional information that we
7 had provided to our non-medical care managers,
8 that any information that our service members
9 receives, a family member needs to be just as
10 educated, just as knowledgeable, for example, on
11 that recovery care plan, as that service member
12 is. So what we try to do is have a more focused
13 effort on making sure that the family member or
14 the spouse or the caregiver was on the same line
15 of communication as that service member. So that
16 was internal training that we provided to our non-
17 medical care providers at the next annual
18 training. And I believe we also included the
19 training agenda from last year in your packets as
20 well. One thing that I do want to mention, and if
21 I can just take 30 seconds of your time, this is a
22 direct to sailor video that we recently had

1 produced for us. It's really focusing on our
2 strategic communications plan, so if you could
3 just show, just the first one. It's 30 seconds,
4 but these direct to sailor videos are actually
5 shown across all the Pentagon channels and to all
6 the ships in the fleet. [Whereupon, a video was
7 played off the record.] Thank you, and now the
8 presentation will carry on with Lieutenant
9 Noriega.
10 LIEUTENANT NORIEGA: Thank you, Merissa. I
11 think we discussed a little bit about the training
12 earlier, but in regards to our new non-medical
13 care managers, we have the one-week training that
14 we do at our headquarters, and then a one-week on-
15 the-job training to shadow one of our non-medical
16 care managers in the field. We also conduct our
17 annual training where we bring all of our staff
18 together and we -- I think you have a copy of our
19 latest agenda for our September training last
20 year. So it's pretty broad, pretty comprehensive,
21 and we try and change it up every year. So the
22 other internal training we do, we conduct our

1 weekly case reviews. Monthly, we have our all-
2 hands teleconference with our subject matter
3 experts, and we discuss new policies, new issues
4 that arise. Some of our external training, we send
5 a lot of our non-medical care managers to casualty
6 training, PEBLO training, case management
7 training. One of the biggest things we're trying
8 to do is send all of our non-medical case managers
9 to the RCC training provided by WWCTP. Again,
10 we've sent nine of our 18 and we're hoping to get
11 the other nine by the end of the fiscal year. Now
12 to move around to some of our best practices, I
13 think Merissa covered the strategic goals. The
14 many other things that we do require our non-
15 medical care managers to provide a weekly report,
16 so to speak, speak to any briefs to be conducted
17 in their areas, any issues that arise and need
18 clarification, maybe some best practices at their
19 location that we can share with other care
20 managers. So we compile all that each week from
21 all our non-medical case managers and we provide a
22 report to Captain Carter, and I think he provides

1 it to Admiral Covell as well. Two of our biggest
2 best practices is our reserve support teams and
3 our Anchor Program, and the next two slides will
4 cover those. So I'll skip those for a moment, but
5 we also conduct site visits. Again, we do our
6 weekly case review meetings, we have a big non-
7 medical care manager and enrollee awards ceremony
8 each year where we bring all of the staff, and
9 this is usually in conjunction with our annual
10 training. So we do our training, and maybe on
11 that Thursday night we will have a big ceremony to
12 honor some of our Wounded Warriors. Any questions
13 on that? I think I'll discuss the results of the
14 surge team, I think -- yes, the next slide. So
15 this is something I think is very unique to Navy
16 Safe Harbor. So essentially, we have 17 reserve
17 non-medical care managers who augment our care
18 managers in the field.
19 So when we mention this training, this annual
20 training,
21 we have all of our non-medical care managers and
22 we also have these 17 surge team members who train

1 with us. So they receive the same level of
2 training that our non-medical care managers do,
3 and then they also do the one-week OJT at one of
4 the major MTFs, and what really is great about
5 this is if it is a major casualty or some
6 catastrophic event where we need to surge more
7 non-medical care managers than we currently have,
8 then we can call on this surge team to mobilize
9 within 72 hours. And so this is an agreement we
10 have with the reserves. This is a one-year
11 voluntary commitment that these surge team members
12 make. They are trained with our non-medical care
13 managers. They partake in our monthly telecoms so
14 that we remain in touch with them, the policy
15 changes. So this is really unique to us, it's a
16 surge team that augments our non-medical care
17 managers in the fields. In fact, when we lose a
18 non-medical care manager, they -- you know,
19 another job or something, we'll go to the surge
20 team. These folks are already trained, so we
21 just, hey, you know, who's interested in becoming
22 a non-medical care manager at Bethesda, who lives

1 in the area? And we'll mobilize them because we
2 have that mobe authority. So these are reservists
3 and they serve really to augment our team in the
4 field. Any questions on that. because I think
5 that's a great program?
6 MASTER SERGEANT MACKENZIE: Have you
7 executed the program in both large and small
8 formats to know that it actually does work very
9 well, and are these people actually retaining the
10 skills that you've trained them on?
11 LIEUTENANT NORIEGA: Yes, sir, each year
12 they train with us and they've partaken our non-
13 medical care manager --
14 MASTER SERGEANT MACKENZIE: I'm saying are
15 they retaining the training, you mobilize them --
16 LIEUTENANT NORIEGA: Yes.
17 MASTER SERGEANT MACKENZIE: -- because if
18 you're --
19 LIEUTENANT NORIEGA: Absolutely.
20 MASTER SERGEANT MACKENZIE: -- and you've
21 got a critical event --
22 LIEUTENANT NORIEGA: Right.

1 MASTER SERGEANT MACKENZIE: -- just because
2 you say, hey, you've done the training, have you
3 retained that, and this is to go by the training
4 they've received and are they going to perform
5 when they get to the job.
6 LIEUTENANT NORIEGA: Well, I haven't had a major
7 catastrophic event where I've had to mobilize all
8 seven of them -- all 17 to augment my field MTFs
9 because they will go on their own and do their one
10 week of training with the MTF that they are
11 closest to working for. But I think if we ever
12 have to come to that, I think this program is
13 going to work. I think we're the only ones that
14 have this right now. I don't know if the other
15 services have this.
16 MASTER SERGEANT MACKENZIE: It is the only
17 thing I've seen, I guess I'm getting at, it's a
18 great program, it's a great idea, but to think or
19 make assumptions without actually executing that
20 authority and go okay, I'm going to bring them all
21 on board in all the different areas and see if
22 this program actually works the way we believe

35d3e2fa-d345-46de-b608-dda506fb6452

1 that it will work.

2 CAPTAIN CARTER: That's something I have to

3 look at and see if I can afford. That's a good

4 idea, do a mass casualty training event and have

5 them all augmented at one time and just do that.

6 And that's probably one of the things that's on my

7 goal number six where I have obtain, attract and

8 retain the best people as Ms. Larson just pointed

9 out to me on the bottom of the chart, this is 6.4.

10 MR. REHBEIN: Personal observation, Captain,

11 there is a command sergeant major at Fort Benning

12 that wishes he had a program like this to help him

13 through some of the manpower shortages, staffing

14 shortages that they see down there. He's

15 specifically looking for -- looking at and for

16 ideas on how he could have some additional

17 personnel to get him through some of those

18 shortfalls.

19 CAPTAIN CARTER: Do you mean there's other

20 services with manpower shortfalls, not just Navy?

21 LIEUTENANT NORIEGA: Another quick note to

22 make on this is -- and I think Merissa talked

1 about this, is as our reservists who are mobilized
2 currently as non-medical care managers, as they
3 demobe, the idea is to have those 17 folks manned
4 by our previous non-medical care managers. So
5 really, in fact we'll have 24 -- 34 across the
6 board. So the idea is as we lose a non-medical
7 care manager to demobilization, they are part of
8 the surge team. now, because they go back to their
9 reserve centers, they commit to this year, they've
10 been doing the job for three years -- two years,
11 and so this surge team eventually will be our
12 greatest resource. So that's the idea as we start
13 demobilizing some of these reserves.
14 MS. DAILEY: So the reservists are giving
15 you their two weeks a year, correct? Is that how
16 you're tapping into this resource?
17 LIEUTENANT NORIEGA: Yes, ma'am.
18 MS. DAILEY: The two weeks a year duty, and
19 they are giving it to you for your annual training
20 and one-week --
21 LIEUTENANT NORIEGA: OJT.
22 MS. DAILEY: -- OJT.

1 LIEUTENANT NORIEGA: Yes, ma'am.
2 MS. DAILEY: Okay. And they'll do that
3 every year with you to refresh their skills?
4 LIEUTENANT NORIEGA: Yes.
5 COMMANDER VARIAS: Actually, being on the
6 fiscal year, we looked to obtain discretionary
7 funding on top of their entitle funding of AT and
8 drills, and so they receive -- what we look to do
9 is capture about 15 to 17 days of ADT, which is
10 discretionary funding on top of their annual
11 requirements.
12 MS. DAILEY: Okay, so it's above their annual
13 requirements. And it's -- you say its end-of-
14 year funds --
15 COMMANDER VARIAS: We're looking to capture
16 that before the beginning of the fiscal year.
17 MS. DAILEY: Okay. So you program it and
18 your command has allowed you to program that
19 money.
20 COMMANDER VARIAS: Yes, we actually work
21 through our office (inaudible) officer at the N1
22 level who controls our RPN within the N1

1 department.

2 MS. DAILEY: Thank you. I'm just making

3 sure -- a lot of these things are the same for

4 every service, so if the Navy's doing it, the Army

5 could do it. It's just someone's got to give them

6 the money or they've got to get into the funding

7 cycle.

8 COMMANDER VARIAS: And one of the things the

9 Chief of the Navy Reserve is absolutely a

10 proponent of Navy Safe Harbor, so he is definitely

11 a good advocate.

12 LIEUTENANT NORIEGA: I think we touched on

13 the Anchor Program a little bit, but again, what

14 we do is we partner with all the naval operational

15 support centers across the country, and when we

16 have a service member who is separating, we find a

17 NOSC somewhere near that service member's home of

18 record and we assign a peer mentor to them. It's

19 a voluntary program. I don't think we've had

20 anyone turn down the program. Again, they still

21 have contacts for our recovery care coordinators,

22 non-medical care managers, but it's in addition

35d3e2fa-d345-46de-b608-dda506fb6452

1 will have this local resource who is assigned
2 before they get there. So this is someone when
3 they get back home who's looking for housing,
4 who's looking for a job, someone in the community
5 who can assist this service member at the local
6 level. Any questions on the Anchor Program? I
7 think we talked enough about the comprehensive
8 recovery plan, but just one note is that what we
9 try to do is we try to initiate the comprehensive
10 needs assessment within 72 hours. So the family
11 is bedside and that's the time when we want our
12 non-medical care managers to really start honing
13 in on what does this family need, are there
14 childcare issues that we need to address, are
15 there financial issues we need to address. So we
16 try to initiate that process within 72 hours.
17 Again, it's case by case and dependent on the
18 acuity of the incidence and on family dynamics and
19 the needs. But we try to initiate that within 72
20 hours and really have the CRP up and going within
21 30 days.
22 DR. GUICE: All right, Lieutenant, could you

1 provide us with the tool that they use to do the
2 assessment?
3 LIEUTENANT NORIEGA: Yes.
4 DR. GUICE: And a sample or an example of a
5 fake recovery care plan.
6 LIEUTENANT NORIEGA: Yes, ma'am, we can do that.
7 DR. GUICE: Thank you.MS. LARSON: Talked
8 about our external relationships. We have MOAs
9 with the VA, DOL and Military One Source. Next
10 slide.
11 CAPTAIN CARTER: I think we've also talked about -
12 initially Ms. Larson talked a lot about it when we
13 were going over our metrics in some of these
14 family care initiatives, and I think a lot of you
15 are familiar some of these like the focus program
16 that BUMED started up on worked like consultants
17 some of the Commander Naval Installation men Navy
18 Child and Youth Programs, the Navy Fleet and
19 Family support systems and all the things that are
20 on the bases throughout the Navy around the
21 country, the National Resource Director of course
22 is a great piece of information to be utilized and

1 leveraged. Military One Source consultants, all
2 that stuff together, it's all part of helping us
3 as far as the caregivers are concerned. Transition
4 team, as you saw from the chart, that's red for
5 me. I've got some work to do in this area. I
6 think when I had my department of liaison rep, I
7 was on the line on here for a lot of that stuff,
8 but he's not enough, and he's a small piece. I
9 mean, I need this - I'm going to get this federal
10 recovery coordinator from Dr. Guice. It's a
11 piece. I had this contracted. It's my athletic
12 manager. That's a piece. The anchor piece
13 coordinator, that's a piece of the transition. I
14 need a VA benefits person I think to help with all
15 that pay and stuff like that. That's going to be a
16 piece. But, what I really need is one guy to be
17 the overall team lead, okay? That we work because
18 transition is huge. I mean, it's employment. It's
19 education. It's resonates. It's interviews, all
20 that piece like that is talking about the mind,
21 body and soul. Is the individual even ready to
22 transition yet? Okay, we - people harp on me and

35d3e2fa-d345-46de-b608-dda506fb6452

1 my command. Well, how many guys do you employ?
2 How many guys - well, first I've got to find out
3 if the guy actually wants to actually make up in
4 his mind that he's ready to leave and not try to
5 go back active service, and he's ready to make
6 that transition leap. Those are some of the areas
7 I've got to look into that transition piece. How
8 do I help that guy make that move to say, "Now,
9 I'm ready. I want to go back active duty. Now, I'm
10 ready to do transition. I'm ready to get out, and
11 I'm ready to follow on with the rest of my life to
12 do something?" That's what I want that team to
13 get into. Some of the initiatives I may be working
14 with, as you've might have seen the news, NAVSEA
15 and NAVAIR are real big on hiring right now in
16 some of the (inaudible), they're actively going
17 out there and pursuing, working with the
18 government. They're actually going out there
19 pursuing and working with the services, the Army,
20 the Navy, the Marine Corps, the Air Force looking
21 for hires. I think that's pretty much evident all
22 across DOD, and then some of the civilian pieces

1 we're looking at is SAIC and Deloitte. Now, if you
2 ask me today, "Bernie, how many people have you
3 placed in employment?" Well, I'll tell you, one
4 right now. One guy out of the shipyard in
5 Seattle, and I've got a maybe with one of my
6 enrollees down in Texas at Ramsey, and I just got
7 another maybe for attending a summit - I think it
8 was Tuesday morning I attended in Leesburg - from
9 NAVAIR.from NAVSEA, and I had the guy in my work
10 group - what's his name? Commander Dave, what's
11 Dave's name? MacAfee who runs the wounded warrior
12 program, they call it over there at the NAVSEA.
13 They say, "Hey, Captain Carter, I've got another
14 potential guy for you." Okay? So, they're out
15 there pursuing that, but I've got to be a little
16 bit more proactive and actively engage with these
17 guys, and that's why I want to build that whole
18 transition piece and make it a little bit better.
19 GENERAL STONE: So, of your four hundred that have
20 transitioned out of active service, what's the
21 unemployment rate?
22 CAPTAIN CARTER: I'm not sure. What is that

1 Merissa? I'm not sure what that unemployment rate
2 is. I have to find that out for you, General.
3 LIEUTENANT NORIEGA: Yeah, we currently
4 don't have those numbers, and again, of that 404,
5 21 percent of those are actually employed with the
6 Navy. So, they've returned to duty. So that
7 transition number comprises of our returned folks
8 and those who've transition out of the Navy.
9 CAPTAIN CARTER: And, that's probably
10 another good data point I want to gather, too. If
11 they got a job, was it through Safe Harbor, or did
12 they do it on their own? Okay, that's another good
13 data point. They might have gone on their own and
14 got a job, nothing to do with Safe Harbor, but I
15 need to be able to track that to say, "Hey, how'd
16 you get employed? Was it on you, or was it with
17 my assistance and my transition team?
18 MASTER SERGEANT MACKENZIE: Sir? One of the
19 things that in your Manpower slide, you talk about
20 transition being returned to duty and veteran
21 status, but as I kind of look at this transition
22 team and employment initiatives, it's all about

1 veteran status. As you take a look at this
2 transition thing, I encourage you to look at how
3 do we retrain folks to return to duty? Return to
4 duty is not all about going back to your
5 assignment.
6 CAPTAIN CARTER: That's true.
7 MASTER SERGEANT MACKENZIE: It's about how
8 do we retain this professional non-active duty.
9 We may have to retrain them. Does the Navy have a
10 way to go about that or is that --
11 CAPTAIN CARTER: That's what I meant, making
12 sure - first, you're right. The emphasis is on
13 the veteran, but first I've got to make sure he
14 didn't want to go back to active duty, and how do
15 we actively get him involved back in that process,
16 and walk him back through that which I think we
17 really - you really work on, right Dave? Next
18 slide for me.
19 DR. COAKLEY: Captain, real quick. In
20 follow-up, in line with what Master Sergeant was
21 saying, is there actually a program or is it just
22 like a case by case basis. Let's say you have one

1 of the guys who in his particular rating, his job
2 in the Navy, can't do that job anymore. Is there
3 somebody at PERS that can either help them, re-
4 class them into a new A-school, or something like
5 that, or is it just strictly a case-by-case thing.
6 LIEUTENANT NORIEGA: It's going to be case-
7 by-case. It really is. It's not a set program to
8 handle those. It's they see those, and they
9 evaluate them case by case.
10 CAPTAIN CARTER: That's not to say it won't
11 evolve into something like that. We'll have to
12 look at the throughput. It could easily evolve
13 into that. What are my top priorities under this?
14 Reduce fiscal climate, and continue resolution,
15 well, I think we've elaborated on this - enhancing
16 the database. I need to stop all that fat
17 fingering and all those where I need a little bit
18 more automation, and I'm not going to lie to you.
19 I went down there and went through the MCWITS
20 system. I thought it was pretty good. I think
21 the Air Force is coming up with something called
22 AFWITS, and I think the Army's doing something

1 called AWITS, and it's even on top of that. If I
2 see a good idea somewhere, I'm going to jump on
3 it. I'm not going to try to reinvent the wheel.
4 I want to leverage something that's working pretty
5 good that can capture some of the same things I
6 want to capture, but a little bit more automation
7 without all this manual input.
8 So, when I query a system and say, "Tell me how
9 ten year
10 olds in all my enrollees," in a matter of minutes,
11 it can spit that out, instead of me having to go
12 dig that out somehow. That's a big piece.
13 Adaptive athletics is not all about the warrior
14 games. I get that all - some people had the
15 impression that adaptive athletics is about the
16 warrior games. It's not. It's about anything that
17 deals with rehabilitation - bowling, fishing,
18 okay, kite flying if you can do it. So, I want to
19 get more of that, and I want to get us off the
20 mindset of just talking about the warrior games
21 and making that symbolic of what adaptive
22 athletics is because it's not. It's about all

1 those things we use to help somebody in the
2 rehabilitation process and recovery. The last
3 thing is I don't think you can ever do enough
4 communication outreach. One of the areas I suffer
5 in is I rely on Military One Source, which is one
6 way. It's calling in. I don't have anything to do
7 out-calling now. So, I'm looking to get more of an
8 outreach capability where I can call out and check
9 on my enrollees, and find out some of those people
10 that have slipped through the cracks that weren't
11 referred or didn't get in the system, and see if
12 they're eligible to be enrollees or get non-
13 medical care help from Safe Harbor. So, that's a
14 big piece on what we're trying to do right now. A
15 lot of growth. MS. CROCKETT-JONES: Can I ask you
16 a question?
17 CAPTAIN CARTER: Yeah. MS. CROCKETT-JONES: Do you
18 have any plans for social networking to do - to
19 support outreach and communication?
20 CAPTAIN CARTER: Go ahead.
21 MS. LARSON: Ma'am, if I can answer that, we
22 actually have a Facebook site and a Twitter, and

1 currently for our Facebook site, we have over
2 1,200 fans through our Facebook. So, we try to be
3 able to provide updated information and links to
4 other DOD initiatives as well. Furthermore, sir,
5 if I may, one other item that we'd like to have as
6 well is our own standalone website, and that's
7 something that we're looking to leverage DOD Live
8 to have our own website outside of the DNPC
9 website where our site currently resides.
10 CAPTAIN CARTER: You see a lot of that theme
11 there, leverage. I mean, there are a lot of good
12 things that are out there, we just need to
13 leverage some of that stuff instead of starting
14 from scratch on it. Just look at some of the
15 things that are out there, some of them that are
16 working well and leverage them to the best of our
17 ability. Okay, that kind of concludes our brief. I
18 want to leave you - but, I want to leave you with
19 some of the testimonials from some of our sailors.
20 Next one here. First I want -- in my back up
21 slides, Hospital Corpsman Justin Rose, I think you
22 saw him earlier, and this is what it's really all

1 about, guys - providing service to the service
2 member. Judi Boice has a rare disease. I think
3 it's called Moya Moya. Medical guys, did I say
4 that right, Moya Moya? It's a rare brain disorder.
5 Okay, she underwent brain surgery yesterday, so
6 we've got to go check on her and see how she came
7 out of that. She originally been for a while
8 working on the chairman's Admiral Mullins' staff
9 as a cook. So, she's going back and forth. And, I
10 think Ms. Larson told you earlier, Master Chief
11 Wilson is now on adaptive care, a program
12 coordinator. He's an amputee, and one of the guys
13 we hired to get back in, we hired to come on to
14 the Safe Harbor team. Master Chief was hurt I
15 think one day with some high winds on one of the
16 amphibs (phonetic spelling) and the gang plank
17 moved and he fell. He dropped pretty far, and
18 didn't lose the leg at first, but maybe six or
19 seven months down the road it eventually had to
20 come off because it was giving him so many
21 problems. Okay. Barring any other questions,
22 that's our brief. I want to thank you for your

1 time and patience today and allowing us to talk to
2 you about our program, and take on some of your
3 recommendations to try to improve this process to
4 provide the best available care to our service
5 members.
6 MASTER SERGEANT MACKENZIE: Sir, as part of
7 your training challenges the anchor program looks
8 to be an outstanding deal, but also presents its
9 own level of challenges. As you take
10 responsibility, then you become responsible for
11 the effectiveness and the consistency of that care
12 to your wounded, ill and injured. Mentorship is a
13 unique thing. Others that have mentorship
14 programs provide a level of training. Have you
15 taken a look at some of those mentorship programs
16 to say, "How do I get a training guide out to
17 these people?", or some kind of training to give
18 you some element of confident consistency that you
19 know your sailors are going to get that when they
20 go to these anchor programs.
21 LIEUTENANT NORIEGA: If I may, I think our
22 anchor program coordinator does have a training

1 guide for the mentors, and one of the things we
2 like to note is we work closely with the NOSC
3 leadership when we assign these mentors. So, it's
4 a not a - it's a vetted process essentially. It's
5 recommended by their chain of command and the
6 commanding officer of that Naval Operation Support
7 Center. So, we try to find the top quality folks
8 and someone who would provide a good mentorship to
9 our enrollees.
10 CAPTAIN CARTER: But, you bring up a good
11 point. I think you get a little standardization in
12 there with your recommendation, though I think.
13 It's something to pursue.
14 DR. GUICE: I think we've pretty much
15 embedded all of our questions as you went along,
16 and we're very thankful for your willingness to
17 play that game with us. It really does help us to
18 kind of - when something strikes us to ask the
19 question right away. So, absent any other
20 questions, I think we will excuse you all. You're
21 welcome to stay, of course. Thank you for all your
22 hard work in what you're doing. We appreciate your

1 time and effort. Ms. Dailey, do we want to - it's
2 almost 11:30 now. What would you like us to go
3 through next?
4 MS. DAILEY: We need a ten minute break.
5 We've been sitting for almost two hours straight.
6 So, please take a ten minute break. I will check
7 on the status of the meal.
8 They might be set up in there. So, we might just
9 flow
10 right into getting our plates, and then we'll let
11 the Navy Medical piece of the effort start.
12 [Whereupon, a short break was taken off the
13 record.]
14 MS. DAILEY: Okay, good news is I have the team
15 assembled. Captain Kass.
16 CAPTAIN BERTHOLD: She's not here.
17 MS. DAILEY: Not here, and I will then let
18 the lead speaker step up and introduce himself,
19 and thank you very much for your patience ladies
20 and gentlemen, the brain trust back there, very
21 appreciative of you, your patience. We're sound
22 like we're an hour and a half behind, but Navy

1 Safe Harbor rolled a couple of my later afternoon
2 topics into the early presentation. So, we are
3 probably -- when you jigger here and jigger there
4 ahead of schedule, but I apologize for your delay.
5 CAPTAIN BERTHOLD: Well, thank you very much,
6 and good morning, just barely. Good morning, Dr.
7 Guice, General Stone and members of the task
8 force. Thank you so much for the opportunity to
9 focus on the care of recovering warriors, and to
10 partner with you - because that's really
11 how I see this process - to improve and strengthen
12 that
13 care. We hope to learn from the questions and the
14 comments that are exchanged today.
15 I'm not Captain Kass. She is very disappointed
16 that she was not able to be here. We thought we
17 were presenting on Wednesday, and she had some
18 scheduling conflicts today that prevented her from
19 coming. I am her deputy. My name is Rich
20 Berthold, Captain Rich Berthold, and I'm a
21 clinical psychologist and a member of the Wounded
22 Warrior team, and I have with me my esteemed

1 colleagues who will be helping to present this
2 morning. I'd like to introduce them, and I'll take
3 you through the agenda at the same time. I'll
4 give you a brief overview of the Wounded, Ill and
5 Injured program at BUMED, and then turn it over to
6 Commander Mo Willis who is our director for case
7 management, nurse corp officer, and then he will
8 be followed by Captain Margaret McKeathern, who is
9 medical corp officer, psychiatrist, who is the
10 director of our deployment health director, and
11 she'll be talking about psychological health and
12 PTSD, followed by Commander Jack Tsao, a
13 neurologist, and our program manager for TBI. And
14 then lastly, the newest member of our team
15 Commander Dave Webster, who is a family physician
16 and aerospace physician talking briefly about the
17 medical portion of the integrated disability
18 evaluation system. Also, with me today, very
19 important members of our team, Mr. Eddie Bueno who
20 is our director for program support, Commander
21 Rosemary Malone, psychiatrist, Virginia Paginelli
22 from our case management shop, and Joan McCloud as

35d3e2fa-d345-46de-b608-dda506fb6452

1 well. I'm glad to have them all here. Let me begin
2 just briefly by talking about the Wounded, Ill and
3 Injured program at BUMED because it's a good
4 summary of why we came to be. In response to the
5 recommendations from the congressionally mandated
6 task force on mental health, and the growing
7 repercussions of the conflicts overseas, any
8 medicine established the Wounded, Ill and Injured
9 program in August of 2008 to ensure this
10 population receives the highest quality customer
11 focused and comprehensive care across the warrior
12 lifecycle. Our program is a dedicated code at the
13 Bureau of Medicine and Surgery, and it is
14 organized around three primary lines of action -
15 the care coordination, disability system, and
16 psychological health and traumatic brain injury.
17 Our program funds are from a congressional funding
18 streams, three different ones - PHTBI, the
19 Psychological Health TBI, Wounded Ill and Injured
20 funds, and then funds from the Post Deployment
21 Health Reassessment Funding stream. The purpose of
22 this slide is really to highlight the five domains

1 around which we've organized ourselves as a
2 program. To provide a little history, in June of
3 2007, congress passed legislation that provided
4 supplemental funding to the Department of Defense
5 to support early detection, evaluation and
6 treatment of psychological health and traumatic
7 brain injury in service members and their
8 families. The oversight for those funds was given
9 over to the office of the Assistant Secretary of
10 Defense for Health Affairs who established a red
11 cell, a fast action cell of service members
12 familiar with psychological health and TBI, and
13 they established an overall rubric for evaluating
14 programs or proposals that were going to be funded
15 using these PHTBI funds. Their rubric was
16 essentially these five domains - access to care,
17 quality of care which includes training,
18 performance enhancement is a term we have chosen
19 to use the original term was resilience -
20 screening and surveillance and then transition of
21 care. We have chosen to adopt those five domains.
22 They actually capture strategically some of our

35d3e2fa-d345-46de-b608-dda506fb6452

1 primary goals in the wounded, ill and injured
2 arena. I'm going to ask Mr. Bueno to just grab the
3 mike here, and talk through this slide briefly
4 just regarding the funding streams and how they
5 are focused across our program.
6 MR. BUENO: Sure, thank you, sir. What you
7 see on this slide is basically how the three
8 funding streams that Captain Berthold alluded to a
9 few minutes ago, how they're distributed among
10 those five domains. It really represents what we
11 call an investment strategy if you will, and the
12 funding breakdown is basically a consequence of
13 programs that have been developed and continue to
14 develop over time in these five domains. You'll
15 note the largest slice of that pie under access to
16 care, and really it's not so much that there's a
17 greater emphasis, but also that it's a much more
18 expensive aspect with respect to buying
19 professionals, clinicians and the support staff
20 for the clinicians, as well as the supplies and
21 equipment that come naturally in the area of
22 access to care. What we find ourselves doing over

1 time is basically adjusting this based on some
2 surveillance leading and lagging indicators that
3 drive us or at least allow us to recognize needs
4 in other areas so that pie will shift over time,
5 but that's basically what makes up the
6 distribution of the three funding streams that you
7 see up above that Captain Berthold mentioned
8 earlier. And, by the way, these funding streams
9 are now base funding. So, under the defense health
10 plan budget, this is a consistent funding stream
11 over the (inaudible) cycle.
12 CAPTAIN BERTHOLD: I think it may be useful
13 just briefly discuss how these proposals come to
14 us, how they're generated at the deck plate level
15 if you will, and how we vet them.
16 MR. BUENO: What Captain Berthold mentioned
17 earlier regarding the red cell, and the work that
18 that group undertook back then gave life to a
19 number of projects that were proposed by folks in
20 the field, and in recognizing that there were gaps
21 in certain areas. So, we have a handful of
22 projects that were considered pilot that were

1 generated from the red cell, and we continue to
2 work with those projects, in fact, the DCOE not
3 too long ago, have begun doing the assessment of
4 those pilots to see whether they are - the live
5 continues for these projects, or whether they need
6 to expand because they have proven to be
7 effective. So, beyond the handful of those
8 projects, we have - we have a process in place
9 that allows any numbers of individuals, that can
10 be clinicians in the field, they could be an idea
11 that is drive from research. There is a process by
12 which some literature may give an indicator that
13 there's a need in certain areas. So, there are
14 individuals out there that come to us with a
15 proposal similar to what happens in research, but
16 naturally this is not research, this is O&M
17 funding. We take it through a review process
18 internally at our (inaudible) and by the way,
19 there is a gold champion for each of these domains
20 that represents that domain, and basically gives a
21 validation if you will of whether or not a project
22 is pertinent or germane to that domain and whether

1 it makes sense. There's a group of professionals,
2 subject matter experts, contracting specialists,
3 budget specialists, financial specialists that
4 come together to review and assess the validity
5 and whether or not a project should go forward.
6 These projects undergo an annual assessment in the
7 same manner that DCOE does for the pilot projects
8 to understand what kind of return we're getting
9 from those projects and whether or not they should
10 be expanded or put to rest. Reality is that some
11 of these projects have a lifecycle, and therefore
12 at a point in time they're basically done with
13 whatever deliverables they were designed to give
14 us. That allows us sort of a cycle if you will
15 where we can entertain new projects and continue
16 to improve in other areas as they become an area
17 of concern for us, or an area that deems expansion
18 or growth.
19 CAPTAIN BERTHOLD: Thank you. With that,
20 I'll turn it over to Commander Mo Willis, and
21 we'll start with the case management program.
22 COMMANDER WILLIS: Thank you, sir. Good afternoon,

1 General Stone, Dr. Guice, and other distinguished
2 panel members. It is a great opportunity for me
3 to present on Navy case management, the chemical
4 side. Basically, my presentation is going to cover
5 the case management process, training, how we've
6 made success and best practices. Our focus is on
7 care coordination, which is central to patient
8 care, and by patients meaning being anyone with
9 medical needs, including family members. This has
10 always been a priority to Navy medicine. In order
11 to achieve the highest quality of care, all of our
12 case managers are RNs, and licensed clinical
13 social workers. In addition, over half of our case
14 managers have obtained some form of certification
15 that are recognized by the Case Management Society
16 of America. We serve all members and beneficiaries
17 with the family centered approach. According to
18 the February 28, 2011 Case Management Report,
19 we're currently managing about 3,922 wounded
20 warriors. When I mention wounded warriors, that
21 includes non-combat and combat. Others rendering
22 case management service to about 2,020 and that

1 includes family members, and all beneficiaries.
2 This chart right here is just to let you know
3 where we're located at, CONUS and OCONUS. Who do
4 we provide clinical case management to? Service
5 members who meet the category two and three, which
6 is identified in the recovery care coordination
7 program, and who do we go after. We go after
8 people that are on limited duty, and anybody
9 that's not going to return to duty in 180 days.
10 We go after the catastrophic. We go after people
11 with complex medical needs, and also anybody can
12 self-refer themselves to case management services.
13 Any provider can refer a person to case
14 management, and also our RCCs, our FRCs, our non-
15 clinical case managers, anyone can refer someone
16 to be assessed by case management. We actually
17 identify these cases because of these reports. In
18 addition, patients can be self-referred by their
19 provider. This is a team right here. This slide is
20 a list of who we're providing family centered
21 care. As you can see that it becomes very complex
22 and overwhelming to service members and their

1 families. So, coordination and collaboration
2 between all members of this team is a priority.
3 DR. COAKLEY: Commander, I have a question
4 real quick. You say that your services, they're
5 identified once they go into LIMDU for 180 days or
6 greater. Does the LIMDU coordinators, do they
7 contact you directly, or how do you get involved
8 in this process?
9 COMMANDER WILLIS: That's a good question,
10 sir. With our case managers work hand in hand
11 with our LIMDU coordinators in the facility. They
12 have access. They go and they talk about these
13 patients. So, it's a given.
14 DR. COAKLEY: Thank you.
15 COMMANDER WILLIS: So, how do we train?
16 Training and education is the back-bone of our
17 program. Therefore, we are always thinking of
18 ways to increase the knowledge of our staff to
19 anything that's going to impact the quality of
20 care. To date, we've had over approximately 50% of
21 our case managers have completed the twelve
22 training modules that are mandated by the DTM.

1 However, our internal data shows a higher
2 compliance rate. We're currently working with TMA
3 to address that issue, the discrepancy there.
4 BUMED Camaraderie Training - we provide well based
5 training to our case managers on a monthly basis.
6 For example, we have the FRC training. Dr Guice
7 provided training to our case managers. We have
8 Safe Harbor, the wounded warrior arrangement, the
9 VA liaison program. So, it gives our case
10 managers an opportunity to know there are
11 resources out there to support them. Another thing
12 that I'm very proud of is our web-based toolkit.
13 This toolkit was designed mainly for new hires,
14 people who - the case managers come with
15 experience, at least two years experience, but
16 they're not familiar with our military culture.
17 So, this toolkit allows them to be able to learn
18 more about the Navy culture, the Marine Corps
19 culture. Our standard case manager competencies
20 were developed to ensure the consistent practice
21 in case management, and also serves as a guide for
22 professional growth. The case management

1 documentation view at the MTF is mandated within
2 our instruction. Also at the BUMED level, our
3 program managers also perform reviews to identify
4 areas of improvement. We continue to look at ways
5 to improve our program. So, how do we define
6 success? The Navy case manager defines success as
7 a seamless coordinated comprehensive and timely
8 care with high patient and staff satisfaction.
9 So, how do we measure up? Success can be measured
10 by
11 improvements made to the program, and their
12 adoption by case managers in the field such as the
13 BUMED IG. We valued our programs so much -- so
14 much that we actually contacted the BUMED IG so
15 that we can have a second eye on our program when
16 they go out to the facilities to look at our
17 process so that we can always continue to try to
18 improve. The SECNAV report that we receive
19 monthly, it gives us a pulse check on what's
20 actually going on out in the field, what's types
21 of patients that our case managers are rendering
22 services to. Also, I'm very proud is being a

1 director, we received an award the first Darling
2 Health Platinum Award affiliated with the Case
3 Management Society of America for the best DOD VA
4 Case Management program based on the development
5 of our care plans and strong proper information
6 reach medical vows to transferring patients to the
7 next level of care and ensuring competent
8 transition over all. This is a reflection of our
9 dedicated staff. It's a reflection of that team,
10 when you talk about our line-up of case managers.
11 You talk about our FRCs our RCCs that are in that
12 facility, makes us had a great impact on us
13 receiving that award.
14 MS. DAILEY: Commander Willis, could you name that
15 platinum award again? Where's it from? Who's it
16 from?
17 COMMANDER WILLIS: It's called the Darling
18 Health Platinum Award, which that is a published -
19 they're the publisher for the Case Management
20 Society of America. We actually have a copy with
21 us, I think. We can leave that for you, ma'am.
22 Site visits - it allows us the opportunity to meet

1 with our case managers and also review the
2 process, and also to ensure that the compliances,
3 for example, with the DTM, the recovery care -
4 through recovery care program, and also BUMED's
5 instruction, and this is also an opportunity for
6 the leadership to give us feedback on our program.
7 So far there has not been one complaint only
8 praises and thanking us for our case management
9 services within our facilities, and also when I'm
10 out doing these site visits, I never pass up an
11 opportunity to reach out to our non-clinical case
12 managers, our FRCs, our VA liaison that are in our
13 facilities. Since 2007, when we're looking at our
14 customer satisfaction survey, we've been hovering
15 around 80%. This is part of the Navy medicine,
16 Navy wide customer service satisfaction survey.
17 So, but then again, this is a reflection of our
18 dedicated staff that are out there, and also our
19 non-clinical case managers and go back to our FRCs
20 and our VA liaison helping that -- making sure
21 that we have a smooth hand-off of our patients.
22 From the DOD Medical Management Guide, case load

1 for case management ranges between ten to fifty
2 patients per case management. Again, I want to
3 emphasize depending on acuities. The DTM for
4 clinical management for wounded, ill and injured
5 service members in the military healthcare system,
6 the standard number of wounded warrior cases to be
7 managed by each manager shall be no more than
8 thirty, with the modification where clinical
9 indicated. For the Navy, this number is based on
10 acuities of the patients. You can see other than
11 Navy Medicine East, the case load renders between
12 23.5 to about 19.6. Navy Medicine East facilities
13 have patients that are lower complexity level --
14 level one and two. As you can see on chart - on
15 the chart on the right over here, Navy Hospital
16 Camp Lejeune, which is large Marine base, the case
17 load from Camp Lejeune is about 28 patients for
18 case managers with the majority of patients again
19 at the level one and two.
20 DR. GUICE: Commander, how are the acuities
21 actually determined?
22 COMMANDER WILLIS: The acuities come from

1 the DTM for case management. We have acuities
2 levels from one to five. One means that - I may
3 not be able to memorize them completely, but I
4 have a copy of that for you. One means that maybe
5 you have contact with the patient maybe once a
6 month. Two means that you may have contact with
7 the patient twice a month. Then when we start
8 getting around the three level, you have contact
9 with the patient maybe two to three times a week
10 at least thirty minutes. Then, five is more the
11 complexity of the patient.
12 DR. GUICE: So, five is the highest complexity.
13 COMMANDER WILLIS: Yes, ma'am.
14 DR. GUICE: But, it's based on the number of
15 contacts required to deal with the problems.
16 COMMANDER WILLIS: Yes, ma'am, and the
17 complexity of the patient diagnosed.
18 DR. GUICE: And, the report's not a
19 prospective system. It's a retrospective because
20 you can't - you're basing it on the month before
21 because you're not going to know what the next
22 month is.

1 COMMANDER WILLIS: Yes, ma'am.
2 DR. GUICE: So, it's retrospect.
3 MS. PAGINELLI: It's a bi-weekly report that
4 comes in, ma'am.
5 MS. DAILEY: That's a great comment. Would
6 you like to pass that back and have it on the
7 record?
8 MS. PAGINELLI: Yes, we get the acuities
9 what we call the second half report. It's not -
10 it's part of a larger report, and we have
11 spreadsheets that give us a population that is
12 currently receiving case management services. As
13 I said, it comes in every other week so that we
14 have a very current picture of the population, and
15 it breaks it down by each MTF. It gives us the
16 number of active duty combat related patients
17 being case managed, active duty non-combat, and
18 then other -- meaning other beneficiaries,
19 spouses, children, retirees, and so forth, and
20 this is all broken down into categories of
21 acuities from one to five. Based upon that
22 information, we have a spreadsheet with these

35d3e2fa-d345-46de-b608-dda506fb6452

1 calculations that gives us the average case load
2 per MTF, and that's reviewed every other week by
3 the BUMED Case Management staff -- and that's
4 something that's really my job. So, I review the
5 case loads, and if I see that it's high going up
6 to - you know, getting close to forty, I call each
7 MTF to find out what's going on. This has been
8 going on since about 2005, so we have a pretty
9 good picture and a history of what goes on within
10 the MTFs, and I know there's certain MTFs that the
11 caseload is high, but I know that they have the
12 majority of acuity one and two patients. So, I
13 call periodically to make sure that I'm on target.
14 For example, the report that I got -- the March
15 14th report, one of the MTFs, their caseload was
16 quite high, and so I called, come to find out in
17 their deployment health, they're down one case
18 manager, and in the other part of the house, so to
19 speak, the she was down two case managers. So,
20 they're missing three staff members, and that
21 obviously is going to reflect the acuity and the
22 case load. So, pursuing this further, come to find

35d3e2fa-d345-46de-b608-dda506fb6452

1 out it's a very remote area. It's - I don't know
2 if I'm telling a tale, but it's 29 (inaudible),
3 and she said it's very rural, and they've got the
4 funds, they've got the approval from the region,
5 but it's just trying to find qualified case
6 managers with experience that are ready and
7 willing to within a year or so to get certified.
8 And, so this is how we sort of measure the success
9 of our case management load in the MTFs, and if
10 you want I can give you a copy of the report.
11 GENERAL STONE: You are currently case
12 managing 6,000 sailors, right - 4,000 wounded from
13 your previous slide.
14 COMMANDER WILLIS: Yes, sir.
15 GENERAL STONE: Four thousand were wounded,
16 2,000 other.
17 COMMANDER WILLIS: When you say wounded,
18 yeah, non-combat and combat, yes sir.
19 GENERAL STONE: Okay, so of those 6,000, the
20 previous non-medical presentation said that there
21 was about a thousand sailors in the Safe Harbor
22 program.

1 COMMANDER WILLIS: Correct.
2 GENERAL STONE: Does that mean that 80% of
3 your case load is not being managed in the Safe
4 Harbor program?
5 COMMANDER WILLIS: I can't speak for Safe
6 Harbor, sir, but one of the things that I can say
7 that all the patients that are over at Safe Harbor
8 are assigned a case manager.
9 GENERAL STONE: Does couldn't we expect
10 that the acuity level four and five are going to
11 be in Safe Harbor?
12 MS. PAGINELLI: Yes, of course. They'll be
13 in category two and three, yes, sir. If they meet
14 --
15 MS. DAILEY: Into the microphone please.
16 COMMANDER WILLIS: This strategy includes
17 when you talk about the combat related, again,
18 it's not just Safe Harbor. We're looking at the
19 Marine Corps, and we're also looking at the Navy.
20 So, we provide case management service again to
21 all the marines, the Navy, the Coast Guard, and
22 that. So, it's just not just Safe Harbor, sir.

35d3e2fa-d345-46de-b608-dda506fb6452

1 GENERAL STONE: So, you have 120 case managers.
2 COMMANDER WILLIS: We have two hundred case
3 managers, sir.
4 GENERAL STONE: Two hundred?
5 COMMANDER WILLIS: Yes, sir.
6 GENERAL STONE: In that (inaudible) -- I'm
7 sorry. In that case management model, do you have
8 data on the affect of that case management model
9 on the recovery or changes in either in patient
10 care, recovery, movement along the course of
11 recovery? Is there data that supports this
12 investment?
13 COMMANDER WILLIS: Yes, I'll say yes. At
14 the local level, a lot of our case managers are
15 actually monitoring that, but one of the things at
16 the headquarters level that we're looking at, we
17 realize that it may be an issue is that we're
18 partnering with the Navy Health Public Health
19 Center along with ADHOC members to look at coming
20 up with metrics so that we can show the
21 effectiveness of our program.
22 GENERAL STONE: So, then by that answer, I

1 would assume that you do not have metrics today to
2 justify this approach to care?
3 COMMANDER WILLIS: Yes, sir.
4 GENERAL STONE: Okay. You need to know.
5 Don't feel bad about that answer. That's the same
6 answer we got from every other service, okay, so
7 please don't beat yourself up on that one. The
8 choice of case management intuitively makes sense,
9 but has not been accompanied by data beyond the
10 civilian sector that has justified the use of case
11 management as a model, and the question is whether
12 this model of case management should be applied to
13 high acuity combat wounded and really just high
14 acuity management within the military, whether we
15 can apply the civilian data to the military.
16 COMMANDER WILLIS: I can say this right
17 here, sir. One of the things we're looking at is
18 with TMA, since you mentioned it, we're taking the
19 lead in the Navy working with TMA looking at the
20 acuity, so, and I would definitely pass that
21 along.
22 MS. DAILEY: Sir, we did some research, and

1 put together a report for case management. So, we
2 can provide that to you, and I - we do have some
3 research information paper that we'll provide you.
4 Ma'am, did you have something you wanted to say
5 when General Stone asked the question about
6 metrics for effectiveness of the case management.
7 MS. PAGINELLI: No, he mentioned the public
8 health folks we're working with.
9 COMMANDER WILLIS: This slide right here, I
10 just wanted to highlight two things, when we talk
11 about best practice. The Naval Hospital at
12 Jacksonville, recently had a Med IG and a joint
13 commission site visit, and one of the things that
14 was brought to our attention is they were very
15 impressed by having a clinical case manager that
16 was actually assigned to the deployment health
17 clinic to help with the pre-deployment briefing,
18 and also the post-deployment briefing. By that,
19 the thing that was important was that the family
20 was involved. So, when that service member
21 deployed, the service member knows that he has a
22 contact back at the facility. His family knows he

1 has someone that he can go back to the case
2 manager, and also, what's most important is that
3 when member returns, if he started having any
4 issues or anything, he knows that he can always
5 reach back to the clinical case manager. This is
6 going to be highlighted in the BUMED's Navy Med IG
7 upcoming quarterly newsletter. Some of the things
8 that's not on the slide that I think is the best
9 practice, and is something that I imagine back
10 about 2005 at our annual Case Management Society
11 of America's meeting this big conference for case
12 managers, we always had a Navy breakout day, and
13 now in the last two years, partnering with Army
14 colleagues, Navy colleagues and also the VA, we
15 have a two day breakout session before the
16 conference for the military, and also the VA for
17 our case managers. So, I think that is something
18 great to share with you. Also, this year, I hear
19 is the first year for the Navy Health Public
20 Health and also force protection, we came together
21 - the Army, the Navy, and also the Air Force to
22 have a half-day breakout session there for the

35d3e2fa-d345-46de-b608-dda506fb6452

1 case managers.
2 DR. GUICE: Commander, I'm still trying to
3 puzzle through this. The clinical case managers
4 at Naval Hospital Jacksonville, what are they
5 actually doing in the deployment health center?
6 You mentioned that they're part of the information
7 dissemination, so are they used as to discuss the
8 post-deployment health issues. I'm still having a
9 hard time figuring out exactly what they're doing,
10 and then how -- what they're doing and did relate
11 to the transit time decrease.
12 COMMANDER WILLIS: Okay, that's a separate
13 bullet, ma'am, I'm sorry. That's a separate one.
14 The one that's funded us right here, and sorry for
15 the mix-up on the slide right here. The reason why
16 we highlighted this particular one right here is
17 that Dr. Coakley mentioned earlier what we have at
18 some of our bases call it transit unit where we
19 have personnel that is an area, that say for
20 example is that if you're on LIMDU or you're on
21 crutches and you're on board one of the ships,
22 you're not allowed to go on the ship. So, what

35d3e2fa-d345-46de-b608-dda506fb6452

1 happens is this particular case manager's
2 recognized by the base commander for - imagine
3 it's stay time in that particular facility at the
4 TPU was around eight or nine days, but after
5 assigning a case manager to that facility, people
6 start to move through there and went down from 89
7 days in 2010 to about 48 days, so.
8 DR. GUICE: So, what did the case manager do
9 to make it decrease?
10 COMMANDER WILLIS: In reference to a
11 coordination of care. Some of these people needed
12 appointments. Some of these people had med
13 boards, and I can just go up and down the line for
14 this.
15 DR. GUICE: So, essentially, they helped get
16 things done.
17 COMMANDER WILLIS: Yes, ma'am. That's the
18 bottom line.
19 MS. DAILEY: And, you said we can probably
20 read about that in greater detail --
21 COMMANDER WILLIS: Yes, ma'am.
22 MS. DAILEY: -- when the Navy publishes its

1 quarterly IG report?
2 COMMANDER WILLIS: Yes, ma'am.
3 MS. DAILEY: And, that would be just rough
4 time for in April, May - any ideas? Okay.
5 COMMANDER WILLIS: I would probably say
6 probably --
7 MS. DAILEY: We'll look for it.
8 COMMANDER WILLIS: Yes, ma'am. I can send
9 you a copy, Ms. Dailey.
10 MS. DAILEY: Good.
11 COMMANDER WILLIS: Thank you for your time. Dr.
12 McKeathern. CAPTAIN MCKEATHERN: Good
13 afternoon Major General Stone, Dr. Guice, and task
14 force members. Thank you for this opportunity
15 this afternoon to talk about psychological health
16 and PTSD treatments. This is just an overview of
17 what I'll be discussing, a brief overview, access
18 to care, quality of care, performance enhancement,
19 surveillance and screening, transition of care and
20 sharing best practices. This slide shows mental
21 health diagnosis. At the bottom you'll see PTSD,
22 and the top two lines referring to major

1 depressive disorder, and we can see that since
2 2007, there has been an increase. We can also -
3 it's particularly major depressive disorder, and
4 that blue line is the Navy line. One thing to
5 note is that we certainly have more individuals in
6 the Navy, and maybe beneficiaries than we do
7 Marine corp beneficiaries. Also, as we are kind of
8 hypothesizing what the increase in major
9 depression is, we certainly know that this war has
10 been long -- a long war, and it has taken a toll,
11 but the good news that we can say is that since we
12 have seen an increased need, we have been able to
13 increase access to care.
14 DR. GUICE: Could you go back to the
15 previous slide?
16 CAPTAIN MCKEATHERN: Yes, ma'am.
17 DR. GUICE: So at the top it's the
18 prevalence in all beneficiary categories --
19 CAPTAIN MCKEATHERN: Yes, ma'am.
20 DR. GUICE: So, it's not just a member --
21 CAPTAIN MCKEATHERN: It's the member and family.
22 DR. GUICE: -- its family and dependents.

1 Have you broken it out by those different
2 categories to look at if you've got an uptake in
3 one of those categories versus another?
4 CAPTAIN MCKEATHERN: I believe that we have.
5 This is actually from our Navy Public Health
6 Center. Captain Berthold, do you --
7 CAPTAIN BERTHOLD: Let me talk about that.
8 Yes, ma'am. We have the ability to drill down, if
9 you will by beneficiary category, and the increase
10 in slope is -- it's almost symmetrical for the
11 active duty member as it is for the active duty
12 family members. The retirees and the dependent
13 retirees has stayed pretty steady which is no
14 surprise. That's the way it ought to be. We also
15 have the ability to break this down by -- for
16 instance what is going out to the community versus
17 what is being taken care of in the direct care
18 military treatment facilities. But, otherwise the
19 slope appears to be pretty symmetrical for the
20 active duty service members as well as the family
21 members.
22 DR. GUICE: Could you do that analysis for us?

1 CAPTAIN BERTHOLD: We can provide that to you.
2 DR. GUICE: I think that would be very
3 helpful and useful for us to kind of see the
4 trending. This is lovely data, but of course
5 you're going to show us some data, we're going to
6 ask you for some more.
7 CAPTAIN BERTHOLD: Sure.
8 DR. GUICE: But, if you can help us with
9 that that would be fabulous.
10 GENERAL STONE: What is your total served
11 population?
12 CAPTAIN MCKEATHERN: Our total service
13 population, I believe for Navy is around 350,000.
14 Moving on to our access to care, we are defining
15 success as timely access to comprehensive
16 healthcare for our warriors and their families,
17 along those lines to address the increased need
18 that we've seen - to address increase need in the
19 mental health arena. As of March 2011, we had 197
20 psychological health active providers who have
21 been added, and about 171 of those positions are
22 currently filled. Certainly as we know, we're

1 moving towards filling a hundred percent of those
2 positions, but certainly with behavioral health
3 providers, there are a lot of competing forces for
4 hiring. We know that there is actually a shortage
5 of providers, but we are certainly doing the very
6 best to recruit. Other measures of success -- as
7 we're looking at a measure of success, we're
8 seeing that there's been an overall decrease in
9 the purchased care percentage. That being the
10 psychological health providers that I mentioned
11 were actually brought into a military treatment
12 facilities, and so we're actually able to see more
13 -- have more encounters within the facilities.
14 Onto my next slide, again, this is actually a
15 slide that is showing all of the Navy direct care
16 outpatient mental health visits. The dotted red
17 line in the middle is really looking at the point
18 where we actually were hiring when I mentioned
19 those 197 positions and 171 filled. That's when
20 they were hired, and we see that there has been an
21 uptick in active duty and guard mental health
22 encounters, and we're seeing that we have more

1 providers, and we've also been able to increase
2 the access to care.
3 DR. GUICE: And that was referred to because you
4 decreased the purchased care, that's a reflection
5 of --
6 CAPTAIN MCKEATHERN: Yes, ma'am.
7 DR. GUICE: -- so, if you added another line
8 on there about purchased care, you would see it
9 going down?
10 CAPTAIN MCKEATHERN: Actually, the next
11 slide actually addresses the percentage of
12 purchased care that we've seen. This slide is
13 actually again looking at access to care and the
14 department of Navy purchased care percentage of
15 mental health care. The kind of take home message
16 is that we've seen - each year, we've seen about
17 point seven percent decrease in purchased mental
18 health care. And, part of that we are attributing
19 to - we're certainly looking at attributing part
20 of that to the fact that we have more providers
21 within the military treatment facilities. MS.
22 CROCKETT-JONES: Can I ask you a question about

1 the slide previous?
2 CAPTAIN MCKEATHERN: Yes, ma'am. MS. CROCKETT-
3 JONES: You have tracking encounters and with your
4 active duty and guard service members, the
5 encounters are going up.
6 CAPTAIN MCKEATHERN: Yes, ma'am. MS. CROCKETT-
7 JONES: In a previous slide, we saw major
8 depressive disorder going up in both family
9 members and service members, but there isn't an
10 increase among family members or dependents in
11 encounters. Are they largely - is that because
12 they're largely being sent out or is that because
13 you're not catching them encounter for treatment?
14 CAPTAIN MCKEATHERN: Well, I certainly would
15 say that with our family members, it certainly
16 part of that may be that they are being seen
17 within the network, and so I would say that
18 probably that is great - may to a great degree be
19 that they're seen in the network VIS and the MTF.
20 CAPTAIN BERTHOLD: Of note is the fact that
21 we - in terms of (inaudible) care for mental
22 health, we can't control the family members. In

1 other words, they can go out into the community
2 without a referral. So, they have sort of an open
3 access up to eight visits I believe is what it
4 calls for. So, this slide here shows encounters
5 within the MTF or direct care system, but we'll
6 provide you the correlation, and you'll be able to
7 see what's happening out in the community as well.
8 MS. CROCKETT-JONES: Yeah, I'm wondering how you
9 get the number to know that family members'
10 incidents of depressive disorder is going up if
11 you're not the ones treating them.
12 CAPTAIN BERTHOLD: We have a database that
13 allows us to view what's happening in the
14 community by virtue of the way the billing is
15 processed. So, we have the ability to see that
16 and track that. MS. CROCKETT-JONES: Thank you.
17 CAPTAIN MCKEATHERN: This was the slide that I was
18 basically discussing showing the percentage of
19 purchased care, decrease in essential purchase
20 care. As we're looking at quality of care, we're
21 defining that as high quality in evidence based
22 health care for warriors and their families. Some

1 of the key - but, we do have technology that
2 measuring can certainly be challenging as there
3 can be multiple variables which can affect our
4 measurements of quality of care. We're continuing
5 to refine our methods and surveillance, and all
6 the - one of our measures of success was looking
7 at the number of individuals who within thirty
8 days, with a diagnosis of PSTD who were on
9 medication, or who received care - who had follow-
10 up within thirty days and were currently at 88
11 percent. Certainly, we're striving to be at a
12 hundred percent, and one of the ways that we're
13 looking actually impacting on that is first
14 certainly making sure that all of our regions are
15 aware of where they are with the follow-up and
16 certainly also with increasing education about the
17 follow-up. Some other - some key initiatives we
18 have really supporting our quality of care are the
19 establishment of the naval center for combat and
20 operational stress control which is actually
21 looking at - looks at all of our processes -- all
22 of our treatment processes, research and really is

35d3e2fa-d345-46de-b608-dda506fb6452

1 able to inform kind of the entire Navy on what
2 best practices, the new research that's out there,
3 and we really have found them to be a wonderful
4 asset. We also another initiative has been to
5 develop and tailor a curriculum for primary care
6 providers in treating behavioral health diagnosis
7 and also we've developed web training
8 opportunities for cognitive processing therapy and
9 cognitive behavioral therapy. The importance of
10 this is that those are two of the evidence based
11 therapies that are actually recommended within the
12 DOD VA guidelines for treatment of PTSD. In
13 another note, when we look at measures of success,
14 as far as medications for the treatment of PTSD,
15 in the first line of treatment and medication
16 actually within the DOD and VA guidelines is
17 selective serotonin reuptake inhibitors when that
18 is required. Again, this is by - this actually
19 speaks to the last bullet when we were looking at
20 within thirty days a percentage of individuals
21 with PTSD who had received follow-up within thirty
22 days, and this is broken out by our regions and

1 also by OCONUS, and then again, it just highlights
2 that 88.2 percent kind of Navy wide. As we're
3 looking at performance enhancements, we define
4 that as sustained optimal forced health protection
5 and readiness for both our sailors, marines and
6 their families. Our combat operations stress
7 control doctrine is actually the foundation of all
8 of our interventions. It's provides common
9 language to address the stresses of military life,
10 and also mentions practical interventions. This
11 doctrine was actually signed out at the beginning
12 of this year by both the chief of naval operations
13 and the commandant of the Marine Corps. Both the
14 Navy and the Marine Corps utilize combat
15 operational stress control programs, and within
16 them they actually provide practical decision
17 making tools for sailors, leaders and families.
18 They are actually based on a color scale with
19 green being ready to go, yellow being maybe
20 someone's having some minor systems, orange maybe
21 a little increased symptoms, and then red actually
22 they may need mental health referral. We've

35d3e2fa-d345-46de-b608-dda506fb6452

1 actually found that it's a common language with
2 our sailors, our Marines and our families are now
3 able to use, and really looking at the
4 interventions. We also created project FOCUS,
5 families overcoming under stress, and this was
6 through our contract with UCLA, and it promotes
7 resiliencies of our families who are facing the
8 stresses of deployment. Another one of our
9 initiatives is the returning warrior workshops for
10 reservists, and this is a weekend workshop that
11 helps to address some of the stresses that
12 families may be - just may be experiencing
13 physically, psychologically, spiritually in both
14 the - in after deployment and something that we
15 found that has been actually very successful, and
16 that we've received a lot of good kind of feedback
17 especially with satisfaction surveys from
18 individuals who have participated.
19 MR. REHBEIN: How long after they return is
20 that workshop held - 30 days, 60 days, 90 days?
21 CAPTAIN MCKEATHERN: Well, it really is
22 dependent on their schedule throughout the

1 regions, and really we leave it up to their
2 schedule depending on when they're able to kind of
3 reach it. There are monthly workshops, and
4 they're in different regions, but we kind of leave
5 it up to the individual to go when it's convenient
6 for them.
7 CAPTAIN BERTHOLD: It can range from two to
8 six months.
9 MR. REHBEIN: So, it's really - it's really
10 not a unit endeavor. It's an individual resourced
11 endeavor, and it's done on a voluntary basis?
12 CAPTAIN MCKEATHERN: Yes, sir. It is, and
13 also of note, a lot of our Navy members are
14 actually deploy as individual augmentees (phonetic
15 spelling). There are some units, but many of them
16 are deploying as individual augmentees (phonetic
17 spelling).
18 MASTER SERGEANT MACKENZIE: Ma'am, you're
19 saying that you're seeing this as a success, but
20 what percentage of your returning reservists are
21 actually taking advantage of this program and how
22 are you measuring your success based on that

1 number?

2 CAPTAIN MCKEATHERN: Unfortunately sir, I

3 don't have the - I do not have that information

4 about the percentage who have attended, but I can

5 certainly look into getting you that, and we

6 currently do have satisfaction surveys. I do not

7 have that data actually here with me, but it's

8 something I can also looking at getting for the

9 task force.

10 MASTER SERGEANT MACKENZIE: Thank you.

11 CAPTAIN MCKEATHERN: You're welcome.

12 Another initiative was the establishment of the

13 Navy Special Warfare Resilience Enterprise, and

14 this was actually tailored specifically for the

15 special warfare group, and looks again at pre-

16 imposed deployment assessments. It involves

17 retreats that are centered on providing

18 interventions after those assessments, and again

19 it focuses on different domains in which the

20 families may or may not be experiencing stress as

21 a difficulty.

22 MASTER SERGEANT MACKENZIE: These pre and post

1 assessments is questions I've asked other people
2 as well.
3 Is this pre and post that deployment, or is this
4 pre and
5 post assessments that come along the lifecycle of
6 your deployments because as we know that community
7 does a significant number of deployments, and it
8 seems that a lot of people aren't looking at the
9 history. It's just, "Okay, this is what he was
10 like before. This is what he's like after," but
11 nobody looks at what he was before based on what
12 is after was previously. Are you guys looking over
13 the history or is this just a focus around the
14 single deployment?
15 CAPTAIN BERTHOLD: We have the ability to
16 (inaudible) but also trending so we can compare
17 unit to unit over time. So, there is the ability
18 for us to measure that and trend it out. This is a
19 - and by the way, there are other interventions
20 that are provided throughout the deployment cycle
21 so it's not just pre and post, but based on those
22 assessments, they provide training and

1 intervention at various cycles throughout that
2 eighteen month cycle that they normally operate
3 under.
4 CAPTAIN MCKEATHERN: Our next slide is actually
5 highlighting progress - excuse me, project FOCUS,
6 and just that we have served more than 12,000
7 people have participated in group or direct
8 individual family services. We've had over 200,000
9 attendees and participants, and this could be
10 lectures about FOCUS, about what the program
11 offers. We've had nearly 1,400 families who have
12 participated in individual family resiliency
13 training, and that is actually individualized.
14 It's eight to ten sessions. It's actually spent
15 with the family, and it might be a family consult.
16 They can - we found actually in our special
17 warfare community that - at our sites, we've
18 actually had families that have had said some very
19 good things about the program, and they have
20 recommended it to other families, but also if a
21 provider is seeing a family, let's say on the MTF
22 and feels that they might benefit from FOCUS, it

1 can certainly refer them. We have found - we
2 actually have rather robust metrics from FOCUS. I
3 have one slide that actually shares satisfaction
4 data, but we also have data on both individual and
5 family functioning, kind of child behavior
6 checklists, and I did not bring all that data with
7 me, but it may be something that if the task force
8 is desirous of seeing some of executive summaries
9 on that, we can certainly provide that. The data
10 that I do include this is really talking about -
11 I'll just show you this next slide, and this is
12 looking at after perception of change, after
13 intervention, and that's non-service member and
14 service member, and the scale is one to five, and
15 this is after they've had the intervention looking
16 at their assessment of what they found - family
17 support they have after the intervention,
18 management of any triggers or any stresses, family
19 goal setting, parent child communications,
20 emotional regulation, and understanding combat
21 operational stress reactions. We see that most of
22 our families are saying that they have noted

1 actually significant improvement in these domains
2 after they've had experienced the intervention. As
3 we talk about other measures of success,
4 operational stress control training, which is kind
5 of where we roll out talking about operational
6 stress control, we've trained over 200,000
7 sailors, and we have noted, and I'm also going to
8 talk more about this on one of the other slides,
9 within the - we have a behavioral health and needs
10 assessment which is a way - since 2008 that we've
11 been able to survey our individual augmentee
12 (phonetic spelling) sailors, and we have noted
13 within that survey that there has been a decrease
14 around questions along the lines of stigma with
15 mental health, i.e., if individuals feel that the
16 commands may see them differently if they seek
17 mental health care, or if it would somehow
18 adversely affect their careers. Additionally, we
19 have trained -- looking at our caregivers, we
20 certainly recognize that our caregivers are
21 actually experiencing occupational stress because
22 we're being deployed along with the other service

1 members, and also responding to situations such as
2 Haiti, and Japan. So, we actually have a targeted
3 occupational stress control program for our
4 caregivers to make sure that we're keeping up
5 their resilience so that they're able to take care
6 of our active duty members and their families.
7 DR. GUICE: Can I interrupt you a minute?
8 You're using the word care-giver here to mean care
9 provider?
10 CAPTAIN MCKEATHERN: Care provider, yes.
11 DR. GUICE: In other briefings we hear care
12 giver and it's actually the individual who's
13 caring.
14 CAPTAIN MCKEATHERN: Yes, ma'am. In this case, I'm
15 referring to really any staff of our treatment
16 facilities.
17 CAPTAIN BERTHOLD: And chaplains.
18 CAPTAIN MCKEATHERN: And, chaplains. As
19 we're looking at surveillance and screening, we're
20 defining success as identification and
21 communication of deployment, health related,
22 health threats to warriors and their families.

35d3e2fa-d345-46de-b608-dda506fb6452

1 Probably one of our great key initiatives has been
2 the combat trauma registry, and this is a way that
3 we can actually track our injured service members
4 and those who are ill from the point of injury
5 throughout the rehabilitative process. And through
6 doing that, we're actually - we've actually been
7 able to impact on maybe the change of some of the
8 transportation vehicles that we use. So, that's
9 just really one point, but really the data that
10 we're gaining from the combat trauma registry has
11 been very helpful, hopefully in making some -
12 well, has been helpful in making positive changes.
13 DR. GUICE: And, for the combat trauma
14 registry, what cases get entered into the
15 registry? Is it all wounded, ill and injured
16 regardless of combat/non-combat, or is it
17 exclusively combat?
18 CAPTAIN MCKEATHERN: Dr. Tsao, could I call in a
19 lifeline?
20 COMMANDER TSAO: For the combat trial registry,
21 specifically, those numbers, there's different
22 databases let me first say, but the one that I

1 believe you're referring to is theater specific
2 information. So, it can be combat related or
3 theater non - like disease non-combat is the other
4 classification which would enter that database.
5 DR. COAKLEY: I can answer that too, Dr.
6 Guice. It's was set up by the Navy Health
7 Research Center, the combat trauma registry, and
8 they do the track just combat patients and anybody
9 else that would be in theater exclusively. My
10 question to the panel is though - to you captain
11 is how does this directly affect psychological
12 care. I work with this database extensively, and
13 I'm trying to figure how does it help you guys do
14 what you do?
15 MR. BUENO: Let me try to answer a portion of that
16 question. That is that some of the trauma, or
17 some of the cases that are identified within the
18 CTR have a tendency to for instance amputation or
19 burns or any significant or catastrophic injury,
20 we know that just by virtue of the severity that
21 there would be some PTSD associated with that, and
22 in some cases some TBI, traumatic brain injury.

1 So, there's an element for us to be able to
2 surmise that there will be some psychological
3 health or TBI related instances, as well as those
4 that are just clearly identified within the CTR.
5 CAPTAIN BERTHOLD: I might also add that it's the
6 database upon which much future research and
7 current research is building off of, and so much
8 of that has a psychological health focus. There's
9 also a piece, and Captain McKeathern will get to
10 it, that some of our the CTR data that is related
11 to brain injury has impacted - the research has
12 impacted as she mentions MRAP development, and
13 other things like that.
14 CAPTAIN MCKEATHERN: And along the lines of
15 looking at the data that we're obtaining from the
16 CTR and also looking at outcome metrics and
17 outcomes of all our programs, we really are strong
18 collaborative relations between the Naval and
19 Marine Corp Public Health Center, who actually
20 prepared a couple of the earlier slides, the Naval
21 Health Research Center and the Naval Center for
22 Combat and Operational Stress. Actually, all of

1 these three entities work very closely together.
2 They're actually actively involved in as we're
3 analyzing our data and looking at outcome metrics
4 we have for all of our programs and projects
5 within the navy and also help as we're looking for
6 clinical effectiveness of our programs. So, these
7 are three entities that are communicating on a
8 regular basis and really helping us to -- really
9 as we move forward with having outcomes measured.
10 GENERAL STONE: Is the behavioral health
11 needs assessment a commander's tool?
12 CAPTAIN MCKEATHERN: It can be. Well, let
13 me back up. Certainly when a particular unit let's
14 say is surveyed, the commander is given feedback
15 at that time. So, yes in that instance, it does
16 offer kind of real time data to the commander, and
17 they're always given (inaudible). So, from that
18 standpoint, sir, I think it could be used - say
19 that it's used as a commander's tool.
20 GENERAL STONE: I probably didn't ask the
21 question very well. Let me try again. Does it
22 identify a high risk sailor, or does it identify a

1 population at risk?

2 CAPTAIN MCKEATHERN: It identifies

3 populations at risk.

4 GENERAL STONE: Could you walk us through

5 the process that allows you to engage that

6 population?

7 CAPTAIN MCKEATHERN: As in how the survey is

8 done, sir?

9 GENERAL STONE: You now have identified a

10 high risk population based on your behavioral

11 health needs assessment. What happens at that

12 point with that population that allows your

13 delivery team to engage? How is that triggered?

14 CAPTAIN BERTHOLD: If I may sir, the way the

15 behavioral health needs assessment has evolved

16 beginning I think I was deployed at the time, I

17 think it was the end of 2009, we actually

18 administered this survey in theater by a mobile

19 care team consisting of mental health providers, a

20 research psychologist and corps men. So, they have

21 a survey plan that usually targets high risk IA

22 populations. That's another thing that's important

1 about this instrument is it is focused on the Navy
2 IA population, and in a context of the mobile care
3 team both using the survey instrument and with
4 focus groups, they are able to provide real time
5 information back to the leadership, and also if
6 requested provide on the ground intervention at
7 the same time. We also take that information back.
8 It's analyzed by NHRC, the Naval Health Research
9 Center, and based on that report, we go back to
10 the line commanders or the populations that we've
11 identified at risk and make recommendations for
12 how to mitigate those risks.
13 DR. GUICE: Could I have you return to the
14 previous slide for just a second? So, you are
15 collecting a lot of information, and that's a
16 really good thing. What I'm curious about is how
17 - if you took something, and you don't have to
18 answer, but you can come back to us with maybe a
19 written way of how you do it. So, under the Combat
20 Trauma Registry, you identify some injury that has
21 high prevalence like TBI. So knowing that
22 information, can you tell us - walk us through all

1 of those things that you say you can do now with
2 that information. What do you do with that
3 information? Performs high quality outcome
4 studies, like what? And, then how that
5 information then relates down to that
6 collaborative relationship with those public
7 health centers and the research centers, and
8 you've got allies, measures metrics. So, walk us
9 through a real life something that you've taken
10 from that first one, you've identified what you
11 need to do, what you've done, and then how it
12 relates to something that created something,
13 changed policy, made something better for someone
14 and then along that, kind of tell us how long that
15 took. That'd be very helpful.
16 MR. BUENO: Yes, ma'am.
17 MS. DAILEY: Ma'am, could you say that
18 again, one more time for your staff? That staff
19 might have gotten it, but this staff might be a
20 little --
21 DR. GUICE: Probably not, but what I'd like
22 to have them do is to walk us through something

1 they've identified under the Combat Trauma, so
2 TBI. We've talked about TBI for years now, so
3 that's an obvious something that I'm picking on.
4 So, I want you to identify how many people have
5 had that particular problem, then you see all of
6 the things that they say they can do with that
7 information or rehabilitative outcomes, high
8 quality outcome studies and how all of that
9 information is then fed into things that turn into
10 program project clinical effectiveness. So, what
11 did you do with the data you got? You identified a
12 bunch of people that have TBI. It's the "so
13 what?" question. So, what did you do with it?
14 What did it drive? And, then how long it took, I
15 think that's one of the things that General Stone
16 was talking about a little bit earlier today with
17 the DCOE. Now, once we start to identify data and
18 problems associated with it, how long does it take
19 to actually improve the clinical care, vis a vis,
20 that particular injury or disease pattern? I
21 think an appreciation of it doesn't turn on a
22 dime, you have to really drill down and identify

1 and understand it, and then figure out the pieces
2 that work. I think that's an important thing as
3 we're kind of puzzling through all of this. It
4 would be very helpful to see a real life kind of
5 data walk if you will.
6 CAPTAIN BERTHOLD: We'd be happy to do that.
7 I think you hit on something, and I'll just throw
8 this out there that we struggle with, and that is
9 the link between the good research that is
10 definitely out there. You mentioned DCOE.
11 There's a lot of research going on that could
12 directly impact our delivery of care for TBI, for
13 instance, or for psychological health, PTSD, but
14 often times, how well information is disseminated
15 is missed by a lot of the end users. So, while we
16 can provide you examples of the best practices
17 that we've seen, I won't kid you and you won't be
18 kidded. Research is hard to disseminate to the
19 level where it is used by end users.
20 GENERAL STONE: That's an interesting
21 comment. Is there a proposed model that would move
22 the generation of good data and good research to

1 the end user in a more effective manner? Do you
2 have a proposal that would allow us to move that
3 data or drive that data movement in a more
4 effective manner?
5 CAPTAIN BERTHOLD: Candidly, no, however,
6 we're currently working - our Surgeon General has
7 just established an office of research that is now
8 working directly with the Gold Champions -- some
9 of our Gold Champions on certain areas and
10 screening to identify a process where we can
11 address these issues. So, we don't have the
12 process, but we're in dialogue now to address
13 those issues.
14 GENERAL STONE: And, what would unify that
15 research with that of the Army's or the Air Force?
16 CAPTAIN BERTHOLD: My preference would be
17 the DCOE. I'm just giving opinion now, but that's
18 the way I had assumed that the Defense Centers of
19 Excellence would function when they rolled out
20 that they would be clearinghouses of fast moving,
21 ever-evolving research and getting it to the deck
22 plate. We have the Naval Center for Combat and

1 Operational Stress Control, and that's precisely
2 what they're doing. They are reviewing the newest
3 research, and they've got a research quarterly
4 that they put out with the list of the studies
5 that we can cite, and that goes out to our end
6 users. We need more of that, but that's for the
7 Navy. You're talking across all services. That's
8 where I would see the role of DCOE, and I believe
9 Captain Hammer is moving rapidly in that
10 direction.
11 DR. GUICE: I would suggest that it's even
12 bigger than just in the military health system.
13 This is something that HHS has been struggling
14 with. For years they've been building their
15 guideline directory. Okay, what they're trying to
16 figure out now is so, the "so what?" Why isn't it
17 being used? Why aren't the clinical guidelines
18 more promulgated? How do get to that next level?
19 We could publish stuff forever, but if people
20 aren't going to use it, it's pretty useless.
21 MR. REHBEIN: Yeah, the research community
22 in general because that's what I do for a living,

35d3e2fa-d345-46de-b608-dda506fb6452

1 we all struggle with how do we get our good work
2 in the hands of the users? How do we deliver it to
3 them so that it actually turns into good for the
4 country? When you discover that model, form a
5 company. You'll get rich.
6 COMMANDER TSAO: Sir, the only thing I would
7 add is sort of similar to along those lines. I'd
8 serve that I recently read an article that the
9 average time for a new discovery to be widely
10 accepted in the medical community is ten years.
11 Now, obviously, we don't want anything that we do
12 to take that long, but my suspicion is that this
13 is a systems process which HHS, DOD, everyone is
14 very interested in and trying to figure out what
15 is the better way to disseminate such information.
16 GENERAL STONE: I think there's tremendous
17 frustration on the part of our line colleagues
18 with the medical care system and the research
19 community of how long it has taken to reach
20 consensus on post-traumatic stress, post-
21 traumatic stress disorder, traumatic brain injury,
22 appropriate acute and chronic intervention in

1 those disease processes, and in spite of
2 extraordinary investment in time and intellectual
3 capital as well as financial capital, the
4 frustration of how long this has taken, the
5 military health care system should be the model by
6 which we transmit. HHS should be the model by
7 which we transmit that. We shouldn't compare
8 ourselves to the civilian community, which can be
9 disjointed at best in the process of acceptance of
10 those advancements. And our soldiers, sailors and
11 marine and coast guardsmen deserve better as we
12 work our way through new disease processes, and
13 work our way through signature illnesses and
14 injuries of this war. Ten years is too long.
15 COMMANDER TSAO: Sir, I fully agree, and I
16 think that one other thing to note for the panel
17 is that early in the war, we were dependent on
18 civilian medical systems to say what is the best
19 practice, but certainly at this stage, military
20 medicine has made advances such as clotting, like
21 quick clotting for the combat wounds, the
22 hemicraniectomy model for severe brain injuries

1 which have helped people recover better than we
2 would have otherwise suspected. So, I think the
3 flow of information is actually moving the other
4 direction now. So, first with civilian to
5 military health system, and now its military
6 discoveries are moving into the civilian sector
7 from health care.
8 CAPTAIN MCKEATHERN: Moving back to my
9 presentation, this slide is really just depicting
10 that since '07, looking at the number of
11 individuals that we've actually surveyed with the
12 behavioral health and needs assessment, which
13 Captain Berthold has given a very nice description
14 of, along the lines with our mobile care team.
15 This is really just listing that since difference
16 between '08 and '10 when we've done the behavioral
17 health and needs assessment, and really all of
18 these questions are indicators of stigma. We're
19 actually seeing them go down. I want to make sure
20 that I also mentioned that JMHat surveyed the
21 Marine Corps, and we actually saw very similar -
22 they saw very similar findings showing that

1 they're really - there certainly appears to be a
2 decrease, a reported decrease of stigma which is
3 certainly a good thing. We are hoping that our
4 education with the combat operational stress
5 control measure has assisted with that, but we
6 certainly know that this is a cultural change and
7 it does take some time, but we're hoping that this
8 continues. Again, as we're looking at
9 surveillance, we've discussed certainly,
10 previously discussed the combat trauma registry
11 database. This is really just listing a few more
12 of the details about cases that we've certainly
13 seen and studied. It also talks about the fact
14 that the findings are published in the journal of
15 trauma, and we certainly have the do about from
16 Dr. Guice about that that we will be providing.
17 The next thing is we're looking at transition of
18 care. We certainly want to make sure that we have
19 seamless transition of care. The first key
20 initiative is the psychological health outreach
21 program. This is a program that was developed
22 specifically to serve our reserve sailors and

1 marines, and what it actually provides because
2 certainly we noted and it's been in it for the
3 past two years, but we've certainly noted with our
4 reserve members have challenges that might be
5 different from our active duties members. Once
6 they finish their drills or deployments, they may
7 be going to places all over the United States, and
8 maybe some places that don't have a military
9 treatment facility nearby and they're going back
10 to their home towns. So, the PHOP program has
11 regionally placed teams who are able to - who work
12 with the reserve units and the individuals, and
13 they are able to actually act as a bridge to get
14 that member services that they need. It can be
15 from financial services. It can certainly be if
16 they're having some psychological health issues,
17 but they actually can help direct them to the care
18 that they do need -- or the care or services that
19 they need. I'm not going - actually we also
20 certainly supporting the - I forgot what I was
21 saying, I'm sorry. The integrated disability
22 evaluation system, and the disability evaluation

1 system, I'm not going to be necessarily
2 highlighting this point, but we do have Commander
3 Webster here who is actually more expert in that
4 area, if there are questions regarding that.
5 Again, on the bottom, we're talking about the
6 throughput from the PHOP that we've been able to
7 reach out to 2,400 reserve component members, make
8 referrals for 1,600 members, and make
9 approximately 300 visits to the NOSC.
10 GENERAL STONE: So, in this group of 1,600
11 reservists who have gotten referrals, made
12 referrals to where and who case manages or care
13 coordinates those cases?
14 CAPTAIN MCKEATHERN: The referrals could be
15 to providers. It could be to Military One Source.
16 I know that the PHOP coordinator remains involved
17 with the member as they're going through - excuse
18 me, remains involved with the member as they're
19 going through their care. I don't have those exact
20 numbers with me.
21 GENERAL STONE: I believe you probably
22 identified the weakest part of your psychological

1 health program, because it's a geographically
2 dispersed force, which is depending on the tri-
3 care delivering network if eligible under camp
4 benefit.
5 CAPTAIN MCKEATHERN: Yes, sir.
6 GENERAL STONE: If outside the 180 days
7 after deployment, it is on their civilian
8 healthcare insurance, and they'll have access to
9 care. My bet is also that your PHOP is not well
10 enough staffed to provide care coordination unless
11 they're completely unique to all other services.
12 CAPTAIN MCKEATHERN: Yes, sir.
13 GENERAL STONE: Thank you.
14 CAPTAIN MCKEATHERN: You're welcome, sir.
15 Then, the last bullet is discussing the returning
16 warrior workshops.
17 MR. REHBEIN: Those returning warrior workshops.
18 CAPTAIN MCKEATHERN: Yes, sir.
19 MR. REHBEIN: It sounds to me if families
20 need to travel significant distances, stay
21 overnight. Are they provided any financial
22 assistance in attending those?

1 CAPTAIN MCKEATHERN: I believe that the --
2 COMMANDER TSAO: I'm sorry. I can speak to
3 personal experience in getting some of the folks
4 that we want screened for post exposure or TBI to
5 these RWWs. The way it works is the service
6 member and one guest spouse or significant other
7 - receives TAD funding. The weekend is entirely
8 paid for. So, their lodging is paid for. The
9 meals are paid for, and there's an established set
10 program that they go through, and it includes time
11 for counseling if they would so choose.
12 MR. REHBEIN: Thank you sir.
13 DR. COAKLEY: Commander, does that include all the
14 reservists for these recovering warrior workshops,
15 or just the ones you're selecting for the post-
16 exposure?
17 COMMANDER TSAO: So, this is - we happen to
18 use this as the venue so that we could actually
19 meet with the specific teams that we were looking
20 at, but for the regular returning warrior
21 workshops, all the IAs are offered the opportunity
22 to go. I know for certain that not everyone goes

35d3e2fa-d345-46de-b608-dda506fb6452

1 for various reasons, and it's by region of the
2 country. So, if they're reservists in the
3 southeast, they will go to a southeast one rather
4 than sort of by unit as you had earlier mentioned,
5 sir.
6 DR. COAKLEY: But, its suffice it to say,
7 all of them have access to this person
8 (inaudible).
9 COMMANDER TSAO: That is correct.
10 DR. COAKLEY: Thank you.
11 CAPTAIN MCKEATHERN: I had mentioned
12 earlier, our naval center for combat and
13 operational stress control, and they are very -
14 excuse me. Certainly as we're looking at best
15 practices -- at best practices within the Navy and
16 the research, they're actually our warehouse for
17 that body of knowledge. The Psychological Health
18 Pathways is actually a program that's being
19 piloted on the west coast, and it's looking at
20 standardizing the processes for the clinical care
21 and helping to coordinating the care of our
22 members who with psychological health -

1 psychiatric diagnoses. The National Intrepid
2 Center of Excellence, which is actually located
3 very close by is looking at providing advanced
4 diagnostics, initial treatment, family education
5 but also looking at - beginning to look at some
6 research in the realm of TBI and PTSD. As we're
7 looking at - and this is something that was kind
8 of somewhat touched on earlier, but we know
9 certainly there are a lot of maybe advanced
10 diagnostics and therapeutic techniques that may be
11 out there that might benefit from our service
12 members, and often times, we may find out about
13 those, potentially from some of the line
14 commanders who might say, "Well, I've heard that
15 this particular treatment is available at this
16 university medical program." So, and then there's
17 who would a service member maybe access that
18 particular therapy that is new and promising. So,
19 there actually is a BUMED instruction 6320.99,
20 which actually is titled, "Advanced Diagnostic and
21 Therapeutic Options for Wounded Warrior Care,"
22 outlines a process by which we're able to identify

35d3e2fa-d345-46de-b608-dda506fb6452

1 analyze and engage innovative treatments that may
2 be available for wounded warriors, and the thrust
3 of the policy is making sure if there is a
4 promising therapy that's out there that may help
5 an individual wounded warrior that there is away
6 to get that wounded warrior to that particular
7 treatment. But of course as we're doing this, we
8 want to ensure that there is full compliance with
9 all applicable statutory regulations and
10 Department of Defense policies, but this
11 particular instruction is really to address that,
12 and came up because of a need that we saw was
13 presenting itself, and people were asking some of
14 the therapies that were out there. The Center for
15 Deployment Psychology is able to train providers
16 and again some of the evidence based treatments
17 for PTSD to include prolonged exposure therapy and
18 cognitive processing therapy. As we're looking at
19 again ensuring best practices, certainly the DOD
20 VA Practice Guidelines for PTSD, within our MTFs,
21 we certainly working to make sure that all of our
22 trainees are being educated in these practice

1 guidelines, and also on an ongoing basis as we're
2 training our departments making sure that use of
3 the practice guidelines is emphasized. We're
4 continuing - also, we're working very closely with
5 all of the services on the integrated mental
6 health strategy, with all the services and the VA,
7 which is really looking at streamlining training
8 and making sure that all the services and the VA
9 are delivering the very best mental health care
10 that we can, and utilizing a practice guidelines
11 and utilizing evidence based medicine. Within the
12 Navy the Psychological Health Advisory Board is
13 actually a board of all - on which all of our
14 mental health specialties are representing, and
15 there's also a Bureau of Medicine, and this is a
16 manner in which we can - which issues within the
17 behavioral health community treatment practices,
18 appropriate mental health documentation and
19 training can be discussed among all the
20 specialists and BUMED advised on this, or if there
21 are any maybe instructions that they may need to
22 revise or looking at any way - or for example

35d3e2fa-d345-46de-b608-dda506fb6452

1 education, making sure that people are receiving
2 education of the evidence based treatments. That's
3 my presentation. Certainly, if there are any other
4 questions.
5 MR. REHBEIN: I apologize for taking you
6 back into your presentation this deeply. I should
7 have better formulated my question then, but back
8 on slide 30
9 CAPTAIN MCKEATHERN: Okay.
10 MR. REHBEIN: -- where we're talking about
11 mental health stigma items -
12 CAPTAIN MCKEATHERN: Yes sir.
13 MR. REHBEIN: -- if I understand this
14 correctly, this is the perception of the sailors
15 as to what statements they might encounter. Have
16 any of these folks been followed and have
17 developed PTSD symptoms to see what stigmas they
18 actually did encounter?
19 CAPTAIN MCKEATHERN: No, sir.
20 CAPTAIN BERTHOLD: It's an anonymous survey.
21 MR. REHBEIN: It is an anonymous survey.
22 CAPTAIN MCKEATHERN: Yes, it is.

35d3e2fa-d345-46de-b608-dda506fb6452

1 MR. REHBEIN: So, there's really no way to
2 track to see whether or not it was proved them to
3 that perceptions were correct or misplaced.
4 CAPTAIN MCKEATHERN: That's correct, sir.
5 MR. REHBEIN: Thank you.
6 CAPTAIN MCKEATHERN: Thank you. Now, Commander
7 Tsao.COMMANDER TSAO: Good afternoon. So
8 again, we'll be discussing traumatic brain injury
9 during this segment. And similar to what Captain
10 McKeathern just presented we will talk about it in
11 the same order. So initially, just to set the
12 stage, this slide that you have before you gives
13 the Navy and Marine Corp. TBI data broken down by
14 reserve and active components. The numbers we get
15 are data that's pulled by DOD through the Armed
16 Forces Health Surveillance System. Most of the
17 numbers that you will see here are actually non
18 combat instances of TBI. So they include combat,
19 which is a minority of all the cases, even though
20 it seems to be getting the most amount of press.
21 But sort of, people will have training incidents
22 so if the Marine Corp. does combat marshal arts

35d3e2fa-d345-46de-b608-dda506fb6452

1 people get knocked out, that's considered
2 concussion. If somebody plays basketball and gets
3 knocked out by an elbow, that's a concussion.
4 Automobile accidents happen.
5 So the numbers that we show are for what we're
6 actually
7 able to from the health records. As you can see,
8 most of the data suggests that the categorization,
9 sort of mild, moderate, or severe which is the
10 spectrum of brain injury from a medical
11 terminology. Most of it is in the mild category
12 otherwise known as concussions. So, in terms of
13 access to care, the -- the key findings that -- or
14 the key issues that we've been addressing are sort
15 of, what we do, sort of from the point of injury
16 and then backwards to the -- our MTF's. And at
17 the point of injury, the Marine Corp. and Navy
18 Medicine have established something called the
19 Concussion Restoration Care Center in Afghanistan.
20 And so, the two main injuries that the Marines
21 are getting are concussion and blast exposure, as
22 well as musculoskeletal and so this center is

35d3e2fa-d345-46de-b608-dda506fb6452

1 designed to be able to address both of them. The
2 staffing is with a sports medicine physician as
3 the head and then there are support staff
4 including physical therapy, occupational therapy,
5 and mental health. Our second main achievement
6 has been in New England where it's a very
7 geographically large area with very few military
8 health care facilities there. Our facility at
9 Groton has established a comprehensive TBI program
10 to evaluate service members from all branches,
11 including Guard and Reserve in -- for possible
12 events that may have led to TBI and also mental
13 health. Our comprehensive casualty, combat and
14 complex casualty care program and C-5 -- otherwise
15 known as C-5 at Navy Medical Center of San Diego
16 has a very active TBI program as well and NAVMED
17 West which is our Western Region, has established
18 something called the office of Neurotrauma, which
19 has enabled them to coordinate care in the
20 Southern California region. So their three main
21 facilities are San Diego, Camp Pendleton, and 29
22 Palms. And this care system has actually was set

1 up so they could minimize the amount of
2 duplication and effort so a service member sees
3 one provider at one place and gets referred to the
4 higher echelon facility for their next set of
5 tests; sort of rather than having the providers
6 reorder everything they sort of -- everybody sort
7 of enters this -- a common database and is tracked
8 through and we're in the process now of moving the
9 -- this pilot program which is how it started, to
10 a system wide, Navy Medicine wide program of
11 office and Neurotrauma so that we will be able to
12 establish satellite offices in each of our regions
13 to help coordinate care within that region. These
14 are some of the measures of success of the
15 concussion restorations center the numbers you see
16 here. They've seen almost 2,000 patients of which
17 300 some have been concussions. Ninty-eight
18 percent have returned to duty. But return to duty
19 is not the only metric that we want to seek and
20 it's not a medically sort of diagnosed metric.
21 It's rather sort of, for the line commander to
22 know that most of the people who are seen there

1 actually go back to duty. Rather what we are
2 instituting at the moment is actually critical
3 follow on. So if you know that somebody has had a
4 concussion, you return them to duty, are they
5 developing new headaches in theater? Prior to
6 this process being implemented, nobody really knew
7 for many of the services sort of - sort of what is
8 the effect of returning somebody to duty. Are
9 they able to function at full effectiveness? Or
10 is there something else going on?
11 And so those numbers will eventually be
12 forthcoming
13 after we've had a chance to - to follow people
14 along during the course of a deployment. The
15 office of Neurotrauma and C-5 also has a separate
16 metrics for the people who go in for their
17 rehabilitation track. Initially people are
18 screened for TBI so you want to make sure you
19 enroll people who actually had a concussion or
20 some sort of brain injury and there's a set of
21 criteria that they use. They use a three question
22 TBI screening tool which was developed by the

35d3e2fa-d345-46de-b608-dda506fb6452

1 Defense and Veterans Brain Injury Center. The
2 WARCAD is something that the Army developed and
3 has been using it at Fort Carson. And then
4 there's addition standardized tools that they use
5 to screen people for enrollment. Now once people
6 are enrolled what happens? Well, they get early
7 education and assurance of recovery and in fact,
8 sort of that's the one thing that's been shown in
9 randomized clinical trial to be effective in,
10 immediately after a concussion is education and
11 expectations of recovery. So, most people know
12 what a concussion is. Most people see people
13 getting better from a concussion and returning to
14 work. And so, it turns out that early education,
15 that things should be getting better and to see
16 your healthcare provider if they're not after a
17 certain period of time is helpful. But even at
18 this late stage, sort of education and outcomes --
19 sort of expectation of outcomes is important.
20 Now, if they are clinically symptomatic, or
21 asymptomatic, they get a different plan of
22 treatment, and then the metrics that they're

35d3e2fa-d345-46de-b608-dda506fb6452

1 tracking now is sort of how are people doing after
2 they return to full duty? Are they returning to
3 full duty and what impact on their lives is all of
4 this making at the moment? So in the past 12
5 months, sort of -- being in Southern California
6 you have all services. All comers, so we've seen
7 about 1,300 patients during this period of time.
8 Not all of whom have gone through the C-5 program.
9 In terms of quality of care, again training is
10 the foundation of our system of care. The current
11 situation in theater is that there is an actual
12 organized system of care. So this is stemmed from
13 Admiral Mullen sending out three great teams --
14 two great teams and the third one just went out to
15 look at specifically what was being done for
16 concussion and TBI in theater. What the initial
17 team found when they went out to Iraq primarily
18 was that there was no organized system of care.
19 They made recommendations; six months later they
20 went to Afghanistan and saw that there were some,
21 there was great progress being made and on their
22 recent visit in January, they actually just

1 reported back that there is actually an organized
2 system of care in place. There's a way to
3 evaluate service members initially when they are
4 exposed to blast events or have been concussed.
5 There's mandatory medical care that's being given.
6 A mandatory rest period as well. But the
7 foundation and the foundation for the evaluations
8 have been set. But to get the information out to
9 our providers, what we've been doing is setting
10 out training programs. And so, we sort of look at
11 all aspects of the pre-deployment, sort of intra-
12 theater deployment and post deployment issues and
13 have tailored programs specifically for those. So
14 for primary care providers, sort of there's
15 general concussion education available.
16 Specialists they get their training tailored to
17 whatever specialist they're in. And then the
18 psychologists and the Corp. men sort of are doing
19 different things as well.
20 BUMED specifically identified one gap that we want
21 to
22 address which is that initial sort of concussion

1 management is mandated to go through something
2 called the -- a Service Member who becomes a
3 patient is seen by the Corp. Men out on the front
4 lines. They get something called the Military
5 Acute Concussion Examination done; or the MACE, is
6 based after something called Standard Assessment
7 of Concussion which was developed by the NFL and
8 the American Academy of Neurology. And that's
9 what you see football players getting on the
10 sidelines. Now, to -- the MACE includes history
11 questions as to was the event concussive in
12 nature, or was it just that you happened to be
13 sort of 300 yards away and you saw something and
14 felt some shaking and you're just jittery because
15 of that? It also includes a brief screening
16 neurological examination. So any red flags for
17 something that may be more serious going on can
18 quickly be identified. And then the third piece
19 is the actual cognitive test. That's a screening
20 test. You have to remember certain words. You
21 have to give certain number sequences, et cetera.
22 Well, to give that in the proper manner, and as we

35d3e2fa-d345-46de-b608-dda506fb6452

1 discovered before we set up this program, not
2 every -- people were giving it different ways and
3 there's a correct way and an incorrect way to do
4 it. Sort of requires hands on training. You
5 actually need to watch people giving it and be
6 able to answer their questions so they feel
7 comfortable doing it. And so, what BUMED has done
8 and which we've set up is a four hour training
9 block for units just before they deploy. So it's
10 just in time training. We review the criteria for
11 the MACE. We review the current criteria for
12 screening people after blast exposure and also
13 what are the clinical practice guidelines for
14 treating people. I mean, right now treatment
15 essentially is rest. But, there's an algorithm to
16 take people through, sort of if they're not
17 getting better, or sort of if there's other things
18 that come up. But the specific MACE piece of it
19 we believe is a model for the rest of the military
20 system and we've expanded now to, we're about to
21 start training with several Air Force Units and we
22 even got an e-mail from Australia; one of our

1 partners, saying can you come down and train our
2 folks who fight alongside yours. So, we believe
3 that what we have is is the model to start with.
4 I think that certainly there's always room for
5 improvement and we work on a regular basis with
6 the other services as well as the DCOE and the
7 defense and Veterans Brain Injury Center to
8 discuss training and how we can jointly move
9 forward and improve things. We also, many of you
10 probably are aware that there's a baseline
11 neurocognitive screening test called the ANAM: the
12 Automated Neurocognitive Assessment Metrics which
13 are -- which is required by health affairs for
14 anybody deploying to theater. So you get a
15 baseline performance and then if someone is
16 concussed in theater, it can't leatherneck at our
17 facility in Kandahar; there's actually ANAM
18 computers there. People get retested and it's
19 been shown to be of some use in counseling
20 patients when they are ready to return to duty.
21 So both in saying: you're not ready to return to
22 duty because your reaction time or something else

1 is slowed, or sort of, everything is good to go.
2 Sort of, you're probably just anxious about
3 things. You're base you've come back to your
4 baseline in terms of performance. But to
5 interpret that, sort of we need our psychologist
6 to help out. And so we've established a training
7 program again which is now used by all three
8 services. In terms of the other things that we
9 are invested in: hyperbaric oxygen therapy has
10 sort of been one of the things that DOD has been
11 working on and BUMED has funded service members to
12 go to an Air Force study down at Wilford Hall
13 which recently completed enrollment, and 80
14 percent of those enrollees were Navy and Marine
15 Corps. And then we also have a separate study
16 that's just about to get going which is sponsored
17 by the
18 VA and the DARPA: Defense Advance Research
19 Projects Agency which is sited down at Pensacola.
20 Now obviously sort of ensuring follow up care is
21 probably the most - second most important thing
22 other than the pre-deployment training and the in

35d3e2fa-d345-46de-b608-dda506fb6452

1 theater care piece. What we're doing is working
2 with the units that have come back to ensure that
3 tracking of their service members is taking place
4 so that people don't fall through this system if
5 they need medical evaluations. And so, we're
6 working with the latest round of Marines who came
7 back or all belong to First MEF. And so we're
8 working with their units to make sure that proper
9 screening is done as well as follow on. The - this
10 includes an additional survey that we're adding in
11 to actually try to quantify blast exposure to see
12 what actually sort of - the service member reports
13 doesn't match up with the questions for TBI
14 Screening that are on the Post Deployment Health
15 Assessment and Reassessment and also the numbers
16 that we have now gotten from this mandatory
17 reporting system for blast events and possible
18 concussive events in theater; otherwise known as
19 the DTM director type memorandum 09033.
20 MASTER SERGEANT MACKENZIE: Along the same
21 lines, is this blast exposure TBI information in
22 all this stuff specifically related to that being

1 tracked over the life of the service member, or is
2 this all centered around pre-deployment and post
3 deployment and post deployment reassessment?
4 COMMANDER TSAO: So in this particular case,
5 we're trying to answer first, sort of, the
6 question of sort of, is there something that
7 happens to people with chronic exposure to
8 multiple blasts? Because we've heard stories and
9 certainly I've heard Admiral Mullens say you know,
10 he met a soldier who was exposed to 30 blasts.
11 The family is telling him that the person is
12 clearly different than they were before they went
13 off on their deployment, but nobody has really
14 answered that scientific question as to, sort of,
15 how much blast is bad. Does it matter if it's
16 sort of small grenade versus large mortars that
17 were blowing up underneath your vehicle? And so,
18 what we're doing is we're serving the units that
19 we know have been hit the hardest to actually have
20 self report of lifetime exposures. People usually
21 remember, sort of how many - roughly how many and
22 we hope to actually get a better sense of sort of

1 is - sort of how significant is the problem and
2 what do we need to change? Our post deployment
3 surveys? Do we need to change how we treat
4 patients or what do we need to do specifically?
5 MASTER SERGEANT MACKENZIE: So in other
6 words, we're getting to that point but we're not
7 there yet?
8 COMMANDER TSAO: That is correct.
9 MASTER SERGEANT MACKENZIE: Okay.
10 COMMANDER TSAO: And again, sort of, we are
11 also - we get monthly reports from the DCOE which
12 receives these blast reports from something called
13 JTAPIC which is a research organization up at Fort
14 Detrick. And so, we're also mining data records
15 to make sure that sort of, these - that everything
16 is entered in the medical record, and also, what
17 is the correlation between just exposure and a
18 clinical diagnosis of concussion? Because nobody
19 really, we have estimates that right now it's
20 about 30 percent, which would suggest that we were
21 under reporting it, or under diagnosing it before.
22 And then, follow on care is obviously important

1 after your diagnosis. In terms of our other
2 surveillance efforts, one of the new changes in
3 the National Defense Authorization Act for 2011
4 was that DOD has to come up for a comprehensive
5 policy for post deployment neurocognitive
6 Assessment in addition to this mandated pre-
7 deployment neurocognitive Assessment. So we're
8 actually looking at the ANAM specifically in the
9 populations that were known to be concussed to try
10 to determine what's the false negative, what's the
11 false positive rates so that we can actually say,
12 is this the best tool to use or do we need to
13 actually change to something that will give us a
14 better sensitivity? Like I said, we're surveying
15 the populations that were most exposed in theater
16 to assess again, sort of outcomes. BUMED is also
17 developing something called the Defense Automated
18 Neurobehavioral Assessment or the DANA. This is
19 actually a hand held device to be used in the
20 field to help, sort of improve the sensitivity of
21 the MACE, but also to give providers another way
22 to do neurocognitive testing at remote locations

1 and even at our larger facilities. It'll have
2 both neurocognitive tests as well as psychological
3 health measures. It stems from another hand held
4 device that was built on a palm pilot platform,
5 and you know how commonly you see those around
6 these days, that we've adapted to have it on a MIL
7 SPEC hardened platform with androids operating
8 system. So right now the system is built. We're
9 doing environmental testing to ensure that the
10 service members who are taking in various
11 environments, say the cold, the mountains, desert,
12 sort of everyone can actually use it and get
13 usable results from it. The next phase of this
14 would be, if it turns out to work, is to try it
15 out in Afghanistan in the front lines with the
16 Corp. men and the medics, but also you need to
17 have normative data so you know what the
18 population is likely to perform on 'X' test of
19 this battery.
20 GENERAL STONE: You mentioned the
21 examination of ANAM as a potential tool to fill
22 the NDAA guidance. Is that a BUMED led process?

1 Or is it a DOD led process with all the services
2 involved in the ANAM evolution?
3 COMMANDER TSAO: So sir, all the services
4 are - are looking at the ANAM issue. Each of them
5 sort of - I would say it's sort of a stove pipe
6 thing. So, this is specific to what BUMED is
7 doing. But the Army has had two research studies
8 already that have reported out results looking at
9 the ANAM. And at the criteria that they used
10 showed that there was a high false positive rate
11 and a high false negative rate as well. I'm less
12 worried about the high false positive rate because
13 those folks, you send them to see the health care
14 provider, then they leave reassured. Now they're
15 worried before they go. I'm more worried about
16 the false negative where you say hey, everything
17 is fine. You're good to go and the service member
18 actually has a problem that needs to be addressed
19 and this can be easily missed if you say they're
20 normal and that's why I'm most concerned more
21 about the false positives. But we work -
22 GENERAL STONE: Is there anything that

1 unifies your work to the other services at this
2 point?
3 COMMANDER TSAO: Sir, we have not looked at
4 our results yet from looking at the post
5 deployment ANAM. We expect to be able to do that
6 over the summertime when we think we have enough
7 formerly concussed service members who have taken
8 this test and then we will hopefully see if our -
9 GENERAL STONE: Okay that's the Navy
10 approach you know, when you say we. Is there
11 anything that unifies the DOD approach to this?
12 Is there any structure that you would submit your
13 work to, to debate this across DOD to unify the
14 DOD approach to this?
15 GENERAL STONE: Yes sir. So, the services
16 meet weekly by phone or in person to talk about
17 all TBI issues. So we're on a phone call with all
18 the services, so Navy, Marine Corp., Air Force,
19 Army, TBI Personnel representatives, the DCOE, the
20 DVBIC, and occasionally the NICOE will call in as
21 well. And then we have our theater neurologist in
22 Afghanistan who also dials into this. So we talk

1 about various issues that effect service members
2 throughout their deployment cycle, and sort of, we
3 basically we present different bits of data, so to
4 - to the group for discussion. So, for example,
5 there was a paper that just came out in our new
6 journal talking about diffuse hemicraniectomy for
7 - sorry, diffuse craniectomy for traumatic brain
8 injury. And so, the paper was debated, sort of
9 summaries were given and sort of, we were asked
10 you know, do you think that this is going to
11 change DOD policy? And so what the medical
12 procedure is they take off the skull on both sides
13 of your brain with this injury. There were some
14 faults that were found with the paper in terms of
15 our critique of it, but we also left with the
16 feeling that this is not something that we would
17 recommend to disseminate throughout the military
18 healthcare system and what they're doing right now
19 with just the hemicraniectomy where they take off
20 the skull flap, only on one half of the brain if
21 it's injured is probably the - is the established
22 practice. And that's what's going to continue

1 until it's shown to either be beneficial or not
2 beneficial.
3 DR. GUICE: I am still kind of struggling
4 with your answer verses the - the question. And I
5 think General Stone, maybe you were asking is
6 there a platform for a consensus conference to
7 pull together among the services specifically to
8 address this particular thing. It sounds like you
9 have a weekly phone call and you guys are talking
10 about a lot of things. I think this would be my
11 guess would - to translate this was, is there a
12 planned consensus conference to come to a purple
13 solution?
14 COMMANDER TSAO: So, so ma'am yes. There
15 have been several meetings thus far over the last
16 few years just about ANAM itself. And there is a
17 plan to meet, sort of in a consensus conference to
18 develop the policy guideline that's mandated by
19 congress. The other efforts that we're funding
20 are something called Breacher Surveillance Effort,
21 and for the Breachers are Service Members who are
22 highly trained to make doors and windows in

1 buildings where there were previously no doors or
2 windows. They work with pilot energy explosives
3 and they came - the Marine Corp. Breachers came to
4 us about two years ago with the complaint that
5 they had some physical symptoms after their
6 training of students and among the instructors.
7 And so, we've been looking at a specific effort to
8 look at the instructor population now. DARPA and
9 ONR office and they will research funding an
10 initial study to look at the students and the
11 instructors. It appeared from the instructor
12 pool, which was very - a small number; the end was
13 very tiny. The - that there was some decrement in
14 performance on the ANAM in the middle of their
15 training period where they were subjected to
16 multiple blasts. And so, with this sort of
17 finding, which then normalized at the end of the
18 training period after people had had several days
19 of rest, we're very curious to see is this
20 something that's truly there or is it just an
21 apparition in the data because the end number was
22 so small? But we feel that it's worth looking at

35d3e2fa-d345-46de-b608-dda506fb6452

1 given the - the various avenues which have been
2 reported back that people feel different after a
3 blast exposure. We're also working on ANAM and
4 correlation with Neurocognitive testing and the
5 paper and pencil traditional tests. And then,
6 we've also purchased a CAREN system which is a
7 rehabilitation laboratory to start characterizing
8 if there are differences in -- embayed eye
9 tracking et cetera with chronic TBI and amputees.
10 And then lastly we're partnered with the DVBIC to
11 conduct a head-to-head study, comparing automated
12 neurocognitive testing instruments in theater to
13 see if one is better than the other. This
14 parallels a DVBIC effort here in the U.S. where
15 they're actually studying these various automated
16 device - computer programs basically; including
17 ANAM. And then, in terms of measures of success,
18 sort of improving the tracking of our diagnosed
19 TBI cases is something that's high on our agenda,
20 and then we've already started building the
21 infrastructure and framework with the Naval Health
22 Research Center and the Public Health Center to do

1 data analysis and report out as much as what
2 you've heard earlier. And then in terms of
3 sharing best practices, we - like I said before,
4 we work with the other services and try to
5 standardize care across the enterprise. Sort of,
6 we discuss sort of what various centers are doing
7 and see, sort of, does it make sense for our
8 resources to model this program after X, Y, or Z
9 center? What is the evidence that suggests this
10 will work or not? We are - our plan is to have a
11 -- to feed this into the case management process
12 so somebody is actually screened, identified as
13 having a problem, they get assigned a case manager
14 and that way they can be followed through the
15 system, help with referrals, make sure that
16 everything gets taken care of, and sort of, feed
17 that into the existing programs at our various
18 sites. We are - we are planning to expand our
19 education efforts as well in conjunction with the
20 DVBIC. Like I said earlier, also, the office of
21 neurotrauma is being pushed to system wide, at our
22 - for our self - for our Navy medicine enterprise

35d3e2fa-d345-46de-b608-dda506fb6452

1 and then the National Intrepid Center of
2 Excellence for Psychological Health and TBI is
3 soon to be at full capacity or full speed in terms
4 of their ability to evaluate patients. And their
5 plan is to take the most complicated TBI's and
6 maybe psychological health PTSD overlap cases
7 initially and there's an active movement to
8 actually try to coordinate care in the National
9 Capillary because right now what happens is that
10 somebody has a TBI question, it's usually who they
11 know or whether they're service specific; and so
12 they call up the service. And so, we're meeting
13 sort of, with the the NICOE and the existing TBI
14 clinic staff to try to set up a process where it
15 comes into one center. The center can then refer
16 them to, sort of TBI clinic, I'd say Fort Belvoir
17 which is going to be established once the merger
18 with Walter Reed happens, the TBI clinic at
19 Bethesda. If they have more serious problems then
20 occasionally they'll go to the inpatient unit at
21 Bethesda, or back to one of the poly-trauma
22 centers that the VA has. Or they go to the NICOE.

1 Are there questions?

2 GENERAL STONE: Please go back to the

3 previous slide. Your number one bullet based on

4 DOD validated definitions, what drives DOD

5 validated definitions? Where is the forum that

6 validates those definitions?

7 COMMANDER TSAO: So the validated

8 definitions sir came from a consensus panel of DOD

9 experts from all the services including civilian

10 researchers and clinicians. And that is the DOD

11 official definition of what is a traumatic brain

12 injury and that came out several years ago.

13 GENERAL STONE: And - and now, in response to that

14 decision of definitions of BUMED.

15 DR. GUICE: Sir, yes sir.

16 GENERAL STONE: It turned off on its own.

17 COMMANDER TSAO: That's okay.

18 GENERAL STONE: It might be telling me something.

19 DR. GUICE: Of course sir.

20 GENERAL STONE: Based on that validated

21 definition from a few years ago, you are now

22 establishing standardized levels of care in a

1 BUMED based process, not a DOD based process.
2 COMMANDER TSAO: So, in terms of our
3 standardization, sir, we actually have used the
4 Army model and their definitions to - to examine
5 sort of how programs should be set up. So the
6 Army, among all the services, I think, has been
7 farthest ahead in establishing criteria to
8 designate their various MEDACS [phonetic spelling]
9 as - and MED SENSE [phonetic spelling], as to what
10 level of care and treatment they will provide for
11 the injured service member. So, it goes from one,
12 which is the inpatient acute, sort of care and
13 also rehabilitation; down to a level four which is
14 - has a provider who knows something about TBI and
15 can feed them, the patient into a higher level of
16 - make referrals to a higher level of care if they
17 can't handle it at their center.
18 GENERAL STONE: The Army actually has
19 validated it at 47 different sites for this level
20 of care over the last two year process. That's
21 correct.
22 COMMANDER TSAO: And sir, we've - we've

1 talked to the Army to make sure that the
2 definitions that we use are unified. The Air
3 Force only has one center out at Elmendorf and
4 sort of we all use the same definitions now. And
5 also, there's a DOD report that is going to be
6 updated that came out in 2009 and is going to be
7 updated by the DCOE, sort of talking about sort
8 of, where things are in the entire network.
9 MS. DAILEY: I - I do have a real quick
10 question since I've got you here. And the panel
11 in the next - next meeting is going to talk about
12 cognitive rehabilitative therapy and TBI. Do you
13 - any - any place in the Navy that would be a good
14 place to address these types of questions?
15 Everyone knows that the cognitive rehabilitation
16 therapy is questionable. But there's a lot of
17 emphasis in unionizing it. What of any work is
18 the Navy doing in that area?
19 COMMANDER TSAO: So, with cognitive rehabilitation
20 therapy there's the main problem is that there's
21 no standard definition of what constitutes
22 therapy. So for modern and severe brain injury

35d3e2fa-d345-46de-b608-dda506fb6452

1 sort of you, tailor your therapy based on what
2 cognitive domains are affected. So if you can't
3 add, you get extra training in mathematics during
4 the therapy. There's a lot of controversy over
5 whether it is of any use in concussion and if so,
6 sort of on the mild spectrum of injury, sort of
7 there's also a severe end. So you can be knocked
8 out cold and have a concussion, or you could just
9 be bonked in the head and have a headache and have
10 a concussion. So, there's still a lot of debate
11 as to sort of what is the appropriate amount of
12 therapy that you need. Because we know that if
13 you and I studies 'X' thing we're going to get
14 better at say, math or you know, if you teach
15 somebody physics and you give them tutoring
16 everyone's going to get better whether they were
17 concussed or not. That's just an example. The
18 Navy - so the DCOE and Health Affairs, sort of
19 have been very involved in this process. There's
20 a DOD study now that the Army is running down at
21 the - in San Antonio; which is the first study in
22 DOD looking at cognitive rehabilitation therapy.

1 Now, we also have pilot programs, sort of in
2 various shapes and forms within the Navy medicine
3 enterprise to institute cognitive therapy. So,
4 the C-5 program for example, they do cognitive.
5 What they're doing is considered cognitive
6 therapy, or cognitive rehabilitation under the
7 broad term. Naval Medical Center Portsmouth also
8 has a similar program. Camp Jejune is setting up
9 a program and then Camp Pendleton has pieces of it
10 as well. So, our feeling is that right now it's a
11 pilot's program within across DOD. So Army, Navy,
12 Air Force, all have sites that are reporting in
13 how many people are, basically getting cognitive
14 rehabilitation therapy. Our plan for the next
15 step is to say, "Let's just identify programs that
16 are of the most robust; seeing the most number of
17 patients. Let's see what the outcomes are; see
18 what people are doing and see if we can correlate
19 whether there is an effectiveness or not to this
20 whole process".
21 MS. DAILEY: And - and the panel members --
22 we're going to bring together a panel, next

1 meeting which we'll - we don't know whose going to
2 be on it yet. We'd appreciate it if you Beck, you
3 would have who you think would be on panel to go
4 ahead and pull some of that data together for the
5 -for the task force. It's just very broad with
6 what you've talked about and we are just going to
7 go ahead and nub down a little bit more in this
8 one particular area.
9 COMMANDER TSAO: Okay. Thank you. At this
10 point let me turn it over to Commander
11 Webster.COMMANDER WEBSTER: Good afternoon, ladies
12 and gentlemen, my name is Commander Dave Webster.
13 I'm a Navy physician. I'm working on the IDES
14 Team League for the Bureau of Medicine and Surgery
15 for the Navy. My topic today is the integrated
16 disability evaluation system. These are the
17 topics of which I will be discussing today. This
18 is a fairly busy slide and I believe that Mr.
19 Williamson pretty much covered most of this
20 yesterday. At the interest of not being redundant
21 and not beating the dead horse, I am not going to
22 go over the entire thing. But what I would like

1 to focus everyone's attention on is the first two
2 phases, treatment and med phase. Navy medicine
3 specifically contributes to these first two
4 phases. Once a determination has been made that a
5 service member's medical condition prohibits them
6 from returning to full duty, and it's important to
7 note that it doesn't have to be at any one
8 specific time. If we know that an injury or
9 illness is going to be disabling -- unsuitable for
10 military service right up front, that that
11 individual can be referred into IDES right at that
12 point. It doesn't have to last a year period.
13 The year long time period refers to the period of
14 two limited duty boards, each of six months. Once
15 that decision has been made, the individual goes
16 into the medical evaluation port phase. And I'm
17 going to elabo -- excuse me -- elaborate on the
18 med phase a little bit further in the next slide.
19 What I would like to stress, however, it's
20 important to note that Navy medicine continues to
21 provide first rate treatment and rehabilitation
22 services throughout the whole process, until the

35d3e2fa-d345-46de-b608-dda506fb6452

1 time that the service member has been -- leaves
2 the service. Sir?
3 MASTER SGT. MACKENZIE: So, that one year
4 time frame, is that your target for long term care
5 cases? Is that your trigger point where you say,
6 "At a year we're going to pull the trigger on this
7 DES process"? Or, is that simply because you're
8 entitled to two six month LIMDUS and then the
9 normal course of action would be that the MEB
10 Board would start if you're not returned to duty?
11 COMMANDER WEBSTER: That's where that one
12 year time period is listed there; however, if a
13 service member develops a condition -- an injury
14 that we know right up front is not going to be
15 suitable, that member can be referred in at that
16 time. In some cases, members can be referred for
17 a third period of limited duty, if we anticipate
18 that full recovery will be occurring in the
19 future. However, that third period of limited
20 duty has to be approved at the personnel level of
21 the -- of the service, for either Marines or for
22 Navy. Okay, this is a graphic representation of

1 the steps within the Medical Evaluation Board
2 phase. I'm going to focus on the referral HEDLO
3 counseling and narrative summary, this is
4 otherwise known as the Medical Evaluation Board
5 Report phase, as these steps are performed by and
6 completed by Navy medicine staff. VA Medical
7 Services Coordinator and Medical Evaluation steps
8 are performed by the VA within the IDES. It's
9 also noteworthy that while it's often referred to
10 as the VA exam, singularly, frequently this
11 consists of multiple exams looking at multiple
12 medical conditions by the appropriate specialist.
13 This graph states total cumulative enrollment,
14 current enrollment and completed cases for service
15 members in the IDES process for the Navy, Marine
16 Corp and Department of Defense, since its
17 inception. As of now, this data covers fifteen
18 out of twenty CONUS military treatment facilities
19 currently operating under IDES for the Navy. The
20 remaining five CONUS MTFs will be online by
21 thirty, June. Furthermore, a plan for overseas
22 service members entered into IDES will be

35d3e2fa-d345-46de-b608-dda506fb6452

1 implemented by the end of the fiscal year. The
2 current plan that is being proposed calls for the
3 PCS of a service member back to a CONUS site, with
4 VA examinations and resolution of the case to take
5 place at a site where that service member can
6 continue to receive the treatment and
7 rehabilitation services that are indicated.
8 DR. GUICE: On your cases completed roll,
9 are those cases where the member has received a
10 DD214, or does that include the return to duty
11 number?
12 COMMANDER WEBSTER: That, that is all
13 inclusive, that's both of those, Ma'am. The
14 return to duty is about, for Navy and Marine Corp,
15 is about seventeen percent. To define success
16 within IDES, we're using the same methods and
17 reasons why the IDES process was implemented in
18 the first place. Specifically, and goal number
19 one is to insure that one hundred percent of
20 service members separating due to medical causes
21 receive disability benefits within thirty days of
22 separation of the service.

1 We're also looking specifically at measures of
2 timeliness as a goal for case process; and as Mr.
3 Willliamson pointed out, there is significant
4 interest in these timelines throughout DOD. We
5 want to make sure that we're focusing on service
6 member's satisfaction as a high priority for this
7 process. If the service members are not
8 satisfied, then we're not doing them a service,
9 we're doing them a disservice. Finally,
10 standardized implementation and coordination
11 across the enterprise, as well as working hand in
12 hand with the VA. So, measuring success for IDES,
13 again our ultimate goal is to provide those
14 benefits within thirty days of separation of
15 service. As you're going to see on a slide I'm
16 going to present here in just a little bit, we're
17 almost at that point; however, we are not quite
18 there yet. So, we still have work to do there.
19 However, it is important to note that compared to
20 the Legacy DES system, where it may be a year,
21 year and a half before that service member starts
22 collecting benefits we have narrowed that gap

1 significantly. We want to make sure that all the
2 legal rights of service members that they are
3 entitled to under the legacy system are provided
4 for them and that legal representation is afforded
5 to the member at all times. Finally, (inaudible)
6 is tracked across Navy medicine and DOD, by each
7 phase of the system and reviewed monthly to
8 determine what goals are being met and where
9 problems exist, so that targeted solutions can be
10 implemented. This table is provided by veterans
11 tracking application data, as supplied by the
12 office of the Deputy Assistant Secretary of
13 Defense for wounded warrior care and transition
14 policy, otherwise known as WWCTP. Average time in
15 each step, days in each step, and by phase or
16 measure and the stated goals are listed along side
17 those.
18 The steps that Navy medicine has direct control
19 over are
20 the referral phase and the MEB phase. For the MEB
21 phase the Navy is under the DOD mean, with Marine
22 Corp cases at the mean. I want to emphasize that

1 we are not a goal and we are not satisfied with
2 this. We have work to do, and I'm going to
3 address what solutions are being implemented in a
4 later slide.
5 MR. REHBEIN: Commander? Can we back up for
6 just one -- one second?
7 COMMANDER WEBSTER: Yes, sir.
8 MR. REHBEIN: I want to be absolutely clear
9 on something on that previous slide. Phase five
10 is outside of your control and you don't have any
11 information on the PEB part of it?
12 COMMANDER WEBSTER: That's correct, sir.
13 MR. REHBEIN: Okay, because those numbers
14 are strange.
15 COMMANDER WEBSTER: I can tell you that
16 these numbers are not additive, because not every
17 single member that goes through a PEB goes through
18 each of those phases, not everybody appeals. So,
19 those numbers will not add up to the average time
20 in that particular phase.
21 DR. GUICE: Okay, just for clarification,
22 it's the PEB, this five, is not within whose

control?

COMMANDER WEBSTER: That's Under Secretary of the Navy, Ma'am, Council of Review Boards.

Dr. GUICE: Okay, so it's not under BUMEDS control?

COMMANDER WEBSTER: That's correct.

DR. GUICE: But it is under Navy control?

COMMANDER WEBSTER: That's correct.

DR. GUICE: Okay.

MR. DAILEY: In your, the things that are under your control and the variation, have you broken it down by site, by performance site; and then if so, do you see patterns that some places are doing it just fine within your specific time frame; and others are two standard deviations above that; and then look to see what is driving those differences?

COMMANDER WEBSTER: Yes, Ma'am. Although I don't have that data here with me today, that is provided by site for each of the IDES sites across DOD. We look specifically at those by site. One of the things that we have noticed is where the

35d3e2fa-d345-46de-b608-dda506fb6452

1 volume of cases are -- the numbers are higher.
2 Where resources are less, in more of the remote
3 sites, numbers are a little bit higher. A lot of
4 focus, in the past, has been put on PEBLO ratio.
5 That, to some extent, where PEBLO ratios are high,
6 that can be true; however, there are sites where
7 the PEBLO ratio is high where timeliness is being
8 met. So, that is not a sole factor in and of it
9 self. So, we are looking at the various sites;
10 and what we can do to help solve their individual
11 problems.
12 DR. GUICE: But just from what you've said
13 to us right now, sites where the volume of
14 individuals going through the process is high, and
15 places where there are because of its remoteness,
16 the relative number of resources, those are both
17 resourcing issues.
18 COMMANDER WEBSTER: Yes, Ma'am. Yes, Ma'am.
19 MS. DAILEY: Real quick, just to recap. The
20 IDES is one of the most heavily data mind process
21 that the Department of Defense has, quite frankly.
22 It is well resourced for getting down -- right

1 down to installation level; and that data is
2 available to the services as the Commander has
3 broken out here. And it is available to anyone,
4 Commanders like yourself, sir, to understand where
5 the roadblocks are in their IDES system. Now, if
6 you've got a Legacy system, the information in the
7 data is not as, doesn't have as much fidelity; but
8 the IDES system has a data collection system that
9 creates fidelity to the 'nth' degree.
10 COMMANDER WEBSTER: Couldn't have said it
11 better myself.
12 MS. DAILEY: What's that?
13 COMMANDER WEBSTER: Couldn't have said it
14 better myself, thanks. This slide indicates the
15 number of cases, Navy wide, that are meeting the
16 thirty-five goals, a day goals, for the MEB phase.
17 And I'm certainly not putting this slide up to
18 brag, whatsoever, but to get an honest look at
19 where we are today. So, what are we doing about
20 this? We, we know we have a problem. What are we
21 doing about this? At the Surgeon General level,
22 this has been added to the Navy medicine strategic

1 goals. At the Navy Medicine Command Executive
2 Boards for the Surgeon General, and for all MTF
3 Commanders, this is being briefed on a monthly
4 basis; and heavy emphasis is being put on
5 timeliness of this particular phase. Also,
6 consideration of tying this measure to performance
7 based budgeting is being considered.
8 Additionally, and I'll talk about this now because
9 it's, it's in its later slide, but it's -- I think
10 I can address it here. We're looking at a test of
11 concept. A group of people went down to Camp
12 Lejune, in February, to include members of
13 Assistant Secretary of Navy, PLAFIS for Manpower
14 and Reserve Affairs, folks from the PEB, BUMED and
15 our Navy Medicine East IDES training team. We
16 listened to what they had to say. We did some
17 education at that particular time; and we
18 implemented something called the Test of Concept
19 for a Narrative Summary. The Narrative Summary is
20 sort of the medical term paper, if you will. It
21 lists what specifically, that individual is being
22 referred to for the MEB and on to the PEB. What

35d3e2fa-d345-46de-b608-dda506fb6452

1 we're trying to do is to use a term that was used
2 earlier as to leverage existing capabilities using
3 AHLTA. Previously, the NARSUM had been a dictated
4 report, usually done by the specialists in which
5 area of expertise that individual was being
6 referred to, to the PEB via the MEB. That
7 specialist would have to generate that report and
8 comment on areas outside of their expertise. This
9 is a very time consuming process. If it's a
10 dictated report, the time for dictation also adds
11 to that time period. What we're trying to do, is
12 we're trying to narrow the focus of the
13 information that is required using PEB guidelines
14 and provide that information via AHLTA. So, at
15 the time that individual is seen by that
16 particular specialist, that specialist will
17 provide a brief narrative summary focused
18 specifically on the area of concern and it's
19 entered into UHLTA. If other areas, other medical
20 conditions need to be addressed by additional
21 specialists, then the members of the Medical Board
22 Department as well as the convening authorities

1 will go out, contact that physician responsible
2 for that and ask him to provide information, also
3 via AHLTA. So, the hope of that is to reduce
4 timeline.
5 GENERAL STONE: So, you make this into a
6 really fast process, what's the value? What's the
7 value of a MEB?
8 COMMANDER WEBSTER: The value of the MEB,
9 sir, is to provide enough data specifically so
10 that the PEB, number one, is the individual
11 physician's assessment of the situation validated
12 by the MEB. Number two, is the PEB being provided
13 enough medical data sufficient for them to make a
14 determination on that individual's status.
15 GENERAL STONE: When your statistics show that
16 eighty-three percent of your sailors go on to a VA
17 adjudication process, right?
18 COMMANDER WEBSTER: Yes, sir.
19 GENERAL STONE: What's the value of the MEB
20 PEB process in total, then? Is it to only the
21 seventeen percent?
22 COMMANDER WEBSTER: No, sir. Under IDES

1 it's for one hundred percent.
2 GENERAL STONE: I understand, but if I'm returning
3 seventeen percent to duty and eighty-three percent
4 are going on to the VA for adjudication of their
5 disability, what's the value then of doing work on
6 a hundred percent of the population?
7 COMMANDER WEBSTER: I'm not sure I understand the
8 question, sir.
9 GENERAL STONE: What I'm submitting to you
10 is that the IDES system has little added value,
11 and if you finish a fitness for duty and a
12 military physician believes that the sailor is no
13 longer fit for duty, then the idea of passing on
14 to the VA adjudication of the entire process a CNP
15 exam is done through that and then seventeen
16 percent that don't meet are returned, you have
17 little added value to this entire one year
18 process. The MEB, in fact, serves only to inform
19 the CNP exam of the VA.
20 COMMANDER WEBSTER: Yes, sir. Okay, sir.
21 As I mentioned earlier, service member
22 satisfaction is a key component of the success of

35d3e2fa-d345-46de-b608-dda506fb6452

1 IDES. Service members are offered satisfaction
2 surveys at the time of MEB completion, PEB
3 completion and transition phase completion. This
4 data indicates that there is a significant
5 improvement of the IDES process in satisfaction
6 terms over the Legacy DES in terms of fairness and
7 a slight improvement satisfaction with care and
8 case management. We continue to strive to improve
9 customer service at all levels. Finally, assuring
10 best practices we are corroborating both with Navy
11 Medicine, with WWCTP, our sister Armed Service
12 Medical Headquarters, the VA components both VA
13 and VHA, as well as regional and local MTFs to
14 make sure that we are implementing this schedule
15 on a standardized basis, reviewing checklist for
16 implementation, and doing periodic review. We're
17 using it as a resource tool for queries regarding
18 best practices, such as IT integration, CAC card
19 access, work space considerations and time and
20 travel standards. And we want to insure that
21 clear communications and expectations are known
22 and being discussed from both parties, both DOD as

1 well as VA. We've established training teams at
2 the regional level to allow for subject matter
3 expert on site training for implementation and
4 review of all practices. And we are considering
5 the review to be done on a periodic basis so that
6 as people move, as people -- new people come into
7 the system meaning new providers, new staff, that
8 they also be trained as well. We're trying to
9 make sure that we disseminate contact information
10 to permit for real time dialogue to look at
11 solutions. What may have already been addressed
12 at one site may need to be addressed at another
13 site at another region. We want to make sure
14 people are talking and coming up with common
15 solutions. And as I discussed, we're looking at
16 the abbreviated NARSUM pilot for help with meeting
17 our MEB timeline goals. That concludes my brief.
18 If there's any questions --
19 CAPTAIN BERTHOLD: And that's it for our Navy
20 presentation. Thank you for your time.
21 DR. GUICE: Thank you all very much. We
22 appreciate the time and effort that's gone into

1 this and your patience over the past couple of
2 days to actually finally get up to the microphone.
3 I'm sure that there will be some additional
4 dialogue as we kind of continue hustling through
5 all of this, but we really appreciate you time and
6 effort. Thank you all very much and I think we
7 take a ten minute break now. [Whereupon, a short
8 break was taken off the record.]DR.
9 GUICE: The final set of briefings. I
10 presume you're Mr. Conner?
11 MR. CONNER: Well thank you, first I'd like
12 to thank you all for saving the best for last, I
13 must put that plug in there. So, my name is Mike
14 Conner, I'm the chief of Warrior Support for the
15 National Guard Bureau. I work here in Arlington,
16 Virginia. Before I start, you've heard a briefing
17 -- I'm assuming most of the members heard a
18 briefing from the Air Force and the Army a few
19 weeks ago, so I don't want to repeat a lot of what
20 they've addressed, I just want to kind of build
21 upon that of how the guard from Army side and from
22 the Air side address the transition process for

1 our guard members. To do that, I first have to
2 lay a foundation and let you know where our
3 program came from. About 2005, General Blum, who
4 was our chief of the National Guard Bureau at the
5 time, said hey we're having a disconnect when our
6 guardsmen come back from active duty as far as
7 transitioning back through all the different
8 processes. His biggest concern at the time was the
9 VA; they're not getting veteran benefits. Mainly
10 because they're a little confused and it's so
11 overwhelming as far as the information you're
12 getting at the time. So he said let's get a
13 program together to do that. And mainly like I
14 said up here in the quote help our guard vets earn
15 the benefits that they've -- or access the
16 benefits they've earned. The first thing our
17 organization did was create a memorandum of
18 understanding between the National Guard Bureau
19 and the Veterans' Administration. That way they
20 knew what we were looking for and what our
21 expectations were and then we knew what they could
22 provide and what their expectations were from the

1 guard. After that, we created 62 transition
2 assistance advisors and put them out nationwide.
3 For those who aren't aware for the guard that
4 includes the fifty states, the District of
5 Columbia, Puerto Rico, U.S. Virgin Islands, and
6 Guam; those three territories. You'll see sixty-
7 two if you did the math real quick in your head,
8 that doesn't add up. Actually, it's sixty-four;
9 some of our states do have two transition
10 assistance advisor and that's either based on the
11 population of the guard in that state -- hence
12 Texas -- or areas like Alaska where geographically
13 it's just kind of difficult to have one person
14 servicing that many people in so many different
15 locations. One of the successes we've had so far
16 with this program is General Blum's guidance was
17 that he wanted us to hire almost all of those the
18 folks to be veterans; veterans who went through
19 that transition process, whether it was the
20 medical review board process, whether it was just
21 a straight transition, whether it was gaining
22 access; whether it was a wounded warrior. He said

1 that was critical because they could relate to the
2 service they were providing. I'm very happy to
3 say that 90 percent of our transition assistance
4 advisors are veterans and 60 percent of them are
5 currently receiving some type of disability
6 through the VA system. The first thing we figured
7 out as we started trying to help different
8 veterans access these programs was the maze of
9 confusion.
10 We all go through -- I know you've heard this from
11 the
12 other services, the briefings that are given, just
13 like you after awhile it's getting the end of the
14 day you're getting tired of hearing the briefings,
15 that's what happens to our soldiers and airmen.
16 Their kind of over briefed and it all tends to run
17 together and all they remember is everyone saying,
18 "I'm here to help, if you need, just call me."
19 The challenge we run into through that transition
20 is that happens on the active duty installation.
21 For instance, I was just at Virginia Beach --
22 excuse me, New Jersey -- in New Jersey at what was

35d3e2fa-d345-46de-b608-dda506fb6452

1 Fort Ticks now at Joint Base. The VA rep came in
2 there and briefed and said if you need anything,
3 you know, just let me know, here's my contact
4 information. The challenge is he's from East
5 Orange New Jersey. The units that he briefed that
6 day were two: One from Pennsylvania, which had
7 Pennsylvania folks, Ohio folks and Maryland folks.
8 So they're not going to be getting services from
9 the Fort Dicks or New Jersey VA. They also had a
10 unit from San Juan, Puerto Rico. They're
11 certainly not going to use East Orange, New Jersey
12 for the benefits. So while they mean well and the
13 person's standing up there is saying, I'm here to
14 help you, contact me. The challenge we ran into
15 is those faces and those names are gone when the
16 service member actually transition back to their
17 state. And that's where our transition assistance
18 advisors can help. It's a familiar face. They can
19 help remind them how to navigate through all the
20 different services that are available to them as
21 they go through that transition. The other thing
22 that we've realized is a lot of times with the

1 climate the way it is, benefits change -- change
2 quite regularly. So what they may have been
3 briefed while they were at the mode site, 30 or 60
4 days later, some of those benefits have changed
5 usually for the better, but they're not aware of
6 that. The other challenge we've there's realized,
7 one of our senior analysts did a study, and I
8 don't mean this in a bad way but you cannot use
9 installation based solutions for community based
10 challenges. The service members -- the guard
11 members go back to the community, there's twelve
12 states that have no military installations
13 anywhere around, so where are they going to get
14 the support? In other states, they may be
15 limited. If you're in Virginia it's great,
16 there's a whole lot of military installations.
17 But still that can be overwhelming for some of our
18 service members. A study that was done about
19 three years ago in the family side of the system,
20 said that 30 some percent of our guard members'
21 spouses believe they're married to a military
22 member. Now that sounds strange, but they just

35d3e2fa-d345-46de-b608-dda506fb6452

1 know the guy that goes down to drill, whether it's
2 a guardsmen or a reservist. Two things come to
3 thought: One, we can try to reeducate seventy
4 percent of those spouses and say, "yup, you're a
5 military member" or we start identifying our
6 resources in a more civilian way so that they can
7 all understand them and apply them. How do we
8 define success? First of all, because we are sub-
9 components of the Army and the Air Force we use
10 the same measures of success that they're looking
11 for. And as you heard before from almost everyone
12 else, it's a seamless transition. The challenge
13 is actually providing that seamless transition,
14 especially when there's systems along the way that
15 kind of create disjoints. How do we do that right
16 now? We're trying to capture state successes.
17 Again, the program was put out in 2005. What --
18 what we do in the guard typically is say, "here",
19 to the state, "these are your basic guidelines,
20 move forward" and then they kind of creatively
21 find ways to support those goals or those
22 missions. What we didn't do, because the program

1 is fairly new for us was capture that data of how
2 they're doing that. And that's what we're trying
3 to do is find out from the state what they're
4 doing it and how they're doing it and then share
5 that information. I've been in this position
6 about a year and a half now. My predecessor, what
7 they did was say let's, like I said, let's just go
8 provide the support and now we're trying to do the
9 analytical data capture and that's why I'm there.
10 Establishing organizational baselines; what we've
11 been doing in the past was following this services
12 baselines, which works really well at that
13 installation, or during the demobe process,
14 whether they're in the transition unit, whether
15 they're in the warrior transition unit or the
16 CBWTU -- providing a standard when they get back
17 has been our biggest challenge. They had certain
18 expectations because they were receiving them out
19 on active duty, but because of some our limited
20 resources, those same services may be not
21 available. So we're trying to establish that
22 baseline and say, "okay this is what we can

35d3e2fa-d345-46de-b608-dda506fb6452

1 provide to you in every single state." We just
2 released a program awareness survey. My biggest
3 challenge was I thought do we know how we're doing
4 out there purely from a marketing sense. Again do
5 they even know about our program? Do our guard
6 members, I'm really pleased right now we're
7 getting about a 30 percent return rate on the
8 survey; we just released that. I'll provide that
9 data once it's completed, but the good news is
10 that most people it seems like right now we're
11 about a fifty percent that are aware of our
12 program and can actually by name identify their
13 transition assistance advisor in their state. Now
14 some of the reasons for that is when the warriors
15 is going through their transition -- when they're
16 actually at the warrior transition unit, we're
17 visiting there. We're going there and seeing that
18 service member. And we do that regularly.
19 Because in some cases, I know you've heard this in
20 the PTSD aspect, they don't remember who all is
21 there and who came in to see them. So if we use
22 that same face there constantly, eventually that

1 starts to sink in that this is the guy that I need
2 see when I get back. It's a familiar, friendly
3 face. And then we just also started a customer
4 service survey. There was one that was done
5 before. The challenge we ran into they were
6 basing the service on the active component; not on
7 the services we're providing. The other challenge
8 we run into is we're not directly providing a
9 service. We're not resourced to do that. What
10 we're doing is acting as a liaison to connect them
11 to the services in the local VA. So what we do is
12 take the hit, for instance, if that local VA isn't
13 providing what their expectation was, then of
14 course, we'll get the hit for that. Conversely,
15 we get the benefit too, if the VA does a great
16 job. And I'll just give you one example of how
17 that happens. When a service member comes back
18 and they go through the transition process, they
19 fill out a bunch of forms. One of those is a VA
20 enrollment form, a 1010-EZ. They fill the form
21 out; that's collected and sent back to the VA and
22 that's their enrollment for that free benefit --

1 for free medical care for five years. It goes
2 somewhere out there. We don't know where yet;
3 we're trying to figure that out. I was just in
4 Virginia Beach, Virginia yesterday at a CBWTU, and
5 they handed these out, the VA rep again from
6 Virginia, servicing five other states, mentions
7 that he's there to help them. Hands out the 1010-
8 EZ and one of the soldiers raises his hand and
9 said, "Do I have to do this? This is the fifth
10 time I've filled this form out." And he is still
11 not in the system. There's little glitches like,
12 of course, you're still on active duty; your VA
13 benefits won't happen until you're released. So
14 why are we wasting paper, time, and energy to give
15 them that form for the fifth time to fill out just
16 to say I've briefed 150 people. That's not really
17 customer service oriented. Now for some type of
18 analysis we do have, I went back through the
19 records and found two years worth of work and
20 where we refer people to. And this gives you an
21 idea, the workload I guess, is a better way to say
22 that - pardon me. The health administration,

1 that's a big one, the VHA; that's where we tend to
2 send a lot of our service members while they're in
3 transition; that's what they're asking about. To
4 the right -- far right -- you'll see it says
5 other. That number has been growing about eight
6 percent in the past each year. And it seems to be
7 growing even greater this year; that other is for
8 the most part other reserve components. Okay?
9 And I say that because all too often when you ask
10 about the guard and the reserve, they look at that
11 as one word -- one organization. The national
12 guard, and the reserve, whether it's Army, Air,
13 Navy, or Marine are, in this case, five different
14 organizations. Okay? So what's happening though
15 is that reservist, let's say, Navy reserve. The
16 Navy reservist is discharged during that
17 transition process; they have a medical review
18 board and they're put out of the system. They go
19 back to their home state. Where are they going to
20 get that support? That follow up care? Now the
21 logic is the VA because you're discharged now,
22 you'll get your transitioning support at the VA

1 there. But the VA is not staffed to do that. So
2 what's happening is, as I mentioned earlier in our
3 survey, more and more of our folks finding out
4 about us, know about us, when those reservists
5 hear about that; they're calling us and saying
6 what can you do for me? Of course, we help them,
7 it's just another veteran. So we do what we can
8 for them. And then we also may know who to refer
9 them to, as in this case someone from the Navy,
10 someone at the local Navy base or if it's Navy
11 reserve center, we'll connect them there. They
12 may not be aware of that. Okay? The VBA, the
13 Benefits Administration; that's that benefits and
14 compensation they're going through. I'm going to
15 be very blunt and honest with you. One of the
16 complaints we're hearing from the VA right now is
17 you're giving us broken service members. All
18 right. That was not the intent of the VA. It's my
19 understanding, it's the obligation of the services
20 to repair that service member or put him back in
21 the condition they got him in when they took him
22 in and then turn him over to the VA and the VA

1 picks up from there. For whatever reasons that
2 doesn't seem to be happening. So the VA now seems
3 to be getting burdened with a lot more medical
4 services, if you will, than they're used to and
5 they're trying to find that specialty care for
6 that. It was just something else that we
7 experienced working with the VA. The next one
8 you'll see is our vet centers. The vet centers
9 have been real instrumental because there's more
10 of them in our states, obviously. The VA medical
11 center, there might be three, there might be one
12 in Wilmington, Delaware -- for instance, depending
13 on the size of the state, they don't know where
14 else to go so they go to the vet centers. Now the
15 vet centers can't provide a lot of medical support
16 but they can provide the PTSD situations, the
17 counseling that they can help and eventually refer
18 them. They're also more localized and most of
19 them are staffed with predominantly veterans who
20 can relate basically. So it gives them that one-
21 on-one contact and our veterans seem to really
22 enjoy that. I'm sure you didn't memorize all the

1 numbers but if you look here on the community
2 based referrals, that's our largest percentage of
3 referrals. And if you're paying attention to what
4 I'm saying, that would make logic, wouldn't it?
5 That's the only place we get our services from,
6 once they transition out, even if they're still in
7 the National Guard in one way, shape or form,
8 their services still come or the benefits still
9 come from the community. It could be the local
10 VFW. And in some states they have private
11 organizations that have stood up. You've probably
12 seen those in the newspaper about this
13 organization and that organization saying that we
14 want to help vets. Well, we're happy to take that
15 for a lot of reasons. Again, I told you we have
16 limited resources, so we don't have the funding to
17 go find that service, having to get that through
18 the community. Your other question was about
19 informational items. We're trying to prevent
20 doing the same thing over and over again, taking
21 the VA, taking the DOD, taking Army, Air Force,
22 taking their literature and reproducing that. We

1 use the same thing. We may just put a sticker on
2 there that has our local point of contact on
3 there, but that information that goes out,
4 whatever it is -- whether it's flyers, or
5 information about programs, we use the same thing.
6 Where we add to that is again those community
7 based resources. If it's a local community type
8 thing, the VFW or a private organization, we'll
9 include that in our packs of information. Now
10 there are some states that have added a single
11 source document that talks about the specific
12 benefits they'll get in that in that state because
13 I'm not sure if you're aware, but there's also the
14 state Veterans' Administration. And each state
15 varies there as far as what benefits they have. I
16 just spoke to the directors a couple of weeks ago,
17 what I'm unfortunately, I'm finding out is because
18 of the financial restraints, some of the states
19 are having to cut back some of those extra
20 services they provided to the veterans. The
21 resources again, just trying to capitalize on
22 what's already out there. When we do our

1 briefings, we talk about the wounded warrior
2 resource center; we talk about the website.
3 Something else to understand -- there's 17 percent
4 of our veterans live in rural communities that
5 still have dialup network for the internet. So
6 sometimes all the flash and bang and bells and
7 whistles doesn't get downloaded quick enough and
8 they're pretty much done with that website before
9 they even started. The good thing I will mention
10 about the National Resource Directory, I think
11 that's one of the biggest successes that OSD level
12 have put out so far. I don't know who's designing
13 it, I'm not here to market for anybody, but I
14 think these were guys who left Google just cause
15 they wanted to commit themselves to the DOD and do
16 something right. Because what I'm finding is the
17 information on there seems to be pretty easy to
18 find and what I like the most -- program wise --
19 is when you go in there and you look for state
20 resources in one of the options, RTA's are either
21 ranked either first, second, or third in every
22 case, which means there's customers out there

1 using them. Because what I've been told is they
2 do a Google based technology where whatever hits
3 the most will come up in the top, you know, one
4 down through ten. So seeing that really gives me
5 great comfort that folks are out there actually
6 looking for us. So can't speak highly enough
7 about the national resource directory out there.
8 Military one source has been another great asset
9 for us. It also helps us bring resources from the
10 local community down out to the states and by
11 county. If you're not aware, most of our services
12 are provided by county, its county agencies, not
13 state. State may have oversight, but again if,
14 when you're talking about that services member
15 actually getting a benefit or a bonus or a
16 service, it's at the county level. Military one
17 source has been phenomenal at doing that for us.
18 They have great resources -- unlimited. If we
19 need anything, we can call them; they'll provide
20 plenty of copies for things if we want to get them
21 out to our service members.
22 Some states will start seeing a trend that is

1 occurring
2 in their demobe process with one their units and
3 they'll identify at the military one source.
4 Military one source will just send out all the
5 supporting literature and they'll offer to send
6 someone if they can. Those are also, they also
7 have a military one source representative co-
8 located at our Joint Force Headquarters state. So
9 Joint Force Headquarters Maryland, Joint Force
10 Headquarters Pennsylvania, that kind of thing.
11 They're co-located at joint force headquarters so
12 they're working with our transition assistance
13 advisors, our family program, our psychological
14 health. It's a team effort; it's a coalition
15 basically. Which is a perfect transition to the
16 next slide. Your question about how are we
17 interfacing with everyone else. We're fortunate
18 because as the National Guard Bureau, we have
19 access to DOD. We can go directly to them to ask
20 questions. We can also resolve issues and we can
21 do the same between the Army and the Air Force,
22 which really works well for us. In some cases we

1 work with the Navy because they may have a large
2 Navy contingent -- in California, for instance.
3 They'll have a more closely working relationship.
4 We're trying to figure out how do we resolve the
5 transition challenge that our service members
6 encounter. Flip through this one real quick. But
7 again, this gives you an idea of what really
8 happens in the state. When they're in the
9 National Guard status, it goes back to the
10 governor and the adjutant general of that state or
11 territory. The important thing here is, and I
12 don't mean this to slide anyone, I'm retired Army,
13 active Army, so I understand this. We think a
14 little bit different. If you're out of -- once
15 you're discharged from the Army, the active Army
16 -- I'll use that as an example since that's where
17 I came from, you're no longer an asset to me or
18 concern. And I don't mean that in a bad way, but
19 you're out and there's other resources to take
20 care of that. The challenge we run into, even if
21 you're discharged from the Army Guard or the Air
22 Guard, the challenge you run into is I still have

1 to look at you at the local Wal-Mart when I walk
2 by. You didn't go back to your home state; you're
3 in your home state. So our customer service
4 satisfaction means when I see you, do I have to go
5 down aisle three so you don't see my face cause I
6 didn't take care of you? Or can I proudly walk
7 down aisle nine and see you and you're going to
8 stop and thank me? And that's significant for us.
9 We have to use all these resources out there
10 within the state. They vary, like I said, from
11 state-to-state and sometimes, quite honestly, I'll
12 give an example of working with the veterans, or
13 VFW, varies by state -- or by county. Some
14 counties they do a great job. In other counties
15 you can't get them on the phone. And that's where
16 we come in and try to figure that out, working
17 with the state level VFW and say hey, we have a
18 little problem in Lackawanna County or wherever.
19 All right, best practices. I kept hearing when I
20 took over the program about best practices. So
21 and so in -- I'll use Pennsylvania so I don't
22 offend anyone, I'm from Pennsylvania originally.

1 They'll say Pennsylvania has a really great
2 program in whatever it is. And then when you
3 start getting down to the nuts and bolts of that,
4 you find out it's because the Pennsylvania TAG and
5 the Pennsylvania Governor, who have been the same
6 people for the past eight years, are really close
7 friends. Their families go out together and they
8 both support veterans and they both love the
9 National Guard. So you have an incredible amount
10 of leadership behind you in doing great things for
11 your state. I cannot copy that in,
12 hypothetically, Maine. It's a different governor.
13 It's a different TAG. Or maybe they just had a
14 reelection, or election and that governor's not
15 there, so the governor leaves and you have a new
16 adjutant general. And you're starting over. They
17 may have the same priorities; they may be
18 different ones. So what we're trying to do is to
19 establish a new baseline and a more formal process
20 of how we establish our best practice. Did you
21 have a question, sir?
22 LIEUTENANT COLONEL KEANE: I think you just

1 answered it. TAG? The Adjutant General?
2 MR. CONNER: Oh, I'm sorry. TAG is The
3 Adjutant General.
4 So when you say "the TAG", you're just stuttering,
5 basically. Okay? Sorry about that. Exactly,
6 there you go. What we've looked at as far as how
7 we should establish these best practices is by the
8 size of the state. For instance, in Delaware, I
9 was just on the phone with the transition
10 assistance advisor there where she was telling me
11 that she's taking one of the veterans down to the
12 state veterans administration to get them enrolled
13 in a specific state program. That's not going to
14 happen in Texas. Delaware being a smaller state,
15 she can do that. It's from one end of the road, of
16 the highway, to the other end of the highway to
17 get that person to each of the facilities. I'm not
18 picking on them, but that's reality. In Texas,
19 they're flying to get to different sites to do
20 briefings. So they're not going to have that same
21 level of care so it's not fair to say here's the
22 best practice, of course it is -- pick someone up

35d3e2fa-d345-46de-b608-dda506fb6452

1 and take them there. That's obviously best
2 practice. You can't duplicate that in Texas. So
3 when you decide to do it, let's look at it by the
4 size of the state and then the next consideration
5 would be obviously be geographic. Geographic,
6 being Alaska, Hawaii -- when you're flying from
7 island to island, that's a whole different dynamic
8 compared to even if it's a large state or small
9 state. The other thing is territory laws. Each of
10 our territories have different laws and agreements
11 with the United States. So we have to make sure
12 that we conform to those. Some cases are not
13 drastic, but one example is Guam. Guam has their
14 right, for instance, to refuse if there's a ship
15 coming in to sea and we say redirect it to Guam
16 because there's guys on there who have leprosy or
17 whatever, Guam can say no. And their agreement
18 says that. So that's the things we have to do
19 what kind of services are available and how are
20 they provided when it comes to territory versus
21 state. So that's why we're looking at that as
22 another way to identify how we establish best

1 practices. Now what we have been doing so far is
2 e-mail. Our transition assistance advisors, it's
3 kind of nice because they're not competitive.
4 Cause like I said usually one in each state, some
5 have two state. In most organizations if you have
6 a couple of folks doing the same job there's a
7 little bit of competition. In our case, it's not
8 that way for the TAAs. They look at each other as
9 an assistant basically; can you help me? I heard
10 you're doing something great in Maryland. What
11 are you doing and how are you making that work?
12 That's what they've been doing for the past five
13 years with each other. And so you'll see some
14 commonality in the programs because of that; cause
15 they did it on their own -- unofficially. And
16 sometimes informally is really the best, best
17 practice. Monthly conference calls. We have them
18 with the VA and then we also have them with DOD.
19 We brought them into the loop because they do
20 provide a lot of services for us. So now we do a
21 teleconference or in some cases webinars, where we
22 can actually see the slides, we talk about issues

1 and then we go through that.
2 And we have the subject matter expert there to
3 answer
4 whatever those issues are. In most cases, those
5 issues are coming from the bottom up. The TAAs
6 are saying I need more information about the
7 educational process for veterans or their spouses
8 or the transferring of their GI benefits to the
9 family members. So we'll get that SME in there --
10 the subject matter expert to talk about that. We
11 also have the quarterly musters at the CBWTU's.
12 It's a little expensive, quite honestly, for
13 someone from Delaware to fly to Virginia Beach or
14 drive to Virginia Beach or where ever the case is.
15 But when they're down there, they're not only
16 meeting with the service members that are there to
17 help them. And by the way they have reservists
18 and active component in some cases and guards men,
19 so we're there helping them all of them at the
20 same time. Doesn't matter what component they're
21 from. But the other part of that is that when
22 they're done with doing their briefing and doing

1 all the one-on-one with the service members, they
2 go to dinner that night. And I've been to a few
3 to see this cause I didn't believe them, to be
4 honest with you. They literally have dinner, they
5 socialize, they talk for a while and then somebody
6 eventually says, okay, I'm having an issue with
7 this. And then they talk about it and they get in
8 the official mode and each other, they share with
9 each other the challenges and possible solutions
10 on problems their having. And then they'll send
11 that out to the rest of the TAA's nationwide and
12 say hey, we had this meeting, this is what we
13 discussed, may be it will work for you; maybe it
14 won't. We just captured that at the national
15 level, unfortunately. We are now. And the last
16 best practice we have is the admiral professional
17 development, we do that in February. Typically,
18 the good part about that is all those other
19 service providers are there, the psychological
20 health people, our family program folks, our ESGR
21 and clergy support in the Army reserve. They're
22 all there and we can communicate with each other

1 and say what challenges are you experiences that
2 cross over in lanes? My predecessor gave me a
3 really good example of how we fit together in the
4 National Guard; how we make this work. If you look
5 at it from a patient care perspective. If you're
6 laying on the operating room table and they're
7 about to do open heart surgery on you, do you want
8 the TAA there? Do you want the psychological
9 health? Do you want the sexual assault? Do you
10 want the family program?
11 A multitude of folks there; you want them all
12 there. In
13 this case you want the guy that's -- the surgeon,
14 right? When they're doing the surgery, you
15 definitely want to have him there. You want to
16 have the OR tech there, the OR nurses, the
17 anesthesiologist. They have to work together as a
18 team to make that open heart surgery a success.
19 If any one of them were out there focusing on
20 their own you're not providing in my mind or his
21 mind as he explained it, an adequate level of
22 care. So for us that professional development is

35d3e2fa-d345-46de-b608-dda506fb6452

1 pretty significant because we can share those
2 stories with each other and say how do we work
3 together? A best practice that we're working on
4 right now we collect a lot of data right now when
5 they go through the transition process. For
6 instance, if someone is demobilizing and they fill
7 out the form through the Army Career and Alumni
8 Program or the Transition Assistance Program, for
9 the Air side, when they go through that, we're
10 collecting the forms they fill out. DD forms that
11 say what do you want more information about? It
12 could be financial; it could be medical, life
13 insurance, all those things. Well, it doesn't do
14 us any good when we just keep the forms and go
15 back and send a report up to National Guard
16 Headquarters, and say look what we did. For us
17 now, is to say we just got this information in,
18 and out of a 100 man unit, 50 people wanted more
19 information on the employer support of the guard
20 and reserve. I need to send that information to
21 my counterpart in the ESGR, by me so he can reach
22 out and contact those guys and in some cases have

1 that all in place before the person even leaves
2 demobilization site. Another good practice for us,
3 I think you've heard of before was the yellow
4 ribbon program. That helps us because we can
5 reach out and be at the events when there's a 30,
6 60, and 90 day event. That gets us on the podium,
7 so to speak, to talk about what we can do. The
8 survey that I told you about earlier that we have
9 out right now, as far as the awareness, it's
10 showing about a 46 percent of the folks find out
11 about us from the yellow ribbon events. The next
12 highest was 32 percent and that's from another
13 service member, which is the cheapest and the best
14 way to market out of all the options out there
15 because that other service member is obviously
16 happy with what we're doing. And they'll tell
17 their friends. If they tell their friends, we're
18 doing something right. I want to also share with
19 you, in Maine, for the transition process and
20 folks don't realize this on the active side when
21 you're transitioning back, if you're going back
22 into the service, not a big issue. If you're

1 going out of the service, it could be an issue.
2 But we had a main unit just go through, and 36
3 percent of the unit was concerned about
4 employment, because they were unemployed when they
5 were going home. And that's a huge issue. Now I
6 know I didn't, address a lot of the medical things
7 because we're not a medical support group; that's
8 not what we're here to do. There's a lot of
9 systems in place for that where they're there to
10 just connect the dots for their service members
11 and answers the questions when they can. And if
12 the dots start to get disconnected, then we
13 reconnect those things. And that ends the formal
14 part of my presentation. I'd be happy to
15 entertain any of your questions.
16 MR. REHBEIN: Allocation of resources. You
17 have 62 advisors spread across the country.
18 MR. CONNER: Yes, sir.
19 MR. REHBEIN: I will use Iowa as an example,
20 that's home.
21 The second brigade combat team of the 34th
22 division is

35d3e2fa-d345-46de-b608-dda506fb6452

1 going to come home this summer and fall. And
2 suddenly your Iowa advisor is going to have
3 several thousand transitioning, demobilization --
4 demobilizing troopers. How do you allocate
5 resources? That one single advisor can't begin to
6 do that job.
7 MR. CONNER: On average, our TA's are
8 managing 4,800 veterans at a time. And that
9 again, is not just Army or Air. That's any
10 veteran in our area. A tremendous workload. When
11 it comes to a demobilization or remobilization,
12 what we're looking at now is adding resources just
13 for that event. For instance, take a border state
14 transition assistance provider -- advisor -- and
15 send them up there or have floaters, if you will.
16 The challenge is that was the hope for this next
17 contract but with the limited financial resources,
18 I don't see that becoming a reality,
19 unfortunately.
20 MR. REHBEIN: The challenge out there is
21 going to be all of those 30, 60, and 90 day unit
22 events are going to be happening at the same time

1 and that person is going to meet themselves coming
2 and going trying to get --
3 MR. CONNER: To a point. When you say at
4 the same time that's partially true, I'm not --
5 just to clarify that. Because of the yellow ribbon
6 corners are also in the office with us, so to
7 speak, they are -- they all coordinate. When do
8 we do these? Because again, there's one of us;
9 there's one psychological health; there's one of
10 everybody in most cases. So they have to say
11 okay, this week -- this weekend will be this
12 portion of the division; this will be or the
13 combat team. They'll send it out like a hundred
14 here, a hundred there and that just keeps you busy
15 even weekend but at least they can reach out and
16 touch every veteran that way.
17 MASTER SERGEANT MACKENZIE: How are the transition
18 assistance advisors linked up with the liaisons at
19 the major medical facilities, like, for instance,
20 at Walter Reed you have National Guard liaisons
21 working there? How are those two pieces linked
22 together and is there a responsibility to one

1 another to communicate?
2 MR. CONNER: It is a responsibility to one
3 another. And the way that we do that is those
4 liaisons, the National Guard liaisons at the
5 different medical treatment facilities provide
6 information; they're the eyes and ears, so to
7 speak. They'll provide that to the local TA.
8 They have a list; we send that to them every
9 month, we
10 update our contact sheet. Our turnover is that
11 high and we just figure the more you put it out
12 there, the more they'll look at the list. But
13 they know then they can call, if it's -- if it's a
14 service member from Maine they can call there.
15 They can call that TAA. The face to face is very
16 limited -- obviously because of the expense and
17 why do I have to fly out to that treatment center
18 when I can just do that on the phone. We
19 encourage our guys to do that, to be proactive. I
20 know most of the National Guard liaisons are the
21 same way because they're told to make sure you
22 contact your POC out there. I will say from an

35d3e2fa-d345-46de-b608-dda506fb6452

1 airside, one of the challenges we have with the
2 Air Force is 214's. There's a self certification
3 process that the airmen does or doesn't do
4 sometimes and the other thing is they'll go for 30
5 days or if it's less than thirty days, I'm
6 assuming it's an administrative burden for them to
7 be constantly cutting 214's. So when the service
8 members are trying to go get the airmen in this
9 case, trying to get their benefits, they're having
10 challenges to get all of the 214's together so
11 that they can show that they add up to a hundred
12 eighty days so they can get the benefits. That
13 again, recording with the military treatment
14 facilities and then the Air Force as a whole, how
15 do we make this a little bit easier for the
16 airmen? A little more of an answer than what
17 you're looking for. You had blue on so I had to
18 throw it out there.
19 MASTER SERGEANT MACKENZIE: Well that's, I'm
20 on active duty guy start to finish. However, I
21 work in the joint environment --
22 MR. CONNER: Oh, good.

1 MASTER SERGEANT MACKENZIE: So I spend the
2 majority of my time as a liaison with Army
3 National Guard special operations forces. I do
4 see some of these challenges, some of these
5 national guardsmen that go back to their home
6 state where the medical professionals think it's
7 in the interest of the family and that
8 cohesiveness and say hey you can go back this
9 route and get some care. And then you find out
10 that they're coming right back because they can't
11 get it --
12 MR. CONNER: (Indicating yes.) That's
13 happened, yeah.
14 MASTER SERGEANT MACKENZIE: That
15 communication between the TAA's and
16 representatives at the medical treatment
17 facilities or perhaps the wounded warrior groups,
18 I think, is a critical piece to say to provide
19 assistance to the medical providers, saying may be
20 this isn't a good thing for this guy because of
21 what limited resource in the state that none of us
22 know about. So I wonder, you know, that

1 communication pipeline maybe needs to be expanded
2 a little bit as part of that discharge process,
3 either through nurse case managers or WTB's, or
4 wounded warrior regiments to say where are we
5 really sending this guy back to?
6 MR. CONNER: And yes, that's a good point.
7 We, the recovery care coordinators, I brief them
8 the new ones that come in every time they come in.
9 The DOD has ask me to come in and do that so
10 they're a little more aware and that's where I
11 give them the contact sheet. I got to tell you
12 honestly, my wife retired, a few months ago, and
13 when she was going through her physical with the
14 VA, she had a female doctor. I'm not -- I'm not
15 trying to ding the VA, we all have challenges.
16 But the VA doctor there was a civilian female who
17 was shocked that my wife did push-ups and had to
18 fire a weapon and was more interested in that.
19 And I couldn't believe in today's age that she was
20 just thinking that way. But it's that awareness
21 and complete awareness. I will say we have a
22 descent, if there was a level to put it on, of

1 communication between all of the components that
2 are out there and our guys are pretty persistent.
3 Sometimes you don't want them calling you on the
4 phone, but -- yes, ma'am?
5 DR. GUICE: Do you all use the E-Benefits
6 portal at all and start to coach these individuals
7 separating to, to use the My E-Benefits portal,
8 which actually because we already know so much
9 about all of these individuals it starts, it's
10 getting to that tailoring of information and
11 benefits and delivering it to people directly
12 through that vehicle? If not, I could get you in
13 touch with the people who, even if it's in --
14 MR. CONNER: No, no. I probably had that --
15 I'm not a good poker player, so you probably tell
16 by my face that I was trying to figure that answer
17 out. The challenge we run into is, the example I
18 can give is, I travel quite a bit and I like to
19 read. So I stop at local Borders or whatever they
20 are, bookstores and I'll always walk in there to
21 buy a book. And I think, darn, they sent me an e-
22 mail that said 40 percent off if I bought a

1 hundred dollars worth or whatever. I wish I had
2 that with me. Well, my son convinced me -- one of
3 my son's convinced to me to get a smart phone.
4 And the guy behind the desk at Borders, or
5 whatever, said you know you can pull that e-mail
6 up on there, and I can literally scan that coupon,
7 which blew me away. And it worked. So of course
8 I called my son and bragged, and said, hey, your
9 dad's getting hip now because he's got a smart
10 phone. What we're finding from our guards member
11 -- and I guess I'm a little bit older than the
12 average guy in the guard -- but the younger crowd,
13 if they want to use the technology to get their
14 resources, they want it now. They don't want to
15 sort through a web site that they've got to find
16 the information. It's the sound bites, you know,
17 generation.
18 They grew up on commercials where that 15 second
19 commercial, they can sing that song and repeat
20 that; they know that completely. But give them a
21 briefing on their life insurance they can't
22 remember what they are just told.

35d3e2fa-d345-46de-b608-dda506fb6452

1 DR. GUICE: E-Benefits is not that. E-benefits --
2 MR. CONNER: Oh, I'm sorry.
3 DR. GUICE: E-Benefits is, is you have to
4 have served; there's a secure log-on --
5 MR. CONNER: I'm sorry, I misunderstood.
6 DR. GUICE: -- and the information is, for
7 instance, if you just joined the military and at
8 the 91st day, you will qualify a VA benefit. You
9 qualify for a home loan. So it automatically pops
10 up and says, congratulations. It's actually to get
11 rid of that problem, so that you don't have to
12 read a bunch of pamphlets and try to sort it out
13 and you don't have to try to Google and figure out
14 okay do I really qualify for this once you read
15 through all the language that the lawyer found it
16 appropriate to put up on your website. So it's
17 really because we know all this information and
18 members can sign up when they join the military
19 and then it's to stick all the way through to
20 later in life and it, it tamers the benefits. You
21 can -- you can self generate the VA preference
22 letter, for instance. And I think it would be a

1 really good -- what I'm trying to say is I think
2 it would be very helpful for your advisors to
3 start to use that and coach people how to sign on
4 and get there -- log on, because it will be a very
5 valuable tool for them to use as they're trying to
6 reintegrate.
7 MR. CONNER: Actually, it is. I need to
8 apologize. From the distance, you probably can't
9 see this, but I just got hearing aids. Fifteen
10 years of reading lips, I didn't hear you say E-
11 Benefits, I just heard you say benefits. We
12 actually had an E-Benefits coordinator at our
13 professional development in February teaching our
14 guys about that and how to use it. And yes,
15 that's an awesome program. As far as getting the
16 resources and that's the other thing that I heard
17 from the TAAs when they started using, it does get
18 rid of all of those web site clouded issues and
19 it's specific to that service member. So I
20 apologize that I didn't hear the question
21 correctly.
22 GENERAL HORST: Just to follow on Dr.

1 Guice's question and discussion of your experience
2 with borders. In your distribution of
3 information, are you using or are you
4 contemplating using the social media? We have
5 found that's a very broad and effective way to
6 share information and would certainly be a benefit
7 to your TAAs. Have you contemplated that?
8 MR. CONNER: We actually started one. I
9 will tell you honestly, I wasn't a fan of it. The
10 things I've seen of --
11 GENERAL HORST: Just because you're an
12 analog person now living in a digital world.
13 MR. CONNER: That's exactly right. I saw
14 things posted on -- they started a transition
15 assistance advisor web -- FaceBook, for instance.
16 Quite honestly, when I saw the whole thing in
17 Egypt, I figured, hey, that -- that is the way to
18 go with the future. Get my head out of where it
19 shouldn't be and do that. My concerns I'm seeing
20 right now if it's not properly managed, I went on
21 to look at it, for instance, and the local TAA did
22 this all on her own, and everybody jumped on. But

1 if I wanted to meet a minority to go on a date, I
2 could do that because it's an open site. People
3 can post on it. So we're doodling, but now we're
4 kind of drawing back on it saying we need to
5 resource it to have someone manage that, have
6 someone look at it, so those type of things don't
7 end up there. But our younger guys are tapping
8 that thing left and right.
9 GENERAL HORST: And that's the point is --
10 is you need to create a system that causes them to
11 go where they normally go to and that's social
12 media is where we're going. And the young ones
13 don't read e-mail anymore.
14 MR. CONNER: Well, in fact, I saw this study
15 with the Army where they've issued smart phones to
16 a couple of brigades and trying this and that's
17 how they're going to communicate, use GPS, and
18 everything. Because that's what I see that all
19 the time. So --
20 GENERAL HORST: I think just as a thought,
21 the guard bureau could probably help the 50 states
22 and territories and get a broad distribution of

1 information --

2 MR. CONNER: Right.

3 GENERAL HORST: -- and take some of the

4 burden of your TAA's in the large states, like

5 Texas or Iowa or what have you. There's some

6 benefits there leveraging in the social media.

7 MR. CONNER: Thank you.

8 DR. GUICE: Any other questions? If not, we

9 thank you, very much.

10 MR. CONNER: Thank you.

11 MS. DAILEY: Thank you, Mr. Conner you're

12 going to be hearing from us for a couple of years.

13 The task force will be around Mr. Conner's my

14 belly button in the National Guard, so he'll be

15 back. Look forward to working with you over the

16 next few years. Our next briefing is from Captain

17 Joan Hunter on -- I've known Captain Hunter a

18 couple of years. She briefed us in 2007,

19 probably?

20 CAPTAIN HUNTER: 2008.

21 MS. DAILEY: 2008, program for the National

22 Guard. So this program has some legs; it's been

1 around for a couple of years, it's also in the
2 growing process.
3 CAPTAIN HUNTER: Thank you, ma'am. General Horst,
4 General Stone, Dr. Guice, members, thank you very
5 much for inviting me. I'm not in the Navy. I
6 confused a lot of my colleagues earlier today.
7 I'm in the United States Public Health Service and
8 I've been detailed to the National Guard through
9 an MOU with the Public Health Service and DOD
10 Health Affairs. So they pay my freight and
11 they've placed me at the National Guard Bureau to
12 build a psychological health program. I apologize
13 if this is old information for you, but coming
14 from the active duty component I always try to
15 share with folks the population that I'm working
16 with. Three hundred fifty thousand in the Army
17 guard; 100,000 in the Air guard and what's been
18 important for me and has been crayoned out for me
19 more than once is the difference between title
20 ten, Title 32, traditional active duty. I still
21 need it crayoned out on occasion, but it's
22 starting to sink in a little bit. This 80 to 85

1 percent traditional has a huge impact on the
2 psychological health services that we offer to the
3 National Guard. And also as Mike mentioned, the
4 Governors really control the National Guard. So
5 in reality what I've discovered you've got 54
6 kingdoms and 54 different days of doing business.
7 That is changing in psychological health, it's
8 taken me a couple of years to sort of get that
9 spin going, but certainly meeting standards,
10 partnering with active duty, military has been key
11 and my other sister services. As I'll get into a
12 little bit with you, but this has advantages and
13 disadvantages and huge advantages for legislative
14 initiatives. It had huge advantages for us with
15 earmarks because the governors and the
16 congressional delegations from the states, with
17 the adjutants general has been an incredible
18 political bonus for us in the National Guard.
19 However, it also has the disadvantages in that
20 each one wants to do something his or her special
21 way. These are the challenges, I'm sure this is
22 not new for you and like every other guard program

1 it has a very heavy focus on the community in the
2 state and local providers. But why I'm here is
3 that National Guard psychological health was non-
4 existent and I can only thank the DOD mental
5 health task force report, which really placed me
6 and gave the guard the authority to request me
7 over there. And that has been the guiding
8 principal that I use to build the psychological
9 health program as it stands today. And we are
10 also looking at -- now that we have about two
11 years under our belt, we are looking right now, as
12 we speak, a second generation of what this program
13 should look like in the future. We -- when I
14 first got over to the National Guard, zero staff;
15 zero funds. And I'm a psychiatric nurse and
16 social worker by training and I've been managing
17 large mental health contracts for civilian
18 agencies through the Department of Health and
19 Human Services for about 18 years. So it was
20 pretty natural that I would assume without any
21 staff and without any funding that I'd be using
22 you for money, end of the year money and that

first year I got over there, I had a statement of work ready, and in thirty days we awarded a contract to put 54 directors of psychological health, which is the nomenclature from the DOD mental health task force in all 54 states and territories. And just in the last six months, the Air National Guard has awarded two additional contracts, their funding is coming out of hide, and they have about 47 of the 89 on board right now and they're just orienting at this time. So we'll be partnering with them at the state level to make sure that we're meeting the psychological health needs of both airmen and soldiers. We have licensed providers. They are licensed to practice at the independent level because they need to be working with licensed providers in the community and at state level. And that also addressed liability issues and quality assurance issues from my perspective to make sure that we had a minimum standard of provider that we were offering to our soldiers and airmen; very complicated cases as well. Funding for this program comes from the DOD.

35d3e2fa-d345-46de-b608-dda506fb6452

1 What's called force health protection money. The
2 National Guard is not entitled to that money. The
3 $600 million that goes to DOD health affairs, we
4 were not entitled to that. I couldn't believe that
5 when I got over there. So a few champions and
6 myself didn't let up on that. Now we get $9
7 million that is force health protection money that
8 is sent back to Congress; it's reprogrammed; it
9 comes back to force health protection and moved to
10 the Army National Guard and then transferred over
11 to the joint staff. That is not going to meet the
12 needs of the next generation of what psychological
13 health should be based on the data that I'll be
14 sharing with you in a minute. But at least it was
15 getting our foot in the door and I'm very
16 appreciative that DOD Health Affairs came through
17 on that for us. We have a mission statement. We
18 have these directors of psychological health one
19 and now the wings are coming on board. And what
20 we're having them do, I think we need to relook at
21 that because I'm very concerned about compassion
22 fatigued. They're attending yellow ribbon events;

1 they're doing assessments and referrals because
2 there is no provision for services -- as far as
3 medical services. We are not allowed to provide
4 treatment but it's a very fine line on what we
5 actually are doing. We'll see folks up to two,
6 three, four, or five times, we'll keep them in a
7 file. But in reality, I have to be really careful
8 because we're not allowed to provide treatment.
9 They should be seeking treatment either through
10 their own private health insurance, or through the
11 MTF or the VA. But that's not a realistic
12 solution in many cases so we're working around
13 that. I also set aside about 100,000 dollars in
14 this contract; probably get my hand slapped if I
15 got caught, but essentially I knew there would be
16 outliers who wouldn't have insurance; who wouldn't
17 qualify for VA benefits would not be close to a
18 provider and we have spent about 97,000 dollars
19 already in this option year of the contract for
20 that particular population. These are uninsured,
21 no resources, the DPH are using particular social
22 programs at the state level. They've exhausted

1 and researched that. Then they come back and we
2 okay them for funds for emergency rooms and things
3 like that. I'm sure you're well aware of the
4 suicide rate in the Army National Guard as having
5 doubled. The vast majority, well not the vast
6 majority, the majority of those cases are soldiers
7 who never deployed. Same with the Air guard,
8 majority of suicides never deployed. And the rate
9 went from 62 in '09 to 108 -- 112 in 2010. So
10 obviously we're looking at all of that. We're
11 partnering with other parts of DOD to deal with
12 that. How do we define success? And I think that
13 is the utilization of this program; that's
14 certainly an indicator. The assessment tools that
15 we're using, the regional management and
16 oversight, taking advantages of the state, the
17 visibility of the program and I am using the DOD
18 VA integrated health strategy and I'm just editing
19 that for the National Guard. We need to be
20 leveraging our chaplains and our medical people. I
21 was placed in the J1, not in the joint surgeon's
22 office because of the anti-stigma associated with

1 someone seeking psychological health services from
2 a unit or an individual who would be determining
3 whether they would be fit for duty, which is what
4 the surgeons are doing on our end, overseeing that
5 process. And we thought, well the DOD mental
6 health task force -- and I agreed with them that
7 -- that position should be placed outside of the
8 surgeons office. We're now relooking at that, and
9 trying to figure out how we can sort of work the
10 fence of both the J-1 and the joint surgeon's
11 office because clearly there is a role -- a
12 clinical role in what we're seeing. And we have
13 to be able to look at what that can be for the
14 guard in the future. This is our data; I apologize
15 for the blurriness of it. It's just the dashboard
16 report and in the first two years, these are the
17 clinical cases that these individual providers in
18 the states have assessed to be of a nature that
19 that they wanted to create a clinical case on
20 them. So we're looking at about 4,500 to 52 or
21 5,300 at this point. Although, it's just a
22 snapshot of the number of lives we've touched from

1 a clinical perspective, we are beginning to see
2 some trends. It's a white, high school educated
3 between the ages of 19 and 35, of course the guard
4 populations is a little bit older. We're seeing
5 that these particular cases that are coming in to
6 us by far are family and marital issues that we're
7 dealing with. That's consistent with the active
8 component as well. We're also seeing depression,
9 psychiatric concerns and PTSD, which is also in
10 line with what my sister agencies and other
11 services are seeing. What I also want to draw your
12 attention to is this lower right-hand corner,
13 suicide risk, high risk and assaults. That's a
14 pretty significant number. Can I tell you
15 categorically that we have saved lives? I can't
16 prove that someone might have committed suicide
17 but did not, but certainly these numbers indicate
18 to me that the value and the return on investment
19 the DOD has made for this program is paying off
20 back to the National Guard. Another number I want
21 to draw your attention to -- MS. CROCKETT-JONES:
22 Can you hold on?

1 CAPTAIN HUNTER: Yes, ma'am? MS. CROCKETT-JONES:
2 What is a high-risk versus a suicide risk or an
3 assault risk?
4 CAPTAIN HUNTER: A high risk is somebody who
5 may have suicidal ideation; may have had transient
6 thoughts about it; may be in a situation that is
7 dangerous; has lost his job; has lost his family;
8 has lost his support systems. And that particular
9 clinician has considered him a high risk case. MS.
10 CROCKETT-JONES: And how, what's a suicide risk
11 has spoken of --
12 CAPTAIN HUNTER: A suicide risk has clearly
13 indicated that he is not happy with his life as it
14 is right now and has thought about it or has
15 attempted suicide.
16 GENERAL STONE: And are these consultations
17 that are being done being done face-to-face,
18 telephonically, through other media sources? How
19 is it -- from the joint force headquarters
20 assignment of this consultant to the delivery of
21 services are performed?
22 CAPTAIN HUNTER: Sir, is this 75, 58, is

35d3e2fa-d345-46de-b608-dda506fb6452

1 what you're looking at? Is that consultation over
2 there? Absolutely.
3 It's a combination of all of the above. These are
4 lives
5 touched. These are senior leaders asking for
6 advice on critical incidences; a suicide occurred,
7 what am I supposed to do with that? As compared
8 to an actual clinical case, this is may be
9 touching base with somebody.
10 GENERAL STONE: Okay. So this is not a
11 face-to-face consultation with a soldier in need?
12 CAPTAIN HUNTER: It could be, sir, but it's
13 not been assessed to be a significant enough
14 encounter for them to create a particular case on
15 that individual.
16 GENERAL STONE: And do your providers have
17 prescriptive authority?
18 CAPTAIN HUNTER: They do not.
19 GENERAL STONE: In your escalating suicides,
20 do you have cases in which you have consulted but
21 then resulted in suicide?
22 CAPTAIN HUNTER: Yes, sir.

1 GENERAL STONE: As you work your way through
2 this and have cobbled together as best you could
3 some sort of an attempt at a delivery system, do
4 you see this as the ultimate solution to a
5 delivery system for this population of a half
6 million great heroes?
7 CAPTAIN HUNTER: I don't think I alone would
8 be capable of answering that question. I think
9 that needs to be an answer myself and the reserve
10 components need to come together and give you a
11 proposal for an answer like that.
12 GENERAL STONE: Are you in agreement that we
13 need to come forward, but let me suggest to you
14 that you have already defined a population under
15 tremendous stress.
16 CAPTAIN HUNTER: Yes, sir.
17 GENERAL STONE: We know from the national
18 institute of mental health, the 18 to 25 year old
19 population in America, has an eight percent
20 incidence of serious mental health problems. We
21 know that in the screening process for accession
22 into the military we do not screen in a

35d3e2fa-d345-46de-b608-dda506fb6452

1 comprehensive manner of that population for
2 behavioral health problems. Unless they have
3 encounters with the law there is little we do that
4 really screens perspective soldiers in a
5 comprehensive manner. So therefore you can expect
6 in your population of half million, to have some
7 percentage with serious behavioral health
8 problems. But yet we provide no comprehensive
9 care system across the
10 continuum of service. CAPTAIN HUNTER: I
11 agree with that, sir.
12 GENERAL STONE: And this is exactly why we
13 must examine for behavioral health services
14 specifically. A comprehensive access to the
15 tricare delivery network, regardless whether
16 you're in title 32 status, title ten not active
17 duty or title ten active duty.
18 CAPTAIN HUNTER: I agree with you, sir. So
19 what are we doing? What is actually preventing us
20 now from being able to move forward and quite
21 frankly in the National Guard, I think our
22 population is overwhelmed with resources and

35d3e2fa-d345-46de-b608-dda506fb6452

1 redundant programs and I think what we need to do
2 in the National Guard -- and I agree with you,
3 General Stone -- is we need to come together and
4 decide which ones are valid for us; which ones
5 have the science behind them to actually work; and
6 how can we create a model in the National Guard
7 that will meet the needs and challenges of the
8 guard population. That really is different from
9 the active duty and I'm sure you hear it over and
10 over again, but until you live that and you
11 understand you're going to use your next door
12 neighbor, your buddy, your friends as a -- as a
13 sort of your support network. You won't naturally
14 go back to one, an organization who will question
15 your need to be staying in the National Guard if
16 you dare to bring up the issue of PTSD or TBI that
17 you think you might be experiencing; that's why I
18 think it spills over to marital and family issues;
19 that's why we're seeing more substance abuse. And
20 in the military, unlike the Department of Health
21 and Human Services, substance abuse is separate
22 from mental health. We're working very closely

35d3e2fa-d345-46de-b608-dda506fb6452

1 with SAMHSA, Substance Abuse and Mental Health
2 Services Administration, another HHS agency to
3 help us with benchmarking and to integrate
4 substance abuse and mental health and not quite,
5 and deal more with a limited use policy. Our Army
6 National Guard has a limited use policy and I
7 understand that, that is going to be looked at for
8 a second time as not being the way to go and that
9 they're going back to a more restrictive zero
10 tolerance. I think personally that that might be
11 a challenge and that will drive people underground
12 again. Recognizing that this is not an employment
13 agency but I understand that the first step that
14 someone might do is self medicate when they're
15 dealing and experiencing with extreme stress and I
16 would hate for that population to continue to stay
17 underground and be fearful of not being able to
18 get the happy in fear of losing their employment.
19 This stigma is still alive and well, I can
20 guarantee you that in the National Guard.
21 We need to look at again, sir, as you mentioned,
22 policy

1 whether it's title 32 or title ten. Many of the
2 states have to put the folks on active duty in
3 order to get them the care they need and that's an
4 arduous and complicated paperwork trail. We are
5 doing a lot of things in the National Guard to
6 address this. We brought about 25 or 30 states
7 because it is a patch work nation when it comes to
8 the National Guard and there are extremely
9 wonderful programs that some states are providing
10 and we wanted to take some of those programs, get
11 them the visibility that we thought they deserved
12 and allow other states to see what they're doing
13 so that they could replicate that if it worked for
14 their particular state. For example, three peer-
15 to-peer programs, California, Nebraska, those
16 types of programs, although they're not directly
17 psychological help they're more in soldiers and
18 family support type services. We looked at the
19 Oscar program that the Marine Corps has. We also
20 brought in the American Red Cross; we're trying to
21 utilize the state resources; State connections;
22 state resources on all sorts of different levels.

35d3e2fa-d345-46de-b608-dda506fb6452

1 We're also trying to integrate, I have 54
2 contractors; that is a difficult integration into
3 a system that has a uniform on it and we need to
4 build a sustainable program that's cost effective
5 and that needs to be the next generation of what
6 this generation of what this program should be.
7 If we have to move it out of a contractor status
8 that's in jeopardy right now in the future to a
9 sustainable force and what does that force look
10 like and what's the most efficient and efficacious
11 combination of folks for the National Guard and
12 how do we connect with the joint surgeon and the
13 Army Guard surgeon, the Air Guard surgeon? I spoke
14 at the break yesterday with General Green, because
15 I understand he had a different way of looking at
16 this as opposed to the Air National Guard, and I
17 wanted to understand what his vision was and we
18 chatted just a little bit and then I circled back
19 with the Air Guard surgeon to make sure we are all
20 on the same wave length. Clearly, bringing our
21 folks together once a year, I built that in our
22 contract. So we bring in subject matter experts

35d3e2fa-d345-46de-b608-dda506fb6452

1 from the active component to share with them. We
2 bring in the best, bright SME's for example,
3 stress inoculation, how do you deal with that in
4 the civilian world? We're also working with
5 USUHS, the Center for Deployment Psychology. Some
6 of our DPH's in the states have worked with the
7 state licensing boards and brought in volunteers
8 in the communities and we've trained them on
9 military competencies and military understanding
10 and military culture. Because many of our lay
11 providers in the states want to help but they
12 don't know how to help and the DPH's placed in the
13 states are a good bridge and licensed to practice
14 in the state where they are. And many of them are
15 involved with these networks. We also have a
16 backup network of about ten thousand through this
17 contract -- contractor. They're called affiliate
18 providers and when there is a surge comes back in,
19 there was a surge question earlier, we will bring
20 in and pay a state rate -- a predetermined state
21 rate for them to help us. But once again, we need
22 them to be trained in the military world and

1 military culture so that they can relate to the
2 men and women. Many of them can't relate and so
3 it's that soldier, airmen citizen, soldier citizen
4 airmen that we need to address in the National
5 Guard. It's 80 to 85 percent who are traditional
6 guardsmen. So their network is going to be their
7 community and we need to capitalize on that.
8 CAPTAIN HUNTER: SAMHSA Substance Abuse and
9 Mental Health Services Administration has
10 something called a policy academy where they bring
11 ten states to Bethesda; and those ten states, of
12 about ten members of the state Governors cabinet
13 through the Governor's office and they will come
14 and they will build plans and policies for that
15 state how they will take care of the veterans. In
16 Realty what they're doing is building a network to
17 support the National Guard. We aren't turning
18 anyone away - we're not turning any active duty
19 folks as Mike mentioned, we won't be turning them
20 away in the future. But clearly we have to
21 capitalize - DCOE is offered to provide some
22 research for us, Major General, Todd Bunting,

1 before he retired built the resiliency center in
2 Kansas for lack of finding something that met our
3 needs, comprehensive soldier fitness master
4 resilience training, a two week course at the
5 University of Pennsylvania doesn't cut it for the
6 National Guard. So we need to take what the goals
7 are of comprehensive soldier fitness,
8 comprehensive air man fitness and we need to
9 translate that into something where we can provide
10 a service or an education or information on five
11 dimensions of a person's life in the 39 days of
12 the year, that the Army National Guard has eyes on
13 its soldiers. And then of course this question
14 came up, but this is really more in the lane of
15 the surgeons, it may be in our lane in the future,
16 I think that's our next generation as we need to
17 incorporate these contractors more with medical,
18 but very carefully keeping our foot in the one so
19 that folks will continue to utilize this program
20 without fear of restitution for seeking help.
21 Then of course, some of our DPH'S may be the first
22 and have been the first to recognize mild tramatic

1 brain injury cases, these are folks that are
2 forget full, family notices that they're
3 different, we're talking six months to a year
4 after their return and it could be very well a
5 mild tramatic brain injury and helping that
6 individual get to a military treatment facility or
7 a private provider that can help determine whether
8 or not that really is the case. And then -- I
9 mentioned Legislative initiatives, we have
10 currently HR 948 and S 325 before Congress,
11 they're working on those bills right now. That's
12 our California Tri-west sponsored embedded
13 counselor model. That's been pretty good. It
14 hasn't been perfect, but I wouldn't expect any
15 particular program to be perfect. That's 16 hours
16 a month, 31 counselors attend drill weekends with
17 the Army and the Air Guard high-risk units.
18 That's 5200 in these for the whole 22,000 of the
19 whole California guard, it comes to about $12 a
20 month per service member, which is a pretty darn
21 good deal. So we're working on the mark up and
22 helping through our Legislative liaison on some of

35d3e2fa-d345-46de-b608-dda506fb6452

1 that language. Because it is a patch work quilt -
2 it's a patchwork quilt when it comes to funding
3 for the guard and psychological health and it's a
4 patchwork quilt for authorizations as well. Our
5 DPHs attend a lot of yellow ribbon events; they're
6 doing a lot of rediness processing. The National
7 Guard has to create -- in my opinion, some sort of
8 a behavioral health response to domestic
9 operations and that's been positively received by
10 the National Guard. The occupational health model
11 of physical, mental, and environmental health we
12 want to be available to our soldiers and air men
13 who are responding to floods, hurricanes,
14 disasters, fires, et cetera, et cetera. We are
15 finding that some of those that are being deployed
16 -- are finding the deployment itself whether its
17 OCONUS OR CONUS -- has been a challenge for them
18 in lots of ways; and so we have folks available
19 and we have crisis teams that we have built to be
20 able to respond to domestic operations. We also
21 need to create standards, guidance, and quality
22 assurance and we need to be evaluating the types

1 of work that we are providing. To be honest with
2 you, we can only send letters out to the Adjutants
3 General of what we would consider a quality
4 psychological health program, but we don't have
5 the authority to dictate to them the way you would
6 expect, sort of, the active component does. We
7 are more of a guide standard setting, setting the
8 bar for them, giving them resources and ideas and
9 best way forward, but it's really up to the states
10 to implement. And this is the draft of -- I think
11 where we will be going in the future.
12 Major General Ross, the J1 at the National Guard
13 bureau,
14 our joint surgeon Brigido General Kirk Martin,
15 have tried to decide where I should be, should I
16 stay in the J1, should I go in the joint surgeons
17 office, where should this program go and how
18 should it go and what should it look like in the
19 future. Clearly the air guard and the army guard
20 want the execute, they want to control these
21 contractors at the state level. I don't have a
22 problem with that. I think that's a good idea.

35d3e2fa-d345-46de-b608-dda506fb6452

1 But I think we need to build quality assurance
2 measures. We need to give them a road map by
3 which to use in order for them to be successful at
4 the state level, otherwise the position itself --
5 I'm fearful would slip and I think I have the
6 support of the guard bureau on that, but there
7 will be more to come on that, that nine million
8 dollars -- is that all we will ever get from OSD
9 Health affairs, I'm not sure. But that was an
10 initial attempt, we need to go back as a reserve
11 component and outline what those challenges are
12 and come up with a model for the National Guard as
13 my responsibility. But there's a director of
14 psychological health in the Navy reserve, in the
15 Army reserve, and in the Air Force reserve. And
16 we created a counsel and we talk to each other,
17 it's informal. We talk about how we're do things.
18 The Navy reserve has this outreach program that
19 they mentioned earlier this afternoon. Captain
20 Torsch and I shared a lot of information --
21 stumble steps that she had when she first adopted
22 that program that I took from her lessons learned

1 to avoid those pitfalls for the National Guard.
2 And then of course, coordination, collaboration
3 and communication is always a challenge. But I
4 can't think health affairs -- I am on conference
5 calls with them -- personal and readiness, Dr.
6 Klineman has gone out of his way to include the
7 National Guard in suicide prevention -- as he
8 should, and I certainly appreciate that. The
9 guard has a seat at the table where when I first
10 came that was unknown and with the numbers going
11 up the way they are, certainly needs to be happen
12 and I certainly appreciate the effort and the
13 ability to make a difference because these folks
14 they really don't have a lot of resources at one
15 level but they have a tremendous spirit and I'm
16 very honored and appreciate the opportunity to be
17 able to be serving the National Guard. I'll
18 having any questions or any concerns that you may
19 have that I can answer for you
20 MS. DAILEY: Captain Hunt - excuse me --
21 Captain Hunt, we are going out to the joint forces
22 in California and Florida and we're looking at

1 these two programs -- the TAA Program and the
2 viewer program -- the tags, the psychological
3 health program, I assume when we get out there,
4 we'll meet the contractor in those two places who
5 you've hired to run their programs is that how it
6 works.
7 CAPTAIN HUNTER: The California state has a
8 slightly different model, the DPH works for the
9 behavioral health officer - and that is Lieutenant
10 Colonel Eric Frye also the California model - the
11 embedded counselor model is getting a lot of pop
12 press right now, that would be Colonel Darce
13 Keller who you would want to touch base with and I
14 could get with you, Denise, afterwards give you
15 their names and contact information so you make
16 sure you can connect with them.
17 MS. DAILEY: What was the -- excuse me --
18 they kick back an idea peer-to-peer, and I kicked
19 back what the heck is peer-to-peer, since I've got
20 you here, what is peer-to-peer?
21 CAPTAIN HUNTER: Peer-to-peer is where you -
22 it's based on a law enforcement model where a law

1 enforcement officer helps a law enforcement
2 officer that is in trouble or act as a mentor and
3 a guide and someone to help you through the
4 system. It's a one-on-one type relationship and
5 the National Guard is doing peer to peer programs.
6 It's pretty much what the Oscar program which is
7 the senior listed program at the Marine Corps, in
8 Quantico - Greg Goldstein heads that up - and he
9 also has come from HHS, and I know him. So I got
10 our senior enlister, our command chief and command
11 sergeant majors involved in that, and got a
12 briefing for them to see -- because I think we
13 need to bring in the senior enlisted folks. This
14 can't be an officer driven, officer implemented
15 program, we really need those first sergeants --
16 they are that key link and without their backup
17 and without their recognition of that connection
18 and having some responsibility and ownership in
19 what we do forward, it won't be successful. Thank
20 you very much.
21 MS. DAILEY: So again we'll see these
22 programs when we go out to California and Florida

35d3e2fa-d345-46de-b608-dda506fb6452

1 at the state level.
2 DR. GUICE: Are there any questions for our
3 panelists while their still sitting at their seats
4 and microphone close at hand. I believe you all
5 excused, thank you for your patience with us.
6 MS. DAILEY: I think that is the collusion
7 of conclusion of our formal schedule, yes?
8 DR. GUICE: Correct. Of course I always
9 have stuff to do for another hour if you would
10 like.
11 MS. DAILEY: Do you want to take five minute
12 stretch and then we'll sit back down and give
13 everybody a chance to settle back in? [Whereupon,
14 a short break was taken off the record.]DR.
15 GUICE: Okay. We'll go ahead and get
16 started again. So that -- I know some people have
17 to get to an airport; fortunately the airport is
18 close by.
19 MS. DAILEY: Yes, ladies and gentlemen, I'm
20 not -- as I said earlier, I'm not going to torture
21 you much longer. I do -- just a little situational
22 awareness, which we talked a little bit about

35d3e2fa-d345-46de-b608-dda506fb6452

1 earlier. Next week, four of us leave for 29
2 Palms, Tuesday morning, and I have a semi-final,
3 not as much detail as I'd like -- holy cow, it's
4 up on the screen, thank you, very much Mike! My
5 fabulous team; reads my thoughts and there it is.
6 So I have a tentative, almost locked in, we have
7 one last meeting with him tomorrow for the 29
8 Palms and you saw me trying to extort the Marine
9 leadership yesterday to greater levels of
10 participation in getting me, in particular, family
11 member focus groups. We'll do a case management
12 review early in the morning. So they want to have
13 breakfast with us, their CG, and the Marine
14 Battalion Commander out there wants to have
15 breakfast with us that morning. So we'll be
16 joining them at Phelps dining facility for
17 breakfast with the Marines.
18 We -- myself and the members will be on post in
19 DVD
20 quarters and my fabulous staff will be out the
21 Fairfield.
22 Initially we will meet, sir, this will be your

1 first;
2 the guys have kind of pulled together a meeting in
3 the evening before our travel arrangement should
4 support that. But we generally the day before,
5 meet that night and talk and collaborate and share
6 previous stories and go over the sequence of
7 events, gaining situational awareness and then the
8 next morning we're hitting the road running. So
9 we have many of the same areas that we look at
10 here. We just kind of push it down to the
11 installation level and see what is actually
12 happening at the installation level. You'll see a
13 couple of telecoms, very small place; only 19
14 wounded warriors here. Again, I kind of,
15 expectation management here. This is not data
16 rich such as we would find at Balboa, at BAMC, but
17 I think, you know, the smaller the locations we do
18 need to try and assess if resources are being
19 pushed down there and this is our opportunity. So
20 we won't see robust facilities and redundant
21 overlapping care issues. We will, in fact see as
22 you heard today, they are down three case

35d3e2fa-d345-46de-b608-dda506fb6452

1 managers. So that, just kind of manage some
2 expectations here.
3 MASTER SERGEANT MACKENZIE: However, that
4 will kind of go in line with our discoveries at
5 Fort Campbell, is the efforts for them to hire
6 enough in these remote locations. And what more
7 needs to be done to assist these facilities
8 surrounded by farmland or desert that are trying
9 to take care of our wounded, ill and injured.
10 MS. DAILEY: Correct. So check your emails.
11 We will send out one that has a little more
12 fidelity to it tonight or tomorrow and then on the
13 back of that, we also have -- once you scroll all
14 the way to the back, would you please. This is
15 our tool for keeping track of notes for the task
16 force. It has worked out relatively well. We've
17 been incorporating it, catching quick notes.
18 Okay?
19 That's really all I have, or actually it's pretty
20 much
21 the last bit of energy I have left.
22 DR. GUICE: Any other comments, concerns,

35d3e2fa-d345-46de-b608-dda506fb6452

1 questions?

2 LIEUTENANT COLONEL KEANE: Ms. Dailey, I

3 have a few things for you.

4 MS. DAILEY: Yes, yes?

5 LIEUTENANT COLONEL KEANE: In light of our

6 dwindling numbers here this afternoon, a couple of

7 questions regarding task force members. Being the

8 last task force member to have joined the task

9 force, it took about three and a half, four months

10 for me to join, I wonder if you could brief us on

11 where we are for finding a replacement for Master

12 Sergeant Hightower, and if there's any work or

13 it's too soon to start looking for a replacement

14 or going with that chief in the Navy to replace

15 Commander Coakley?

16 MS. DAILEY: Yeah, one situation at a time

17 because it changes dramatically. Right now,

18 Secretary of Defense is not signing membership for

19 any task force. In his -- in DOD, he's in the

20 process of creating a plan for efficiencies. I

21 think some of the more senior leaders in here will

22 -- are feeling his initiatives on efficiencies,

1 and one of them is he's got a squeeze on the
2 federal advisory committees whether they are
3 discretionary -- which we are not -- or non-
4 discretionary -- which we are.
5 But he is not signing any membership packages. So
6 anticipating any membership fill is a waste of
7 energy.
8 LIEUTENANT COLONEL KEANE: Ma'am, one last
9 thing. We also discussed at our first trip and
10 third trip a letter of appreciation, a certificate
11 of appreciation. I think we're getting close to
12 it being a month out from our first trip. Those
13 things are always better tooth sooner than later,
14 instead of waiting until we have like a designed
15 certificate, I think a letter from the co-chairs
16 thanking our guides might be appropriate?
17 MS. DAILEY: I agree. And Phillip's working
18 on that, wherever he is. And we're pushing it.
19 We'll get it. We'll get it.
20 DR. GUICE: Okay. Any other -- absent any
21 other burning issues, we will adjourn. WHEREUPON,
22 the proceedings were concluded at approximately

1 3:55 p.m.

2 CERTIFICATION OF TRANSCRIPT I

3 certify that the attached transcript of the

4 DEPARTMENT OF DEFENSE TASK FORCE took place on

5 March 31 in the year of 2011 in Maryland.

6 I, the undersigned, do certify that this is

7 a true, accurate and complete transcript prepared

8 from the electronic recording taken by Mark

9 Mahoney of Beta Court Reporting on the

10 aforementioned date and that I have verified the

11 accuracy of the transcript by comparing the

12 typewritten transcript against the verbal

13 recording.

14 Mark Mahoney

15

16

17

18

19

20

21

22

35d3e2fa-d345-46de-b608-dda506fb6452