

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

L'ENFANT PLAZA HOTEL
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WASHINGTON, D.C. 20024

PARTICIPANTS:

Chairmen:

General Charles B. Green, M.D.
Dr. Karen S. Guice, M.D. M.P.P.

DoD Taskforce Members Present:

Commander Timothy A. Coakley, M.D.
Lt. Colonel Sean P.K. Keane
Master Sergeant Christian S. MacKenzie
Major General Karl R. Horst
Major General Richard A. Stone, M.D.
Command Sergeant Major Steven DeJong

Non-DoD Taskforce Members Present:

Mrs. Suzanne Crockett-Jones
Mr. David K. Rehbein
Mr. Justin Constantine
Mr. Ronald Drach
Dr. Russell Turner, M.D.
Dr. Steven J. Phillips, M.D.

Staff Present:

John Booton, Vice President, Operations
Bella Gonzalez, Business Manager
Denise Dailey, Executive Director
Stephen Lu, Web Developer
DeQuetta Tyree, Executive Assistant
Jim Wood, Records Manager
Philip Karash, Technical Writer
Heather Moore, Events Planner
LaKia Brockenberry, Travel Coordinator

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P R O C E E D I N G S

GENERAL GREEN: Okay everybody, welcome. Let's see if we can figure this out. All right, now everybody welcome. We've got audio. All right. I'd first would like to introduce Command Sergeant Major Steven DeJong, welcome. Okay. Confirmed last night, which is wonderful. He has served for over seventeen years, had two -- I'm sorry, he's a member of the Indiana International Guard; served for seventeen years and has had tours in both Afghanistan and Iraq. He's a recipient of the Purple Heart and the Bronze Star medal. Command Sergeant DeJong will fill the National Guard seat previously occupied by Master Sergeant Brett Hightower, who retired earlier this year.

I'd also like to congratulate Dr. Jessica Jagger, from the ICF research team. Dr. Jagger -- where is she? There she is. Okay. Successfully defended her dissertation on two of May, has been awarded her PhD in social work from Virginia Commonwealth University. Let's give her a hand, okay. So I think that because we've had several changes in membership, what we'll do is go around the table quickly and introduce ourselves once again. And then we'll get started with the official trip report. So Command Sergeant DeJong, would you like to start?

COMMAND SERGEANT MAJOR DeJONG: I'm Command Sergeant Major Steven DeJong, glad to be here and finally

on board with you guys. Still trying to figure all of this out in a short period of time, but happy to be here.

MASTER SERGEANT MACKENZIE: Master Sergeant MacKenzie, otherwise known as Mac. Special operations representative on the task force and helicopter guy by trade. So as always, it's good to be here.

DR. PHILLIPS: Good morning. Steve Phillips; retired lieutenant colonel; physician; part of the Department of Health and Human Services; work the NIH.

LIEUTENANT COLONEL KEANE: Lieutenant Colonel Sean Keane. I work at the VA I'm the Marine Corps liaison to the VA.

MS. CROCKETT-JONES: I'm Suzanne Crockett-Jones. My husband was wounded in 2004 in Iraq in an air ambush and I'm happy to be here.

GENERAL HORST: My name is Major General Karl Horst. I'm the Commander of 21st Headquarters National Capital Region in the United States Army Military District of Washington; I'm a career infantry officer and have served most of my time in tactical units with three combat tours.

DR. GUICE: I'm Karen Guice. I'm a physician. I'm currently the executive director of the Federal Recovery Coordination Program at the Department of Veterans Affairs and I serve on the Task Force as the VA

representative.

GENERAL GREEN: And I'm Bruce Green. I'm a family physician and the Air Force Surgeon General.

MR. REHBEIN: Dave Rehbein, I'm the -- I'm a dual career, one as a research scientist at Iowa State University in the Department of Energy and secondly, at location through the American Legion, having served as, I'm now past national commander of the American Legion.

MR. CONSTANTINE: I'm Justin Constantine. I'm an attorney with the FBI on account of the terrorism team. I'm also the major general in the Marine Corps and I deployed to Iraq in 2006.

COMMANDER COAKLEY: Commander Tim Coakley. I'm an emergency medicine physician and currently the deputy force surgeon at the Navy Expeditionary Combat Command physician and had multiple combat tours with supporting the United States Marines and special operations.

DR. TURNER: Good morning, I'm Russ Turner. Retired Air Force; family practice aerospace physician from San Antonio.

MR. DRACH: Good morning, Ron Drach. I'm an individual member and I'm recently retired from the U.S. Department of Labor of Veterans Employment and Training Service.

DR. GUICE: Well, thank you, everybody. I'm

going to make the unofficial announcement. This is my last Task Force meeting. I am leaving my VA job and going over to the Department of Defense so my position here on the Task Force as the VA representative will be re-staffed from VA; that's currently in the process and we expect formal concurrence and notification and all those other things that we have to do to get someone signed into the Task Force. But what we have to do, since I also serve in the Task Force as the non-DOD co-chair, the non-DOD members of the Task Force need to kind of huddle today and come up with a strategy, a new nomination for a vote, end of tomorrow. So just be thinking about that as we go through the next two days. Thank you.

Okay. We are going to start our official part of the meeting by discussing the installation visits, specifically the second set and the final set, up to this meeting. We visited the Marine Corps Air ground Command Center at 29 Palms; the Naval Medical -- Navy Medical Center at Balboa; Joint Force Headquarters and Community Based Warrior Transition Unit in Florida; and the Joint Force and Community Based Transition Unit in California. So I'd like -- let's see, Dr. Phillips, are you going to do the -- are you going to start with the 29 Palms visit?

DR. PHILLIPS: I can.

DR. GUICE: That would be great.

DR. PHILLIPS: I can.

DR. GUICE: Thank you.

DR. PHILLIPS: I can't remember the exact date, but we were there for three days. As you may or may not know, 29 Palms is in the middle of the Mojave Desert; it was breezy and cool and dusty. They are somewhat isolated. Their unit -- the base is preparing Marines to deploy. So they are an active unit ready for combat. They were a significant number of wounded, sick, ill on the base. A large number -- nearly two hundred, were not in the Warrior Transition Unit or the regiment and there was some discussion about why they were not in the units.

There was a significant number in the Warrior Transition Unit and we had some focus groups with E1 through E4; E5 through E8 and family members. And I think you will receive those reports, so I don't know if you want to go into discussing the focus groups discussions that we had?

DR. GUICE: Why don't we go with just the basic information from each person and then I think we'll kind of have a robust discussion about, all the focus groups that we found at each one and I think that might be a way to kind of bring it together. And just cautionary that let's maintain the privacy of the individuals that talked to us at the focus groups. And sir, I only sent the notes, my

quick notes to the team that went, so they don't know -- the rest of the members, don't know or did not see that.

DR. PHILLIPS: Well, I'll just give you a broad overview. We met with the commanders and the CADRE. There was discussion as to the care and treatment and management; there was discrepancies between the discussion of what the CADRE and the managers and the teams were able to provide to the wounded, sick, and ill. The base has a small hospital -- small clinic facility where basic treatment can be provided. Other than that, the folks had to go to either Balboa or Camp Pendleton for further care, depending on what their issues were.

Overall, the physical facilities seemed to be adequate. The care coordinator seemed to be the key people for management of the wounded, sick, and ill. There were a lot of different questions and discussions related to individuals who either did not receive the management that they thought that they should receive or individuals that did not know about either the units or what could be done through the units. Generally, there seemed to be --

GENERAL GREEN: Can I ask for clarification? When you say people that you talked with that didn't know about the things in the unit, were you talking with people that were outside the unit in the --

DR. PHILLIPS: People in the unit who finally got

there, said that initially they were not aware of these units existed or what they could do.

MASTER SERGEANT MACKENZIE: Can I jump in there real quick?

DR. PHILLIPS: Sure.

MASTER SERGEANT MACKENZIE: The -- one of the things we found is that we did have some interaction with people who were not in the wounded warrior battalion detachment there and we also found that there was a lack of knowledge and those who did have knowledge through the individual rank structures, were then told by the operational unit that they didn't qualify for that service. So they were literally struggling on their own within the unit trying to get their own care, while this segment of care and tracking and management was available, but they were told it wasn't available to them

GENERAL GREEN: And did we talk to any of the leadership to find out how they discriminated as to who was in and who was out? That's kind of been a common theme; that's why I ask.

MASTER SERGEANT MACKENZIE: Right, we were not afforded the opportunity to talk to any of the operational command structure. We were -- we were basically guided through what we were there, which was to visit the Wounded Warrior Battalion Detachment, some of the hospital

leadership, the recovery care coordinators, non-clinical case management personnel; that was what we were there for to visit. We discovered this when we were there, but there was no opportunity afforded to actually talk to any command structure outside of that.

MS. CROCKETT-JONES: Let me jump in because I think I might hear your question a little differently. When we -- we did get parameters from the WTU about who they accept and they are, perhaps more narrow than others based on their remoteness and their ability to -- certain critical levels of care would -- would eliminate someone from the WTU because that care could not be provided. So the WTU did have a sort of a tighter definition of who qualified to be in that unit. What was -- what seemed to be in question was who instructed -- was how a soldier could get to the unit. There seemed to be a discrepancy in -- in who had the power to determine whether a marine got into the unit. Long units seemed to, in some cases, have more power to yay or nay a marine than a medical decision. And this was a matter of concern as we looked at it because sometimes there were outright discrepancies between what medical folks were saying was appropriate and what the line unit chain of command.

GENERAL GREEN: Yeah, you're both kind of capturing two sides of the spectrum. But even when the

programs came in, if you remember I asked a lot of questions about who's in and who's out. And the problems with some of these definitions in terms of what constitutes a wounded warrior. And that particular, that definition and who is receiving the services -- I should have just said wounded -- but from wounded, ill, and injured is kind of what I anticipated we would find as when we went out to the various sites. So this is kind of a validation that's -- it may not be as clear in terms of who should be receiving specific levels of service, which is what I'm trying to find out.

DR. PHILLIPS: Yes, and there was a general sense that we got just from about everyone, that if you were wounded, sick, or ill and you went to a WTU, you were looked down upon. This was not in the spirit of the Marine Corps. The other glaring thing that I noticed as a physician and having served in the military is that if an individual -- if a soldier received limited duty from a physician or medical facility -- when I served it was written in stone. According to the repeated comments we heard from the Marine Corps was that this is simply a recommendation and that we can ignore that. General Stone and I debriefed -- we debriefed the command authority there in great detail, and I don't want to put words in his mouth, but perhaps he can elaborate on some of the issues.

MASTER SERGEANT MACKENZIE: One of the other things that we found with that facility was out of the number of facilities that I visited and that the team visited, this was the most -- we had the most numbers as far as people wanting to talk to us without being a part of the general group. We had more walk-ins for all the focus groups than anywhere else. I mean, literally the first night when we were doing the family focus group, we were all busy trying to stay on top of the number of people coming in because they actually saw us and said hey, I need to get this word out, but I don't want to do it in a potentially public forum because you guys need to know what's going on. So very eye opening, but yet very challenging because there was that many people that came to us and said hey we want some one on one time with you. So it was good to see that our program worked to provide these people a venue in order to relay to us what was really going on, but it was also at the same time disheartening to see that many people in such a small facility that had major issues.

GENERAL GREEN: How are we able to capture some of the one on one -- did they make it into some of the things that came to us, did that make it into any of the reports?

MASTER SERGEANT MACKENZIE: Yes, some of the

overall debriefing contains some of that stuff.

GENERAL GREEN: Okay.

MASTER SERGEANT MACKENZIE: So it is in there.

DR. PHILLIPS: The overall debriefing is still in rough draft but there were very, very specific examples and some common themes.

GENERAL GREEN: Any other common themes other than who's in and who's out in terms of the availability of services and this comment that was regarding the overall, if you were in the program that was a sign of weakness, basically -- if that's what I'm hearing you say.

DR. PHILLIPS: One thing that I think that supports the other issues of physicians orders being recommendations is that medical appointments off base were a lower priority than some of the other activities that may have been going on base, like a visiting dignitary or a special program that someone had to be engaged in. And of course, if a troop missed the appointment, they had to go through the whole cycle again for a long period of time to get that appointment.

MASTER SERGEANT MACKENZIE: They actually canceled appointments on some of the guys so they could be there to clean the barracks for us to arrive. So exactly, so it was -- it's not what we were looking for. But one of the other challenges was that the very same people who were

supposed to provide them that leadership where they're trying to get into the Wounded Warrior Battalion were the same people that were holding them up some times six to eight months before they find out if they get approved to go into the detachment.

And in level of care, they also seemed to provide -- they almost seemed to be the very same, the major road block to these guys getting to Balboa or getting to Camp Pendleton. And then when they would go down there, then they weren't part of the big Wounded Warrior Battalion west at Camp Pendleton, so it was almost like they were second class citizens when they went down there trying to get appointments because well you guys are up at 29 Palms; you're not down here with the group.

So a lot of -- a lot of incidences where guys paid out of their own pocket to get down there or other marines drove other marines to get them down to their appointments. Not a lot of reimbursement that was happening to these guys and individuals that were just fighting hard to get their medical care and get themselves better. And they would do whatever -- whatever it took. And in some cases, drive down; attend their appointment; and drive back the same day, just to get it done.

COMMANDER COAKLEY: General, I've been stationed at 29 Palms in my career, and also in Camp Pendleton. A

lot of familiarity with the area; this trip is not insignificant. To travel 29 Palms to San Diego is a -- I can't state this more plainly, an all-day event. First of all, they have to wait for their transportation. Then when they get down there, if they have to coordinate with the hospital, because that is their tertiary facility, and then travel all the way back. So for --

MR. CONSTANTINE: A couple of hours, isn't it?

COMMANDER COAKLEY: A couple of hours at least each way and what Master Sergeant was saying is so true; that if the marines, a lot of them are paying out of the pocket. And this is all second hand information from what I heard from Major General Stone, that is a severe issue. I also wanted to state, I think, that it is absolutely important that Major General Stone gives his trip debrief, as well. He has several other comments that were related to me, even though I didn't attend that trip, I was in San Diego with him, I think it would be important input to the committee.

GENERAL GREEN: And just one other clarification, was there an obvious differentiation between people who had ill and injured versus those who were wounded? Is that what we're -- is that where we see the biggest discrepancy? In other words, is there a difference in how they treat the folks that are with profitable or illness or those kinds of

things or versus people who have, obviously, injuries tied to the war?

DR. PHILLIPS: The whole concept of posttraumatic stress was looked down upon. We've, I heard the comment repeatedly that if I had a visible wound I would be treated a lot differently than I am because I had psychological wound. I want to say it wasn't -- let me just add a few more things to my comments.

The overall theme seemed to be that they were so focused on their day-to-day lack or attempt to get better care that they could not think long-term and plan for their transition back to the military or back out to civilian life. Again, a repeated comment was if we're, once we're broken they just kick us aside.

Now, it wasn't all bad. I mean there were some very, very serious caregivers there that were working very, very hard to improve the situation. I think a basic problem, if I may say, is that it's somewhat unfair to the line units who are getting ready to deploy, who have a specific mission, who aren't really trained from day one and whose mission is not to care or engage with these Wounded Warrior Detachments. And I think that is where a basic issue lies.

There are a lot of other things I think General Stone might want to debrief us on though I don't want to

put words in his mouth. We did have caregivers come to us and say that there are issues, privately and individually outside of the focus groups.

MS. CROCKETT-JONES: I also want to say that on a positive note they did have excellent vocational rehab opportunities. They had an individual there who was very proactive and who was doing an excellent job coordinating lots of mentorship and programs when he could find them. I mean, he was really inventing his own wheel on this a bit. And that was one positive thing.

I'd say that one other issue that came up that I don't want us to lose sight of was that there seemed to be -- and this was not the only place, but it was very clearly stated at 29 Palms, if you were getting treatment for post-traumatic stress, you were not getting treatment for TBI at the same time; that they were sequential, there was a territorial aspect to treatment. Somehow if you were -- had started down a path of treatment with the folks in behavioral health, you basically had to wait until you had reached some sort of threshold or almost were finished a series of treatment before you could address and get involved with the folks who were doing TBI assessment and care. Which seemed a little -- and this was not the only place I saw this, but it was a very glaring separation there and is one that because it was so obvious and

everyone seemed very comfortable with this separation, that it made me want to look at more closely is everyone doing this; that -- that seemed at odds with some of the stuff that we're being briefed earlier.

GENERAL GREEN: Have there been early assessment in terms of TBI before they put them into a PTSD program? In other words, I guess what I'm wondering is do they basically feel the problem was less concussion and more PTSD and that's why they chose the tracks or you're saying that --

MS. CROCKETT-JONES: I'm not sure they got there to say, how clear, you know, the weight of the issues was. I didn't get an impression that this was, you know, done on an individual basis, like if this person needs this track. It was more like you don't -- you do this and then we'll do that.

DR. PHILLIPS: My impression, if I may add, is that it was not a scientific decision. It was an administrative decision.

DR. GUICE: My comment to General Green was that and this is something that is what the professions are struggling with a little bit because they traditionally have been, you know, kind of -- you went to behavioral health and you went to psychiatric health and you went to neurology and neuropsychology. So it's how do you blend

these programs because many of these individuals -- and you may have, if you add in not just behavioral health, but then either medication use or overuse or substance abuse.

You know, it's really you've really got a real Gordian Knot of symptomatology. And the treatment has got to be, sort of, what's the most prevalent and pressing problem at the time that's got to address all aspects of it. And I think physicians and other health providers are now just coming to grips with that and how do you address the multiple -- the individual whose got not just one, but three or four of these issues that overlap in symptomatology and how do you peel it back and figure which things to address and in what order. And I think it's we're just now trying to grapple with how do you develop a program or treatment protocol that will do that. I don't think that's probably not just unique here, but something, it's everywhere else, too. It's -- it's just a problem.

DR. GUICE: All right. The next --

GENERAL GREEN: It's starting to --

DR. GUICE: Okay.

GENERAL GREEN: I just wanted to say this is starting to sound very positively here. It's good to hear actually the things that you folks are seeing and I'm sorry I haven't been able to get out and see some of these things personally. So thanks for sharing all of this. All right.

So we're going to go to the next site?

DR. GUICE: Okay. The next site was Balboa. At Balboa -- I think I'd like the other members of the group who were present at Balboa to pitch in at any time and add their comments. I think overall we were a bit disappointed. The presentations were done in a very odd manner as opposed to what we've received at other places; where, you know, people come in and they tell us about their programs and they tell us how it sort of fits in their overall scheme of the management of individuals at that particular site. We sort of didn't get that at Balboa. They kind of -- for each of our sessions they came in and sat across the table from us and we -- they basically down waited until we asked them questions.

So it was more of an Easter egg hunt in terms of trying to figure out -- you know, tell us about your program and how is this working, and how's that working? And it was very hard to extract information. So I think that led us to being overall disappointed in the quality of the information we were provided. We out briefed it as, to the leadership there as a missed opportunity for them to tell us what they do and what they do well. And I think that was a shame.

Some of the take home messages, though, their case management system, they have a little different way of

doing it there. They have the C5 program -- which is their amputee rehabilitation program. The individuals that we spoke to who were in that particular track, spoke very highly of it. They thought it was a good way to manage all the issues they were facing. There was a disconnect, though, with case management and the guys were not happy with um -- they said they would make appointments for us and won't tell us.

We have -- you know, it's kind of like -- there was some sort of, really a communication issue between the case managers and the service members who were there. The Marines did a good presentation. We had a good sense of what they were doing and how they were operating within the unit there. The individuals who were in the focus groups did point to the RCC's as being extraordinarily helpful and helping them figure stuff out.

One of the epiphany moments for me was, you know, we continually hear that the integrated disability evaluation system takes too long and their efforts to kind of streamline that and figure that out. In listening to these young men and women talk, part of their decision making is happening during their limited duty. And since they can get one or two of those pretty easily, I think by the time they get to IDES, they've already separated, I mean mentally they're already prepared to move on. So

instead of having to wait around for another to process paperwork is part of the underlying, what we're hearing is that IDES takes too long, takes too long, takes too long. Because I think by the time they and certainly with the individuals we spoke with, you know, they were on their second limited tour of six months.

So by the time you take a year of that and you've rehabilitated and you've learned how to adjust to your new situation, I think most of those individuals have mentally decided what they're going to do next and would like to just get on with it and then they're faced with having to wait for paperwork. So, Commander Coakley?

COMMANDER COAKLEY: The visit out there, again, what Karen said was true. There is really now, it just seemed there was no interest in briefing the committee that, when we were out there. It was like an Easter egg hunt, as Dr. Guice said. And that was the general sense that we received is, yeah, this has been all briefed up in Washington, so what do you want to know?

There was some good things; some of the safe harbor managers repeatedly said that they went above and beyond to help them out. The C5 program was cited as one of the favorite things cause they were able to get things done. The coordination issue was a big thing with the medical case managers. Several of the people that we

talked to, as well as some of the briefings we got, we got mixed information. And it was difficult for them to try to figure out where they were going to go. Particularly, with the Navy enlisted that were there.

And the focus group that I was with Mr. Drach on, in that they wanted, there were enlisted corps men and they were treated completely differently from the marines and it's was interesting to me. They were with their units overseas, in which they received a lot of casualties and they themselves were very seriously wounded and when they returned, they were completely ostracized from the marine side even though they were stationed with the marine units. What I mean by ostracized, they were completely separate. There was no interaction at all; they felt like they were completely on their own. A lot of them wanted to return to the units up at Camp Pendleton just up the road; that's not a big trip by the way. Everything was coordinated by these specialists and the rehab and the prosthetists and so forth. But they were still told that they needed to stay there. That was a big source of frustration for them.

The other thing with the, that was cited, again the multiple times is when they were first back, five east is the ward that they were placed, when they were initially transported back from overseas. On that ward, it's not just the wounded veterans, it's everybody; it's a general

ward. But that's where they go. So they are intermixed with other patients. A lot of them had psychosocial issues upon returning back. You can imagine they are just now starting to realize what their traumatic brain injury where they were. They were having nightmares and they were just told you're lucky you didn't lose an arm and a leg, you know, there's other guys that had it worse than you. And that was stated by at least three other people. It was a general institution, kind of attitude overall.

But one of the recommendations I had was if they could put, see the sensitive issues within these individuals, these warriors coming back, these are wounded warriors especially, they're going to have posttraumatic stress. They're going to have a lot of other issues so it would be nice if they had their own place to go. And that was one of my things I said, a ward, separate portion of the ward, anything where they can have people trained and know how to take care of that.

The other thing that I found was the CADRE. After being, after interviewing and going to a couple army bases, the army does a good job or is getting better, I should say at selecting the CADRE based on their abilities and also, they get reimbursed for doing that. The people that are in the MET holding battalions at the Naval hospital, that's where, basically, what they're wounded

warrior holding area is. They're not -- and most of them have no idea what these individuals have gone through and they treat them as if they, as any other enlisted there, let's say for, hurt themselves and other ill or injured person other than the combat wounded individuals.

The combat wounded individuals that are there, they feel more lost than anything else. And that goes for the marine side, too. The NET is also for the marines there as well. Guys who are triple amputees are expected to go out and as Dr. Phillips said, they're on limited duty, but they're like, no, no, no; you still have to go out and clean the barracks and do all these other things, those are recommendations. That's shocking to me because I've spent almost my whole career with the Marines and that's something I feel very strongly about when I say as a physician, this person shouldn't be doing that and it's obvious, it's visually obvious they can't do it, they still make them go out there and do it. There's a lot of communication, I just got a sense that there was not a lot of organization, as far as, just the overall concept, there was some excellent things they did well.

But as I already stated, the C5 program and their orthopedics department there and prosthetics lab is absolutely state of the art. Nothing but raving reviews from those guys. In the focus group, I was really able to

get the palpable sense that it was far worse before; they're getting better; they're trying to make strides towards it. But the unit commander there, his major focus and he stated to Dr. Guice several times, even though we were telling him some of the things that were wrong, or I should some of the things that should be corrected, there are low lined, his only focus was that to charge the committee with coming back and stating to Congress that we need to come up with a national strategy on wounded warrior affairs. We understand that, I think that's pretty plain to see.

But it's -- my only take home and any other members that were there with me is that, I think, just a little more, a lot more organization would have helped out with these guys, for sure.

MR. DRACH: Just picking up a little bit on what Commander Coakley and Dr. Guice said. Let me just do a little bit of a contrast. I was out at Balboa about a year and a half ago, when I was still working with the Department of Labor. I was out there for a DECO conference and a couple of us took some time out because we were working on a major project, America's Heroes at Work, focused on employment for returning service members with PTSD and/or TBI. And we went over because the Department of Labor contact there, Joe Moran, had been talking to me a

lot about the good things going on out there. So we went over and it was like, the people that we met with were walking around like peacocks, you know. We want to show you, the best in class.

This is what we are doing. We went to the amputee clinic, talking to them and they were just so proud of what they were doing. We went and saw what they were doing with virtual treatment with PTSD. They had something that was sort of -- at that time, kind of cutting edge and hadn't really been fully embraced by a whole lot of people. But it was virtual therapy for PTSD. And again, nothing but pride and as Dr. Guice said, we had to drag everything out of them. It was like, what are you here for?

And I'm not sure, one side of me says they were intimidated; here's a group of high-level people, a DOD commission set-up by Congress to come out and look at us. They're not looking necessarily for the good things; they're looking for the warts. They want to -- they want to ding us. Well, if you're coming to see my operation and I thought that, I would want to put my best foot forward and put my best face forward and say, look at the good things that we're doing. Sure, we have some problems, but here are the good things. But I don't think we got that.

Excuse me -- another thing I found and I think it

was at Balboa, cause the two trips are kind of -- they were so close together, they're kind of running together a little bit. One of the wounded in the focus group and maybe it was after the focus group told me that he resented being in a unit that had non-combat ill and injured, or ill and sick people that got their injury through sports events, or whatever. They thought -- he thought that the combat wounded should be separated from the non-combat -- my hearing aid just went off.

And I've never heard that, and I've been doing this for forty some years. I've never heard from the Vietnam era or this generation that there should be a segregation of combat versus the non-combat. I found that to be a little striking. There was, you know, overall I think the wounded, ill and injured are frustrated, they're scared, they're not being adequately informed, or if they are being informed, sometimes it goes over their head. They don't see how it applies to them and their particular situation. They, you know, when you ask them questions, well, I heard about that, but I don't know about that. Oh, yeah, somebody told me about it but I've never met anybody that does it.

There was a lot of the -- the barracks lawyer type stuff; they're hearing it word of mouth rather than the source. That seemed to be some frustration that they

just didn't know where to go for help. As Dr. Guice pointed out, there was a high level of satisfaction with the RCC's, and we're going to hear from Mr. Carrington, on the RCC program.

And I've had some involvement with the RCC program over the years and I was very happy to hear that because I think overall they're doing very, very good work. So, I, you know, the worst case scenario, this is a Washington Post article waiting to happen, both from what I heard about the 29 Palms while we were there and what I heard this morning. L. A. Times is just waiting in the background to get a hold of these stories.

DR. GUICE: Okay. Any other comments about Balboa? All right. The next visit was the Florida trip and the issues that we discovered and talked to the command structure there. We seemed to be one, an organizational issue in terms how the CWTU is aligned under the -- in terms of the structure --

GENERAL HORST: The Warrior Transition Command.

DR. GUICE: Yes, so there seems to be some sort of, it could be corrected the way they were reporting now is a differently. And it probably needs to be rethought. They also seemed to have an issue with resources and that maybe a reflection of their organizational structure. There seemed to be a high turnover of the nurse case

managers there, which made it difficult for the individuals to feel like they had continuity between the case managers. Sometimes the handoffs between the different case managers sounded like it just didn't go as smoothly.

The CWTU in Florida is unique. They don't actually have, they have an office, not a structure for the wounded warriors. The wounded warriors are out in three states; basically at home. And I think they do have difficulties and challenges getting the right resources in the local communities and then providing that knowledge transfer to their structure within the unit there to really manage the information and get the resources aligned appropriately for these individuals.

GENERAL GREEN: Was the turnover problem GS or active duty or mixed; do you know?

DR. GUICE: It was mixed. It was a mix.

GENERAL HORST: The turnover was particularly compo 2 and 3.

DR. GUICE: Yes, the service members didn't seem to be aware that they had any legal services to be provided or someone to go to when they had questions if they were in the MEB/PEB process or if they had other questions of that nature, they just didn't know where they were supposed to go. They had all been screened for vocational rehabilitation, which we thought was really wonderful. But

they had had absolutely no follow up from the VA. Nothing came back, they didn't know whether they qualified; they didn't know whether they had -- it was kind of like they were in limbo.

The non-medical case manager support in these -- individuals they get called once a day, so you know, they do seem to be trying to make sure that they are in touch with these individuals and it's, you know, making calls for three states is a pretty daunting task, but they seem to be doing that okay.

GENERAL HORST: Can I add something?

DR. GUICE: (Indicating yes.)

GENERAL HORST: I got the impression that they made the calls, but it was to simply checking the block to say that we have made the call today. It was -- I have to make sixty phone calls a day. Incidentally, I do it on my own personal cell phone because I have not been given one. I talk to all of my wounded warriors -- we talk and decide what time we're going to talk the next day. There's really no transfer of information. There's nothing useful coming out of it, other than, yes, I have contacted my wounded warrior each day.

DR. GUICE: It was a sense of I can check that box and move on. None of the wounded warriors know what a comprehensive transition plan was, they said -- one of them

said, yeah, I kind of think I remember something about that a long time ago. But I haven't seen it; I don't know what it is. So that doesn't seem to be quite permeating the system down to that level.

GENERAL HORST: And I think that's a critical shortfall in that WTU, because if you recall back to the briefing that General Williams gave us from the Warrior Transition Command, the absolute cornerstone of the WTC program was the Comprehensive Transition Plan and here we have a WTU where none of them knew what we were talking about. So from a strategy program planning standpoint the higher headquarters says this is the most important thing. And where you get to the lowest level for execution, no one knows what you're talking about. So that's a huge disconnect in terms of being able to meet the objectives and goals that we've set out for the program.

GENERAL GREEN: Yeah, one of the questions I have is that did we ever receive a Comprehensive Transition Plan? I mean, we were shown how they captured it in the electronic health system, but I don't think we were ever actually given one. And so the visibility of the Comprehensive Transition Plan is somewhat in question. It may be useful at certain sites based on the electronics, but I don't know if they found a way to put it that if you were the wounded warrior, can you look at your

Comprehensive Transition Plan?

GENERAL HORST: The -- the challenge that the CWTU had -- Dr. Guice mentioned the lack of resources. The CWTU is not resourced the same as the Warrior Transition Units. Wounded warriors in the Warrior Transition Units get a cell phone, they get a laptop computer, they get all kinds of technology to help them. In the CWTU, they're not issued a cell phone, so any communication via telephone is done via their personal cell phone. They're not issued a computer, so any access to any automated products and programs is done through their own personal computers. So that's -- the fact that they don't have the enabling technology is another very large disconnect in terms of continuity of WTC is attempting to accomplish.

DR. GUICE: I think that the difference for me was when we were at Fort Campbell. The members there said when they were on base they could access their CTP, they knew what it was. They could get it; they could see it. The difficulty came when they were home and they couldn't access back into the system because they didn't have CAT card accessible computers at home. So there was a bit of a problem there, but they knew they had a CTP, they understood how they could get to it while they were on base.

At the CWTU in Florida, they all said, 'huh'?

They had no idea that there was such a thing. So I think that you're absolutely right. It's done, it's getting pushed out in some spots and in some spots it's still an unknown entity yet.

MS. CROCKETT-JONES: The other thing is in noticing that there was -- in some places, there was less knowledge about what the CTP was or what its purpose was. And I do actually -- I did actually get nurse case managers to give me blank copies of what they were using. What -- but I heard at least once someone say, well we use a kind of CTP and on another case someone said do you mean the eight question one they give me or the one that's online? So I think that there's a serious inconsistency. It's not clear that everyone's using the same or the same format even, for what they are calling or what a soldier or service member believes is the -- the CTP.

The other thing I wanted to say about the Florida visit, was that in talking with the joint forces headquarters and then with CWTU, there was no real interaction between those two entities, even though they could be leveraging some resources. I mean, there were resources that folks at the joint forces headquarters had organized and packaged, which were completely unknown to the folks at the CWTU. And I understand structurally that there doesn't have to be a connection, but it was a missed

opportunity.

GENERAL GREEN: Can I just ask for clarification? The joint forces headquarters is -- I'm not familiar with that.

GENERAL HORST: The joint force headquarters was the Florida National Guard.

MS. CROCKETT-JONES: And the Air National Guard.

GENERAL HORST: Florida National Guard is Florida Army Guard and Florida Air Guard and hence, the joint force headquarters for Florida. If I could follow up on that comment from Suzanne. The take-away from joint force headquarters Florida was there appeared to be a challenge of access into the program. There was a road block somewhere for wounded warriors to get into the CWTU.

The impression that we came away with was, it was at the state level; it was a National Guard issue, not allowing them to go to the CWTU. They tended to go to the WTU at Fort Stewart in Georgia, rather than the CWTU in Orlando. There was also an impression of some parochial attitudes about issues of WTUs access and which ones were appropriate to get the care they needed. This was important because Florida had just redeployed a brigade of combat teams. They had a pretty significant body of folks that needed to get into the program, but there was a sense of frustration of being able to get it.

DR. GUICE: I think that leads to again, what are the criteria that gets you into this or that. And it seemed to be kind of an issue there as well. I mean, they tried to explain it to us and it wasn't kind of matching up with the visual that we were getting either from our focus groups. So they know they gave us the criteria and then we sort of bounced that against the people we saw in the focus groups and somehow there was a little bit of a disconnect between what we were told and what we had observed.

The other issue when we talked about the MEB -- this is truly a place where the soldiers or service members are left kind of on their own to figure it out. Generally, what it sounded to us is there one or two individuals who try to figure it out and they disseminate the information and they rely on people who went through the process to help them understand what they're going to be experiencing and how to think about going through any MEB/PEB process. Someone said that the CADRE really didn't know or understand the process and couldn't explain it very well to them, so they were left on their own to figure out that information. And that, of course, as we all know can lead to all sorts of interesting urban legends.

GENERAL HORST: One additional comment along that same line is when we asked the question about the PEBLOs, none of them knew what a PEBLO was. And none of them had a

PEBLO. Most of them in the MEB process knew they were in it, but couldn't tell you what phase of the MEB they were in. And they were kind of, as Dr. Guice said, negotiating that gauntlet on their own absent assistance from PEBLO.

MR. DRACH: Just picking up on that, one of the barracks lawyers, we called in Orlando they actually had, as I recall, was a quick book series on the MEB/PEB and none of the people in the focus group -- there was probably ten or twelve people in the focus group -- had ever heard of it or seen it except for one. And he knew exactly where it was. It was right outside the room that we were sitting in and he walked out and got one and showed everybody. And none of the -- none of the other wounded, ill or injured saw this quick book and it was right there. I mean, it was like from here to there away from the room that we were in.

The other couple of other observations was one on the case manager hand off, as I recall again, some of the comments was not only was there sometimes a bad hand off, but part of that bad hand off was the case management file was not always complete; not all of the case manager's notes were incorporated into the file that was being transferred to the new case manager. And I don't know whether it was just, you know, people that were doing those didn't want their particular notes to be seen by somebody else; maybe they put something in there they shouldn't have

put in there or they felt might be damaging.

So anyway, that was one of the problems that came out. In the voc-rehab area, and this is sort of a rhetorical question, well, right now under the law, the voc-rehab, VA voc-rehab is very limited in what they can do while you're still on active duty, unless there is a memo rating and they can get the process kind of started. They can talk about the benefits and so forth.

The rhetorical question in my mind is if the RNE could serve somebody while still on active duty, is there a possibility that somebody that wanted to stay in, but needed some training that the VA voc-rehab could provide that training while they're on active duty to prepare them for a new MOS. Is that something that is feasible in the - - and would the wounded, ill and injured being interested in taking advantage of that to learn a new skill so that they can be transferred into another MOS?

GENERAL GREEN: And of course the problem is that services also have to define what their needs are in terms of the MOS itself. One question, just coming from what you said Ron, on the book being right outside the room but nobody being aware of it. Has any -- do any of the visits -- this is an overarching question, explore anything with social media in terms of way to get the things out or to create connections, whether Face Book, or webinars, or any

type of efforts -- I'll say secure pages and messaging, I know that's just now coming out. Is there any effort to try and reach people electronically?

DR. PHILLIPS: My impression was that both at Fort Campbell and 29 Palms that there wasn't an active, official attempt to do this. But that there was a lot of social media communication among the wives, and when the technology was available among some of the wounded warriors. But again it was not at the level that we're seeing that's universal on TV every day.

GENERAL GREEN: I bring it up, we're going to meet with the, obviously the care and transition policy folks today. It may be something that, where we are thinking about how to create links or how to make it more readily accessible for them.

COMMANDER COAKLEY: This was also in the previous San Antonio visit -- probably the strongest method of communication was the people talking amongst themselves. So that far out stripped any codified program that they had. They all were quite good at taking care of each other. In fact, it's almost like a union -- almost.

GENERAL GREEN: I know that we're dealing with a little bit of a generation gap in terms of how information is shared right now. I'm wondering if we're seeing that. Also, with some of the young people, in terms of how they

get information versus how we're offering information.

MS. CROCKETT-JONES: Let me just say that this has been a question we've asked at several visits. Some places believe that there was a policy restriction preventing them from using social media. Others said that they had circumvented the policy restriction but hadn't gotten any one to actively create a social media site so that there is a push to use it, but not a lot of leadership proactive -- I don't think see how they could use it. I don't think they're seeing the benefits.

I don't want to derail this if there's more to comment on social media, but there is one other topic that I'd like us to look at it, and it was very obvious to me at the CBWTUs, both visits. Both CBWTU's have a list of requirements to be -- to be in the unit, which includes a stable residence and it implies a support system or stable family situation. It's a specific requirement to be in the unit but there is absolutely nothing, a standardized policy wise or program wise, to empower any of those folks and those families to have information that would help them be that support or to assist their recovering service member.

So there is -- seems to be a very big gap, some of it driven by sort of cultural concepts; some of it just, I think for lack of oversight. There is a gap between what we are saying we expect from family members and what we are

-- whether we're helping them do it. There are resources available; there is no connection being made for those folks to connect them to those resources. And the -- in general, CADRES seem to believe that is outside their purview completely; that it is not part of their job to inform family members. That was just -- that's the impression that I got overarching, you know, in a panoramic way. But it is most notable at the CBWTU's where we almost have defined expectations and no -- nothing to fill the gap.

DR. GUICE: To me it seems like a repeating theme and we'll go ahead and get to California in a minute, but a repeating theme -- is it's not because we don't have programs; it's not because we don't have infrastructure. The communication and getting the right information out at the right time seems to be an ongoing struggle and how you do that and how you deliver it.

I think part of the hesitation with using social media is you have to monitor it very closely so the right information is getting out and you're not starting to promulgate funny stuff. So I think that's one of the concerns that people have is how you do it. Now DOD and VA have both invested a lot of hide time and money in to developing E-benefits. And no one knows about it. I mean we go out to these places and the service members go, what,

what is this? And you know there is, it's tailored information; it will fill out forms for you. We've got avenues of information, but somehow the information about the information isn't getting out, even.

DR. TURNER: I think just that absolutely, I think what we're seeing actually to be most accurately is a disparity or an inconsistency in how the information is getting out. Just to add to General Green's concern, the unofficial system of all the people communicating was probably the best joint service thing I've seen. You had many people from different services would migrate to the service providing the best information. And we saw that clearly in San Antonio when if one service wasn't getting it, they would go to the other service to get it and the Air Force would go to the Army who had an excellent, you know, way to get information out and so they all -- again, you saw the Army taking care of their Air Force brethren because of this unofficial system.

MASTER SERGEANT MACKENZIE: The thing that I find is that social media has been embraced as a way of helping each other out. Because like what you were alluding to, Dr. Guice, was that none of these official organizations have taken the responsibility of training our service members and families as to where this information is. It's like hey we put it all out there on the web, it's up to you

to go find it. And that's where that social connection between the spouses -- between the service members where they're finding bits and pieces of this information because no one is taking the responsibility to sit someone down and go okay, here is where you go to do this. Do you need any help? Do you need any assistance in finding this information? Or sitting down with e-benefits, or sitting down with any of these web sites. You know I revert back to what I keep saying and I keep seeing in every location is you don't know, what you don't know.

You know, as a wounded warrior and a guy who was looking for all the right answers couldn't find anything or couldn't find people to help, most of my knowledge comes from the job I do, not because anything has been looked after as a wounded warrior. And that's the problem we keep seeing I think, across-the-board is that nobody is showing them where to go; it's just all out there and they want to check that the block and say we've put it out there.

GENERAL GREEN: In my interaction with the House and Senate staffers -- the permanent staffers -- the other thing they point out is when you look at the brochures, it's not uncommon to see six, eight, or even ten web sites on a single brochure and the question is, is there a way to link this information?

DR. PHILLIPS: Let me just add that information

management and communication is my day job. I have a big staff that does this. It is a very, very difficult situation. But that's what I get paid to do. And basically our overall slogan is 'just in time information, just what I need information'. What we have done and we have finished a pilot and now based on embedding information specialists, within certain sub-populations that need them. I mean, we have information specialists sitting in the Secretary Operations Center, downtown Humphreys building. They are now five hundred of these folks around the U.S. I mean, they all have day jobs; some are very specific and spend time with it. This is really for disaster preparedness and response activities.

But again, in looking at what we have visited, and what we have done, information and delivery of that information of understandable information is one of the most difficult aspects of this whole program. And perhaps we have to think it through and discuss it more, but perhaps training people as information specialists and being able to deliver that information through various means. Social media, of course, being one of the major ways of doing it. But depending on their age and population and where they are related to their injury and recovery phase is something we seriously have to look at. I'm more than happy to jump.

MR. REHBEIN: I tend to look at the WTUs and social media from the standpoint of think back to a small business when web sites were coming in and the silver bullet was you have to have a web site. Well, the small business looks back at you and says how do I do that? I think the WTUs and social media, like Face Book pages, you know, some of them have -- luckily somebody with some talent, with some feeling for the thing; how to do this; how to make it effective? But most of them don't. And I think what Dr. Phillips just said about training and information specialists and showing them how to get that message out amongst their population. How they can do that effectively.

Web sites, in my experience are becoming less and less useful because there are so many of them out there and so the people that used to go to web sites are now talking to each other with Face Book and all of the other alternative methods and we need to -- we need to figure out how to get WTUs trained to talk to their people that same way because it's much more effective. The message is tailored to that population rather than a web site trying to reach everybody.

GENERAL HORST: Sir, if I could double back your specific question about technology and social media. I saw a real dichotomy between WTU in proximity to a MTF and a

WTU to a CWTU. And the WTU is in close proximity to the MTF, they're all equipped with computers, cell phones, technology. And they all tend to be more connected technologically in proximity to MTF. You go to the CWTU where there are no computers; there are no cell phones and where you would expect to be able to leverage technology because of the dispersion of the wounded warriors across three states in the CWTU's area of responsibility.

There's no technology. And so close proximity to the MTF, big technology, dispersed wounded warrior population and a community based WTU no technology. And I would tell you that the CWTU in Orlando was with exception, the only technology they had was cell phones, provided by themselves. Other than that, it's a complete analog operation and that's across three states.

GENERAL GREEN: In our interaction at the various sites, have we taken on how people get information. Have we talked at all to the folks in terms of -- and I don't mean person to person, I mean have we talked to them about, do they have computers, or web access? Is there anyone in the community that we're talking with in terms of the wounded, ill and injured that wouldn't have access to electronic media? I mean I realize there are some that are injured to a point, but the families, the point would be is do they have access to it?

I'm just wondering do we kind of understand how this generation, and I'll use that term loosely, but how our generation of wounded, ill and injured, if we can are getting information, whether it's electronically, all face-to-face, is it by telephone? I mean it's a combination of all the above, but do we have an idea on their preference?

DR. PHILLIPS: Let me just give you my impression -- that's my impression and of course, others may disagree. I say that it's all of the above. It's more mouth-to-mouth. There's an awful lot of families and troops out there that are just economically making ends meet and or hardly making ends meet and cannot afford to have a high speed modem or a, you know, smart phone and so forth.

GENERAL GREEN: I mean, clearly that's why we have case management ratios. I mean, that's why, when we put these programs in place was to allow it to be face-to-face communication and so if that's not happening or because of turnover it's not continuous, or et cetera, et cetera, then we have a problem.

DR. PHILLIPS: Let me just say, and I don't mean this in a negative way, but if a beer salesman at the Phillies baseball game can have people Tweet him as to where to come and deliver the beer and to what row and what seat, I think we could possibly use that technology. Again, I don't mean this in a --

MR. REHBEIN: It's even a bigger problem and I'll just refer to California for a minute. Out there it's a four state area: Washington, Oregon, California and Nevada. There are some really remote areas out there, where we have people in a community based WTU, they may not even have the access to high speed Internet.

GENERAL HORST: Sir, I think there's, I think that there's an expectation that they should be operating in a social media and in a net domain. I think we have, I think we have a program problem within the wounded warrior constellation. If there's that expectation in there to use social media, we have to, number one: man the -- we have to man the WTUs to have someone who will monitor media. The second thing we have to do is we have to equip them to tools to access the media and the third thing we have to do is train them to use that. So it's a manning, equipping, training issue if there was an expectation that we want them to operate in that domain. Other than that, it's just whatever you're comfortable with, whatever you can afford, wherever you're at, it's really without direction and kind of catch as catch can as to how effectively we are using social media. So I think we've got to -- I think we've got to be specific if we have an expectation that they're going to do that.

DR. GUICE: I think there are some concerns

certainly on the medical side because of the privacy issues. You know, having secure messaging for those things related to health. It's one thing if the patient initiates the e-mail or the texting to you, but if you have to reach out to the individual, then you have to do it through secure messaging and I think there's a barrier there that is put there for a reason. So I think that you can probably communicate a lot of information without necessarily crossing into the medical information, you know, where you -- where you can get help for financial assistance and you know, there's a, probably is a line where you have to incorporate the secure messaging and then teach people how to use it; I think that's part of that -- what we're talking about here is that if people don't know how to access it.

In all the web sites that we have, and we put a ton of this stuff out there. But you know, when you need something specific it's very frustrating to try find it and then to understand what you're reading. I mean, I don't think we do really good job of writing to the level of knowledge and the level of understanding to someone who is capable of reading it and actually turning around and putting it into action. And there's just, you get overwhelmed pretty quickly when you're trying to find something very specific.

GENERAL HORST: Again, if we want to operate in that domain and we want to secure it -- eBay, PayPal, you know, everybody has figured out to move secure data on a non-secured network and that's the sort of the expertise that we need to introduce if we want to operate there. But I think it takes a conscious decision to create overhead to enable or create that capability within this wounded warrior population. It's a conscious decision and that's I think that's something we can talk to the legislators about and say, look if you really want this to go, this is the sort of thing we need to direct or have directed to us.

GENERAL GREEN: Yes, just keep it separate because of HIPPA because of health information drives that secure messaging. But for all of the other information we've been talking about, that can be -- I mean, the stuff on benefits and the way to process and go through the MEB, and getting specific; what's the next step, or even who my contact would be for that. All that stuff can be on social media, Face Book type. You should be able to Google, frankly, and find out what the most common hit is, you know, to get where people are going for that information. But when it comes to now your personal health care, because of the HIPPA laws, or you want to talk to the doctor, this is where the secure messaging comes in.

GENERAL HORST: But I think there's this whole

notion of accountability and command in control, particularly in the communities' transition unit. Okay, I'm going to make sixty phone calls a day. Ding, I've checked a block. You know, why isn't the platoon Sergeant or why isn't the nurse case manager communicating with the wounded warrior electronically where they're more inclined to discuss issues or medical, past relevant information; talk about appointments, talk about Comprehensive Transition Plan other than great, good to talk to you today. I'll call you tomorrow at twelve.

DR. PHILLIPS: This may not be within our mandate, but I would ask consensus and perhaps support, if you would like I can take my staff and develop a pilot study that would involve perhaps using cell phones to pass a specific type of information. I mean we would design something. Being cognizant of personal identifiable information and if we can, we can apply it to one of the units and that's within my official duty, if we're interested in that. It's a small step, but every step will take us to conclusion.

GENERAL GREEN: I think that before we step towards something specific in terms of an interaction, we probably need to just think through some of the things that Carl's talking about in terms of how are we going to man; how are we going to equip; how are we going to train to use

this? And the reason I bring up generation gap, and I'll use a personal example. I talked with my daughter who is 19 last week, you know, about fifteen thousand texts last month. And you kind of go, fifteen thousand texts? How do you do that? But that's -- they're communicating differently and so how do we actually intercede to get to where they're actually seeing what we need them to see. And how do we avoid being junk mail in the system that they use?

DR. GUICE: I'm going as robust as this, and Denise is going to kill me if we don't discuss California. So let's go ahead and get to that, we'll finish up Task Forces and so who's lead in California? Who wants to talk about the California issues.

MS. CROCKETT-JONES: We found at the visit that we had repeated a lot of the same structural issues. There were still some issues regarding turnover, staffing was at critically low levels and they had -- with all the same issues of orders what -- the amount of time someone has minus their training minus their leave time left, turnover, it was just disheartening. So that WTUs, were finally, had had multiple nurse case managers in short periods of time. Sometimes administratively shift back and forth with no -- it was a little hard discern even what was driving some of the shifts and changes. Do you want to talk about the --

MR. REHBEIN: The one thing we did run across, they had put together a table of the duties of the platoon Sergeant and how much time it took to accomplish each of those tasks that the platoon Sergeant was expected to do. And he could get those tasks accomplished in a standard 90-hour week, which obviously you know you could do that for one week, but that's all you can handle. But that's the first time that we'd seen any kind of quantifiable data on how that -- what those tasks are.

GENERAL GREEN: So with the platoon sergeant -- and I don't know what training goes into being a platoon sergeant for a WII type tracking system. But that's different than a case manager. So what is the platoon sergeant -- we have this specific ratios for case managers, and I realize from what you said that they had a gap there. Is a platoon sergeant trying to pick that up? I mean can you help me understand that what goes into those 90 hours?

MR. REHBEIN: No, in fact, in fact if there is one place that I have seen what we call the Triad was really working, it's out in California in the community based WTU. The nurse case managers and the platoon sergeants occupied the same space in the administrative building, so they were talking a lot. The platoon sergeant wasn't necessarily picking up nurse case manager duties. In fact, the service members that we spoke with in the

focus groups all said that they spoke with their case manager once a week.

They realize, I think the distances involved that they can't get face-to-face very often, so they've compensated by really ramping up the communications part of it. Yes, it's by telephone, but it's -- still they're still to their nurse case managers. I didn't look at that table in any detail to see what they had in it, to see, you know, and I don't have any --

MS. CROCKETT-JONES: I can say --

MR. REHBEIN: To say, I don't have a lot better judges of how realistic it was, but it was the first time we'd seen anything like that at least as a beginning.

MS. CROCKETT-JONES: And I can say that at the CWTU's, the platoons sergeants have no squad leaders.

MR. REHBEIN: Exactly.

MS. CROCKETT-JONES: So basically his ninety hours was really a platoon Sergeant and a couple squad leaders' worth of time. You know, he has no one to whom he can delegate any of that, which in WTU, he would normally have squad leaders. I can also, I would like to say that in their choice of collocating the CADRE and nurse case management, although they had routine meetings, for the Triad of care, to review sort of the big picture, that collocation meant that crises, which in other places wind

up eating up a huge amount of time for a platoon Sergeant who's doing things by phone.

They get that -- a crisis gets handled in a slightly different way, you know, if something that comes up can be discussed. Something on the horizon that the nurse case manager might see doesn't wait until the next weekly meeting. So there seemed to be a more organic working of that Triad of care. And it certainly seemed effective. The focus groups were very positive at the California CWTU.

MR. REHBEIN: They were. In fact, there's a side benefit to this CWTU that several of them expressed and that was being in the community based Warrior Transition Unit had saved their marriage. One of them members in the focus group said that and heads went up and down and nodded in agreement all over the room. Because they said if they had had to be away from their home for another year to year and a half receiving treatment, spouses had said I can't wait. So, but that's a double edged sword, because in order to be in the community based unit, there are some restrictions on the level of PTSD.

And I think if word spreads that this is a good thing to do, there's a danger there that people are going to hide their PTSD in order to qualify. And once they hide it, then they can never reveal it because if they do reveal

it, then they're no longer qualified; they've got to go back to the medical treatments. So that's kind of a double edged sword.

There's another concern out there that I had, the primary care physician for this unit was retiring. And he was not going to be replaced on a permanent basis. He was going to be replaced by doctors on a rotation. This was a very dedicated individual. I don't care who you replaced him with, you're weren't going to get that level of dedication. But doctors on a rotation can't get involved with their patients, not like a permanent assignment.

And there are -- I'm sure you ran into this in Florida too -- there are some issues with Tricare delivery out there, too. And that's just the nature of Tricare, I don't know how deeply we want to get into that, but this doctor spent a lot of his time communicating with the Tricare physicians to keep track of what was going on with the people in the WTU. A rotational doctor isn't going to have that kind of motivation because he doesn't develop the connection, they don't develop the connection with the patient. That was a real concern out there.

MS. CROCKETT-JONES: I also want to point out that one of the things that became more clearer there, but which had started to be hinted at in Florida was that soldiers that had very divergent experiences depending upon

their Demob site. There is obviously not consistency in the structure and in how that process works for those folks and when they get Demobed and how -- how they're -- the process of those who know they are going into some sort of Transition or care --

GENERAL GREEN: Can you give an example? Are you just talking about information that's shared with them or is there something more specific?

MS. CROCKETT-JONES: No, more specific and whether they were going to -- some referred to medical treatment right away, some were basically assessed minimally, and told to get further care down the line. Some demobing has very proactive with testing like MRIs and getting that work done so that there's a better assessment of where this WT needs to go. And others were much, seemed much less organized. But there's a real complication here in that there is a super pressure from WTs themselves and actually, from all of those demobing; they want to get home. So they're not always acting necessarily in their own best interest. And so there's a real push and pull situation here and in that demobing seems to be an area where we need to look.

We didn't do that this year, but I think in hearing from these folks, it's become apparent we need to see how the process of funneling WTs into various, into

wherever they go, how that happens at the demob sites because we're not hearing the same thing everywhere.

MR. REHBEIN: There was a great deal of underlying tension and we didn't get into it very far between these folks and Fort Lewis. And to the point where I think it was, it was getting to be a temptation for these folks to blame a lot of their problems on Fort Lewis. I don't know what led to that, we didn't delve into that, but you could feel that undercurrent a lot. Because Fort Lewis would continually come up as a potential source of problems. We know there have been some other incidences at Fort Lewis.

GENERAL GREEN: Was that the common referral area, is that what that is? Is it just because they couldn't get referrals when they felt they needed it?

MR. REHBEIN: A lot of them, a lot MOB and Demob happens through Fort Lewis.

GENERAL HORST: I think Suzanne brings up a real good point. We ought to look at the Demob process. When we were at the joint force headquarters in Florida, we heard all kinds of horror stories about the Demobing that they went through at Fort Stewart. Just -- it was in light of all the problems they had. Well, Rick Stone and I kind of looked at each other and we went and pulled the after action review that takes place after Demob. And the after

action review submitted by the brigade that demobed was radically different than what we heard from the joint force headquarters.

I'll use this term, and I'll be very delicate, there was some disingenuous reporting between the state headquarters and the BCT. And we pulled the AAR out and looked at it and what state headquarters said and what the Demobing unit said was different. So I think we have to -- in our next round, we have to get into the phenomenon of demobing because as Suzanne said, the push at demob is to demob, get home and get on with life and to pass by some of these medical issues and post mobilization, these things manifest and then the challenge is how do you get back into the system once we've gotten home and now these medical problems have started to manifest.

MR. REHBEIN: One of the other things and we heard this at joint forces headquarters out there is the Transition assistance advisor for California is not allowed to go to Fort Lewis. He only works within the state of California. There is a Transition assistance advisor at Fort Lewis and that's who gets used up there. But that prevents any connection between the California advisor and the units.

Now I'm sure that Transition assistance advisor is looked at as a Fort Lewis person and once you leave Fort

Lewis you lose all contact with those folks. So whether or not it's a good idea, I don't know. But I think we ought to look at whether or not those folks ought to be able to go to the demob sites and develop some ownership with their units and come home with them.

GENERAL GREEN: Can I ask a clarification, I'm trying to understand between services. So with the patients that are the CWTU, are they on man days -- if they have been identified as having an ongoing medical issue, are they on man days? Is there any financial pressure to try and determine whether these folks should be on man days or incapacitation pay or any of those kinds of things that are available to the reservists and the guard? Are they being maintained on an active duty status while they're problems are being dealt with?

COMMAND SERGEANT MAJOR DeJONG: Sir, yes, they are; they're maintained on an active duty status.

GENERAL GREEN: Well, that's what I mean by man days. But so basically they're maintained on an active duty status. Is there a central a tracking mechanism for the number of people that are in that status whether, and again in our world, there's a combination of man days, which is you are on active duty status and then incapacitation pay, which is paid to augment things that you may not be able to do in your private sector job, from

what I understand. I didn't even know about the incapacitation pay until recently, but there's actually more than one system for maintaining the reservists and guardsmen where they can receive some care.

COMMAND SERGEANT MAJOR DeJONG: Sir, they are maintained on active duty status with -- as an active duty status with full benefits. The way it's supposed to work and they do lose track of soldiers from what I found out just from my experience from the different levels of Command. They're supposed to report to an armory to their closest home of record and work there and then your CWTU location maybe very remote from where that armory is and you're relying on, on the honesty of personnel and people to track that soldier as to being in his place of duty when he's supposed to be there within medical care and being the number one priority and when a major operation or procedure doesn't work, then they go through the full convalescent leave process. They process leave just like any active duty soldier would, that is again tracked at that remote location. And that seems to be an ongoing theme as far as what I've experienced what I've experienced in the Midwest with some of my own soldiers as far as just getting that unity of command in tracking everything.

Part of what we've worked through the state of Indiana and there's a monologue there that I talked about

on the conference call the other day is that, the adjutant general of Indiana has actually developed a subcommittee under his direct control to a joint forces level office for nothing but soldier and family support from the MOB process, through the demob process. It's an O-6 command, who has a great working relationship with Fort Knox, which is our closest Warrior Transition Unit itself. And with that is a multiple means of communication, social media and other ways that the family can then access into what is available. Again, it's just a model that at any given time I'd like to present that and show where we're going. I've done some research and some other states have something similar, but if nothing else, if we could standardize that, it may help things around the nation.

GENERAL GREEN: So just a question for our researchers. Do we have a good idea of numbers that are in these -- that are being maintained on active duty, that are in the CWTU's or whatever the equivalent is in terms, I know we track them through a medical continuity cell. I'm not sure how the Navy and Marines track their people, but do we have any ideas on the numbers that being maintained on active duty?

MS. DAILEY: Yes, sir. On the, in the community based Warrior Transition Units is when information is readily available from the -- the Army Warrior Transition

Command, so we can count noses for the Army. In the Marine Corps, now the Marines doesn't have a community based warrior transition concept. They have detachments and battalions, so you can track everyone in the AFW2 program and you can track everyone in the Navy Safe Harbor Program. Who's embedded in the patient squadrons and in the medical hold Navy squadrons has not been visible to us.

The COMPO 1 -- excuse me, COMPO 2 and COMPO 3 that are in the community based warrior transition units and in the WTUs are on active duty. They're on title ten. The individuals who are in limited duty status or have a line of duty investigation for COMPO 2s and COMPO 3s -- COMPO 3 National Guard are being tracked by the joint forces headquarters and their medical sections at the joint forces headquarters. National Guard, I'm talking National Guard in each state now.

So line of duty investigations and limited duties at the National Guard level is tracked at the joint forces headquarters and at their surgeon -- their state surgeon level. Those individuals who are not in the WTUs or in patient squadrons. Does that -- am I tracking there with you? There are various layers that are not visible in the community based warrior Transition units, but are tracked in the National Guard at the joint forces headquarters.

GENERAL GREEN: Yes, I guess it would be nice to

understand the scope of the problem we're dealing with to actually see if we couldn't put this so each of us kind of has overarching -- I really understand the WTUs; I know their numbers. I fairly well understand the community based warrior transition units. On the Air Force side I understand our medical continuity cell in terms of the people we're tracking, both guard and reserve. And I'm not as familiar with the Navy's system. So it would be nice to kind of understand what we're dealing with.

And then if we want the patients' squadron numbers, which would be obviously ill and injured, but not necessarily being tracked by the wounded warrior program, I'm not sure they're as effected by the policies we've been charged to review. But, I mean, again its back to who's in and who's out. What are we actually -- even for us, who are we looking at? Are we looking at all wounded, ill and injured service members regardless whether they're in a program or not in a program or are we looking at all wounded, ill and injured that happened to be associated with the military at this point? You know, we should ask the same question for ourselves, who are we looking at?

MASTER SERGEANT MACKENZIE: One of the things to that, all we're going to see is who is being tracked. And that's -- that's where a lot of the problem is, is trying to figure out who is actually being tracked and who is not.

I know from the special ops side because of and I'll go back to this demobilization problem, we actually put a national guard guy at Fort Bragg, where the majority of the national guard soldiers MOB and DEMOB out of or had in the past just to kind of follow up on some of this stuff because of the problem with demobilization and that go let someone else take care of it mentality, or okay, you look fine; drop off your gear and head out the door or you know, whatever other number of reasons that happened in that realm and lack of knowledge of the guard process and the individual state process at an active duty facility who's trying to help them get on, you know, thanks for your help, have a nice day.

So we actually put a guy in place just to prevent those failures from happening and try to stay on top of it and track these guys, staying on, you know under the medical retention program and keeping them on orders to get them the treatment they need to prevent them from being turfed back to their -- back to their city, back to their town and then them trying to scramble later to get back on orders because of their medical condition has worsened now that the adrenaline has dropped and they've gone home. So unfortunately the numbers were going to get from those systems are only those being tracked and not actually addressing the, I think, problem that Suzanne and the

others are bringing up.

GENERAL GREEN: I guess, I just don't -- I don't know that we need to go out and try to identify find new people to be tracked. I mean, you either identify to this system or you don't identify to this system. Because sooner or later, they'll identify to this system. I mean, if they have an issue that's actually somehow restricting their activities or restricting their performance of their duty, they'll identify eventually to the system. And so trying to find those people -- I don't disagree they won't get Demobed, don't misunderstand to make sure we're trying to do the best we can to identify them and make certain that they know the resources that are available to them, but for those who choose to minimize a problem and basically carry on because that's their choice, I'm not sure we should be going after those folks.

MR. DRACH: A couple of thoughts on the question. In the guard or reserve, okay, you have them perhaps in the CWTUs and some are going to stay on with the guard. Some are going to be discharged permanently with a disability or not. The ones staying are they getting the typical DEMOB process? Do they go through DEMOB and the other thing I know about DEMOB, personally is the DOL part of it about reemployment rights and/or should we consider doing some site visits at DEMOBs?

COMMAND SERGEANT MAJOR DeJONG: With my experience with that it is a -- I guess, a pseudo DEMOB, to where they get up to certain portion of it. And once they're tagged medically, something they need care, they'll be referred to a WTU or a CWTU. At that point, their DEMOB pretty much stops. They get reassigned to wherever the need to go and they work that process.

And in the history of this has gone through to where once the soldiers come out of that, the CWTUs or even the WTUs on that side if they weren't assigned after that, was that they just kind of came back into the guard. They weren't afforded the same luxuries as a lot of the other soldiers are with the new yellow ribbon programs that are out there, which is part of what the model of our adjutant general has started to where Rock Island is one of our -- is the main CWTU in our area. And the colonel that runs -- is running the model and that program actually goes to Rock Island once a -- once every so often. He has pretty good communication with that commander and when they are going to DEMOB a lot of soldiers out of the CWTU, they're afforded the same yellow ribbon program as the rest of them are, so then they can see what benefits are available, how to access the benefits, families are there and it opens the door to what hasn't generally been opened.

And from what I'm understanding, around the

nation may or may not be available based off of the programs they have in place.

DR. TURNER: Before I know we're running head long into the 9:45 end of the time, but before we finish I just want to ask the committee as we synthesize all these things on trying to keep track of all of this, I just want to bounce this off.

This is kind of a summary of kind of the trends I'd like to see if I'm missing anything. It's like we've got a lot of brilliant work going on out there, certainly individually. Some of the trends that we've been seeing is -- let me see if I get this right. We've got a pretty much got a wide disparity or inconsistency of care provided or the integration of the care between units.

We've got, number two: a wide disparity of who gets care or who's eligible for care. Number three: is we have a disparity of leadership structure and effectiveness, which leads to trouble in providing care. And number four: I've got is that we have a wide disparity of availability of information dissemination. And perhaps as the Command Sergeant Major says, perhaps part of that is from no common policy or standards base, cause as you know, there's no standard or even a resourcing standard. Is that kind of what everyone is hearing?

GENERAL HORST: I think we have a disparity of

resourcing as well.

DR. TURNER: Right, a disparity of resourcing.

GENERAL HORST: I think that's an important point.

DR. TURNER: Okay. Thank you. Again, I'm just trying to synthesize this.

DR. GUICE: Right, with the one on information, it's not, when you say it, it sounds like there's a disparity --

DR. TURNER: It's an inconsistency.

DR. GUICE: I think, it's different. I think it's the disparity is an information consumption. It's how you use the information. It's not that we don't have it out there and it's not available. It's how you consume it and the way you consume it and when you are able to hear it.

DR. TURNER: I certainly think that's a component. Certainly, what I saw though is -- is there -- and again, General Horst said, it's just getting it out there. I saw difficulties in people actually obtaining information. Some people would say, you know, I haven't, the only way we found out what's available here was to go to another unit and ask them the question.

DR. GUICE: But then it becomes an issue of informational awareness. So I think it's not that there's a lack of information, it's a lack of awareness of the

information; a lack of having to get the information and the consumption of the information. So I would hesitate to say that -- and I don't want the impression to be that we think there's not sufficient information, cause that's --

DR. TURNER: Right. It's how the information is provided.

DR. GUICE: It's the delivery and it's the consumption and it's the knowledge of where it is and how to get it. I think that's -- those are the keys.

DR. TURNER: The delivery of it.

MS. CROCKETT-JONES: Can I just add one more thing to your list? One thing that we've seen inconsistently -- on inconsistency is appropriate timelines for transition. Everyone seems to have made random and not really data based decisions regarding what are appropriate timelines.

It seems it's made administratively without any real data support and we're seeing really disparate ideas about how to measure those timelines and where people fall; whether the time lines begin only in a WTU, or whether they begin in the military treatment facility; whether they had time on a limited duty in a unit is included in the -- there's lots of disparity on what is an appropriate timeline for a transition.

DR. TURNER: It's almost a little of expectation

management as well.

MS. CROCKETT-JONES: Oh yeah.

DR. PHILLIPS: Russ, you may want to also add I mean, my thought is there is a huge disparity and the authority that medical staff have over the wounded warriors related to their decision making. It's ignored in a large degree -- to some degree.

MASTER SERGEANT MACKENZIE: One of the things I go back to this every time and on the information card, is the accountability of the information providers, making sure that people know that this information is there. You know, you can't just put it out there and then say I've done my job. It's the same thing we ran into at Fort Campbell where the caregivers, although they're on government orders to care for this individual, they were not provided the resources to be that care giver, nor were they included in the conversations. I remember we ran into that where it was, hey, I told the service member, you know, he's on a narcotic roller coaster suffering from TBI and yet, nothing was told to the families. So that's just one of those things that accountability is key.

MR. DRACH: Just to follow up on that, it's one thing to give them the information, but what is the timing from when you give them the information because sometimes there's information over load. I think the accountability

is very, very good. But perhaps, what is built into that also is repetition. So you may have to give it to them one day right after they had their meds and they're not there; it goes completely over their heads. So how do you build in that follow up to keep plugging away at it?

MASTER SERGEANT MACKENZIE: Well, that's within my job; that's what we do. I mean, it's that -- you're required to make sure that these people know this information. We continue to follow up. We continue to provide them resources they can read and then follow up with it. Where are you at? Do you understand? Do you have this information? Which is, you know, a lot of the work we do is making sure that they have it. But across-the-board, that's what I'm not seeing is that follow up to go they understand this; they are resourcing it; they are actually getting into this stuff and understanding where this stuff is coming from.

COMMAND SERGEANT MAJOR DeJONG: And again part of that, in some of the ignorance that I have in not being at all the site visits. Fort Knox, for instance, rebuilt on their entire WTU and part of what they did there and I don't know if anybody has been around there, is they actually in put an SFAC, which is a soldier family assistance center right on the footprint of the WTU, which had every resource right there. Because at different

installations around the nation if you're relying on a young soldier, who one is injured, and two doesn't have the funding possibly to get to the different places around a several hundred acre facility, that soldier is probably not going to one, take initiative to get there if he doesn't have the funding nor, he may or may not remember that it's there.

The way that WTU at Fort Knox was designed was to have a constant reminder of what was there and while the soldiers were interacting there, those members would actually be in the same building and kind of come out and kind of interact and remind them of what the services were there for them.

GENERAL HORST: Sergeant Major, the SFAC is a standard design requirement for each WTU. That's a requirement for all the Army WTUs. And I'd like to put a strategic bow around the list of operational and tactical issues that Russ, kind of, lined up for us. The thing that troubles me the most out of the visits, those of us in uniform have been trained to follow a set of military principles in how we organize. And the principle that appears to be violated in this is the one of the unity of command.

I'm concerned about the command in control of the wounded warrior program. I can speak to the Armies, most

specifically cause and I did not see Navy, Air Force or Marine; but I did see the Army. And we have a serious structural problem with command in control of the Warrior Transition Units.

DR. TURNER: I would certainly like to add for the all the probable, national or college graduate of the ICAF in there and I think resourcing in addition to the unity of command. I think resourcing is raising its head as well.

MS. DAILEY: And can I get a wrap up real quick. Mr. Constantine was out in California and I'd like to get him to wrap up with his observations out in California.

MR. CONSTANTINE: Okay. Yeah, I'm going to pile on a little bit on what James said, but I also have some other about issues as well to raise. First and foremost, this CWTU I was impressed with the attitude of the staff there. For the major who was a CO to his master sergeant to master sergeant major to the lieutenant colonel who is in charge of case management didn't have a -- these folks care about the wounded warriors. I only think our unit had said just talk the talk and they're walking the walk they're committed to the wounded warriors.

That being said, they are under a crushing case of -- their numbers are authorized compared to the numbers they actually have was debilitating. For some of the notes you have, for instance, let's see there are -- let's see,

they are authorized sixteen nurse case managers but they only have twelve and they all really have full caseloads; that's a big deal. There's a big difference between twelve and sixteen is significant. Same with how many staff across the world, we saw a chart, and it was almost embarrassing how (inaudible) the disparity there.

So that is something that is probably not unique in California, particularly that's going to affect them in the next six months. The master sergeant who is the back bone of the unit; he is leaving. The doctor who Dave talked about who's been there for seven years; he's a colonel. He is so personally invested in this program, it's amazing. He talked about how he used to get packages on all the wounded warriors, now he gets a note. He goes back in -- gets all of all of their x-rays, MRIs, every recreates a file for them and goes on as a complete package. He has a wired system with whatever rotating doctor comes in there with the best intention is in no way going to be able to recreate what this gentleman has done. They talked about how the case managers can't access the audit system, which of course, is a big problem and it doesn't make sense in this day and age to have those issues.

Again, on case management it's a one to twenty is the ratio, but the most current information would be one to

twenty-eight. They have overcome that to a certain extent by working hand in hand with the platoon sergeants. And another aspect of them working so closely is they're able to deal with a wounded warrior trying to play mom against dad on that because they're right there, and oh she said what? And puts her right on the phone and they can check that right there. So that saves a lot of time.

There's a three-year rule with the chain in command, which I guess is probably statutory I'm not sure about that. But in how many hours they can actually be able to bill before they actually move on and that is a big problem out there. As I said, all but two of the platoon sergeants are going to leave coming up soon, and that job takes a long time to do it effectively. As we said in other places they spend three hours on the phone checking with their troops and maybe that's not best use of their time because the platoon sergeants are clearly frustrated. They care about their troops, they want to do the best they can but they are mandated to do that and for what sometimes.

Again, Dave mentioned to get into the CWTU, you have a list of criteria and one is that you cannot have significant PTSD or TBI issues. I'm thinking right now of the -- with the staffing issues and they are all aware of that criteria. They said that everyone's aware of that

criteria, and it's a real -- just to have them come forward with their issue because it is such a benefit to be in the in the WTU. So we understand that issue. That's something that has to be reconciled. Every wounded warrior there had a bad nightmare story about Fort Lewis, whether it was the care they got, lack of compassion there, the administrative hurdles that they had to overcome, waiting around there for so long. And apparently in California, they're supposed to move up to Fort Lewis, and then that caused a lot of turmoil for people who thought they were going to move and they were ordered, thinking it was going to be short term. That's not something we can address, that's a different issue.

But there's a lot of things going on and also nothing to do with us or the wounded warrior issue, but it was an issue, generals out there who got in legal trouble, which again not a wounded warrior issue. But that affects the morale. And when you see it -- some of these senior leaders are, at least going for a long time and they go zapping resources, yet this unit is struggling with to getting resources that they need; that kind of stuff on a holistic level affects everybody.

So I guess to wrap up, I was impressed with the level of dedication out there. I haven't gone to any other CWTU's and I was impressed with this one, but they are

about to, in about four to six months from now have a real shock to their system when people start rotating because they have to, not because they want to.

DR. GUICE: Okay. I think it's time for a break. We've used up about half of our break already. If everybody could be back at -- Denise when would you like us back?

MS. DAILEY: Five after; ten after.

DR. GUICE: Five after, please. Thank you.

DR. GUICE: Okay we are back from our break and we would like to go ahead and reconvene the session. We had in a prior Task Force meeting discussed the feasibility and desirability of having the MRNA's for the services come in and present a panel and kind of their thoughts for us to delve into the effectiveness of the senior oversight committee, which is one of our legislative to do boxes. We understood that they would prefer to have that done on a more selective longer time to allow more time for an in-depth interview. So we have constructed that. Denise and her team have provided a -- an agenda for that; that's under tab B. And what we'd like to do now is to look at the dates and times and see if you can match your calendar with the need for these interviews. So kind of -- we'll take a couple of minutes for people just to see what the

schedule is here. These have -- these have already, all been put on the calendars at the MRNA's; correct, Denise?

MS. DAILEY: Yes, sir -- yes, ma'am. These are on the MRNA's calendars, these dates and these times. And so I am seeking individuals whose calendars are available. We, once we obtain a member, I will fold in with a researcher to go with us and we'll make all the arrangements, quieting into the building, et cetera, et cetera, et cetera. We'll take care of it from there.

DR. GUICE: And then while you all are kind of doing that --I'm going to ask you to multi-task and on the first page is kind of a discussion guide that the team has put together, reminds us what our legislative mandate is and then some questions that they've put together for us to consider in terms of, you know, how do we need and feel, is it best to be constructed in an interview process to get to the answer, which is for the legislative mandate to assess the effectiveness of the senior oversight committee. So we need to have a little bit of a discussion about are these the right discussions to ask and then the scheduling -- I'm going to ask you once you sort of figure out the scheduling and if you can participate in one of these, just tear this out and give it to Denise at the next break. I think that

will probably be the most efficient and she can tally it up and see if we've got -- need somebody else for one visit or we don't have anybody for a third.

MS. DAILEY: It looks like I've got a volunteer here.

GENERAL HORST: In looking at my schedule -

GENERAL GREEN: Mike, please.

GENERAL HORST: In looking at my schedule, I can support the Army MRNA visit on the 24th.

DR. PHILLIPS: I can do the 24th; this is Steve Phillips.

MASTER SERGEANT MACKENZIE: What is the date on the joint staff visit?

MS. DAILEY: Oops, I apologize. I'm going to have to go back through my emails real quick, yeah.

GENERAL GREEN: Can I just get clarification? Are we -- you're saying that an individual plus a researcher, are we going to send one or two people, what's your intent, Denise?

MS. DAILEY: Yes, we don't want the party to be too large, so one to two members. Myself, and I would send a research member also to, to be a part of it, to understand so we can collect the information. I think Suzanne here is going to save me on the joint staff date;

it's the 23rd of May.

DR. GUICE: I think it would be prudent if we had two Task Force members participate in each interview. I think that is a better strategy.

MASTER SERGEANT MACKENZIE: This is why I was asking cause the week of the 26th of May, I can be available. But the three June and on, I cannot. Cause I'll be actually taking leave -- personal time, so amazingly enough. But that's why -- that's why I was asking on the dates cause I mean if you're going to bring me up out of Tampa, it would be to do a couple of visits.

DR. GUICE: I think we're going to have to cancel your leave.

MASTER SERGEANT MACKENZIE: No, ma'am.

DR. GUICE: Actually, initially we thought one DOD and one non-DOD person for each interview; if we can swing that. If that works for peoples' schedules.

GENERAL HORST: I would agree to the third of June or May 24th.

DR. GUICE: Yeah. Yeah.

COMMAND SERGEANT MAJOR DeJONG: I can do June -- three June if you need a military member on that.

MS. DAILEY: And who's speaking?

COMMAND SERGEANT MAJOR DeJONG: Command Sergeant Major DeJong.

MR. REHBEIN: This thought tends to fall into the portion of the reports that General Stone and Colonel Keane and I are responsible for, if that's the appropriate word. I can make any of them that you choose to have -- that you need to have one of us on.

MS. DAILEY: Okay, so you're -- sir, you're available for, I mean I don't have anyone going into the 26th with the Air Force MRNA's. No one -- so can I put you on the 26th, sir?

MR. REHBEIN: Yes.

MS. DAILEY: Okay. Thank you.

DR. PHILLIPS: Denise?

MS. DAILEY: Yes.

DR. PHILLIPS: I'm available on the 26th as well, Steve Phillips. I'm available on the 24th and/or the 26th, however you want to utilize me.

DR. GUICE: Denise, which ones do you still need individuals?

MS. DAILEY: The 23rd, joint staff, 23rd. Did I -- did I miss someone who volunteered the 23rd?

MASTER SERGEANT MACKENZIE: I did.

DR. GUICE: Okay. MASTER SERGEANT MACKENZIE: I said that, that whole week I'm available.

DR. GUICE: Okay.

MASTER SERGEANT MACKENZIE: So we just need to

work the travel deal, but I'm available for that week, so.

MS. DAILEY: Okay.

DR. PHILLIPS: I'm available on the 23rd, as well. The 23rd, 24th and 26th. For Phillips, if you need me.

MS. DAILEY: And keep it in mind this is -- this is just one of our first layer here. We still need to schedule the two deputy secretaries, Deputy Secretary Gould and Deputy Secretary Lynn and definitely want to get those done before the end of June. And I'm seeking, at least the earliest, the first two weeks in June.

DR. GUICE: One of the things that I talked to Denise about, both deputy secretaries are testifying before Congress. And so their written testimony will be available and it -- both of them the panoply of things that the SOC has addressed. And that might be a good thing to review for those individuals who would be involved with those particular interviews. Just, it's -- I think the hearing is today. So it's publicly available beginning today.

MS. DAILEY: One of the conflicts ladies and gentlemen we scheduled this at the same time that they are testifying and their staffs are sitting behind them right now. So --

GENERAL HORST: Denise, are we meeting with the principals or are we meeting with their assistants?

MS. DAILEY: Right now you are meeting with their

principals. And they have asked also to have their SME's in there. But so far, I've not had anyone say, okay, the next level will be there. But right now I'm on Mr. -- can't remember everyone's names, but we're on their calendar.

MS. GUICE: You know, Denise, I would suggest that when you go to VA to do the interview for the Deputy Secretary Gould and the team, you include the DOD VA collaboration office.

MS. DAILEY: That would be Mr. Medvie.

DR. GUICE: Mr. Medvie, okay. Just to make sure they, because they're actually the point for coordinating on the VA side.

MS. DAILEY: Correct.

DR. GUICE: So much for the SOC office on the DOD side?

MS. DAILEY: Correct. And just if I get everyone to take a look, one more time at June the third, I've got the 24th covered, I've got Sergeant Major DeJong here. I'm sorry, am I missing you?

MR. DRACH: I can do the third.

MS. DAILEY: I'm sorry; you're going to do the third?

MR. DRACH: Yes.

MS. DAILEY: Thank you, Mr. Drach. I have

MacKenzie and Phillips on the 23rd. I do have Mr. Rehbein, yeah. Any DOD available on the 26th?

MASTER SERGEANT MACKENZIE: Yes, ma'am.

MS. DAILEY: Master Sergeant MacKenzie. Okay. Dr. Phillips, I'm going to bring Mr. Rehbein in. I won't need you on the 26th. And Master Sergeant MacKenzie are going to do the 26th of May with the Air Force. Oh, good. Okay. So let me recap. Got the 24th of May, Army MRNA's, Major General Horst and Dr. Phillips. And the Navy MRNA, Command Sergeant DeJong and Mr. Drach for the third of June and the 26th of May, I have Mr. Rehbein and Master Sergeant MacKenzie with the Air Force. And on the 23rd of May with the joint staff surgeon, I have Master Sergeant MacKenzie and Dr. Phillips. Great.

DR. GUICE: Okay, thanks everybody. Now let's turn to the first page in that section under tab B and just kind of go over the questions quickly. And bounce them against the legislative mandate and see if that resonates pretty well in terms of a guide. Obviously, there are other questions that you can pursue as well, but in terms of kind of things to be thinking about as we are setting up these interviews. Certainly, to at least ask a standard core of questions so that you're getting apples to apples answers so we can have a comparison at the end, an assessment of the effectiveness after all of these

interviews.

GENERAL GREEN: I would suggest -- just I'll start this off, the other standard question think we should ask from the MRNA's is who their expectation is regarding who's in these programs. I really think we should get from them who have been working this who they feel are in this wounded, ill and injured category because we're struggling to understand it, and I think if we got it from all three, we'd find out whether they're still struggling with it or not.

DR. GUICE: So in terms of a question then would be to ask them to clarify eligibility criteria for the programs that they're responsible for?

GENERAL GREEN: The problem with asking eligibility is that all are inactive duty guard and reserve who are going to be eligible for the programs. The real question I'm trying to find out is what they are looking at in terms of the SOC efforts and the additional efforts they have been putting out. Does that apply to all ill and injured or is it a subcategory of ill and injured? Clearly from the wounded side, we know how that's playing, but this definition of who's part of this and who's not part of this on the ill and injured is very problematic.

DR. GUICE: Okay. Any other suggestions for questions?

MR. REHBEIN: Not necessarily a suggestion, but I would like some clarification in number one, information transfer. That covers a multitude of area and I guess I -- transfer between who? Between the two agencies? Between the agencies and the warriors?

DR. GUICE: It is between the two agencies.

MR. REHBEIN: Okay.

DR. GUICE: But given the discussion that we've had today, I mean, that's an interesting point. You're talking about the amount of information that -- it's there and but maybe we should be asking them how are they assuring that information is being disseminated and consumed by the right individuals? I mean, how are they what's their role in getting information and communication, uh, communication strategies for making sure that people understand where the information is and how to access it. It does seem to me that that should be in their lane; unless that's not -- my thinking is wrong on that.

MS. DAILEY: Yes, and they are lots of questions we can put in here. I just want you all to, kind of put parameters on this. This is designed to talk about the relationship between the DOD and the transition to VA -- that's the mandate. So I need you in that camp when you're talking with them.

MASTER SERGEANT MACKENZIE: Which is still a

valid point is, you know, are they accountable for it and how do they guarantee the information is being passed?

DR. GUICE: I mean we have the observation that we've got very complex systems of care and benefits. Just a given, and given that complexity, making sure that people have the right information at the right time, in the right order is a critical piece. I mean, we've identified several places where individuals are struggling with getting good information at the right time. And yet, we know it's there. So, you know, how are these two agencies working because we now have VA benefits that are being applied within the DOD framework; that didn't used to happen. We have traditional VA benefits that active duty service members are now eligible for; before it used to be DD-214; it was a line in the sand, you know and you didn't get it until you crossed it. So now that you've got sort of one agency folding into another and some kind of wrap around from the other side too, when people separate and retire. You know, how is this, all this information coordination being handled because we're identifying some gaps in that it sounds like.

MR. DRACH: And following up what Mac said earlier, what accountability standards have you established?

LIEUTENANT COLONEL KEANE: Ms. Dailey?

MS. DAILEY: Yes.

LIEUTENANT COLONEL KEANE: Are we going to provide these questions to them in advance?

MS. DAILEY: Correct, they already have them. Any changes we make, we'll be updating and I'll be sending them the bios. And any updates to this and some other read ahead material for them.

DR. GUICE: I think one of the things, you know, again, staying in the DOD VA spaces is how are they assuring we hear everyone talk about warm hand offs, but how, where's the accountability for the warm hand off? How is that actually being tracked, monitored and assessed for effectiveness? Are we really doing that? And if so, where and how and take those best practices and promulgate them across the system. But you know, the warm hand off is certainly what we've heard, these individuals are part in parcel of making that happen and certainly the SOC is focused on that a lot. So that would be another thing that's exclusively in this domain. Any other thoughts, ideas, concerns?

MR. REHBEIN: I guess number four; we're asking them is the SOC the best vehicle going forward for sustaining some of these programs. A parallel question to that is what do they see as a better vehicle for some of these issues?

DR. GUICE: I think -- I think --

MR. REHBEIN: If they come back and say no that SOC isn't the best. I think we need to start them thinking down the road of, if your answers is going to be no or may be or maybe not, what do you kind of guidance do you give as a better way to go?

DR. GUICE: Could I ask the researchers to put together a one page on the joint executive committee and kind of the legislative mandate for that, as well as how it currently operates because there's that structure so that you will understand and when you go in and speak to them.

MS. DAILEY: Yes, that's in the reference handbook. We did that last fall. So going to the reference handbook and looking this reference handbook over that gives background is -- should be a prerequisite.

DR. GUICE: Okay. Are there any other thoughts, ideas, questions?

DR. PHILLIPS: I'm just going to say the meetings are coming up very soon, but if we have some more, if we digest something on the way home tonight or tomorrow, can we send you an electronic note?

MS. DAILEY: Yes, and just want you to keep you all in mind this is you're a visual into the senior oversight committee. And Congress is very interested in exactly the language that's here; there are no hidden

agendas. This is exactly what they want to know from you. And their language was very specific. So we want to keep it in that ballpark.

DR. GUICE: We have a few minutes now before I think we're going to -- we have until 11:30, so I think Denise would you like to go ahead and start talking a little bit about report planning, since we have some time now?

MR. REHBEIN: Karen, may I ask one more question of Denise?

DR. GUICE: Yes.

MR. REHBEIN: Denise, prior to these visits will we be supplied with some bio and information on the folks that we will be meeting with?

MS. DAILEY: Yes, yes; it will go both ways. Once I get who's going, I'll be able to get a package ready for you guys and I'll be able to lock down the package for them.

MR. REHBEIN: I'm sorry to interrupt. Thank you.

MS. DAILEY: Yeah. We do have an hour here ladies and gentlemen, so I would -- we always have I don't want to truncate this. I know it's a little -- it's tough to stimulate conversation. So I don't want to let this opportunity go in which you might want to discuss this a

little bit more. However, I always have other material that I can talk with you about.

MASTER SERGEANT MACKENZIE: Funny how that happens. Do we know yet how we are going to work travel for those of us out of town.

MS. DAILEY: We're going to work it very quickly. In fact, I know my staff's working it right now.

MASTER SERGEANT MACKENZIE: Wow, that was a hint I guess.

GENERAL GREEN: Yeah, because this is only a week away, and we're, I mean the first one's what, the first one is what -- the 23rd, I think. I guess as we sat here and we talked about potential added questions et cetera, it is fairly important that we understand that as we talk with these senior folks, there's going to be divergence of opinion regarding what each of the services thinks, has come out what they got and wanted through the SOC. If the SOC has been effective, et cetera. And so we may want to, you know, the other thing that's not here yet is are we giving them an effective venue to talk about service position versus what actually came out of the SOC, cause you're talking with the services individually.

And so are we asking -- you know, all the questions that I see are really geared towards what has the SOC done and then the question would be is there something

that the services are proposing or wanting to take forward that the SOC has not supported. Do you know what I'm saying? Cause right now we haven't given them an venue other than to talk about the SOC, even in the things we were talking about. Whether or not that we want to kind of give them an open ended question about is there something the service would really like to see that has not made it through the overarching SOC decision process.

MS. CROCKETT-JONES: That I think seems to fall under question five. If -- basically if we're asking them how they bring things to the SOC and how that works out for them, we can -- I just think that would fall sort of naturally under that. If we -- if this is the guideline for this conversation, I think that's where it should be added in to say how has that worked for you in the past? Not just how you would do it, but what results have you gotten. What if they're -- what don't they support -- what happens if they don't support an idea?

GENERAL GREEN: Yes, I guess where I'm going with this is not so much to challenge a process of the SOC or how they should to bring things to the SOC. Because they don't have the ability, I mean, I've sat on the SOC, they don't have the ability to bring things to the SOC. The thing is that each of service also have the ability to implement programs within the scope of what's been approved

by the SOC that are different. And so is there something that they feel they've done extraordinarily well? And that's not maybe an overarching SOC program because we'll find out fairly quickly how aware they are of some of the problems we've seen when we've gone down.

I'll use the Air Force one that Mac pointed out in terms of the resourcing of some of the case managers and getting the resources in place. But you could talk to any of the various issues we talked about today in terms of the trends, and find out what they are doing now more independent of the SOC to try and plug gaps if you see where I'm going. So it's not so much the process of they get something to the SOC, and whether they're happy with the process, as much as I'm wondering if there are things that they're actually doing independent of the SOC that are with -- that fall under the overarching scope of what the SOC has approved, but not necessarily having gone back to the SOC to get it more widely applied.

DR. PHILLIPS: There is one area I'd be interested in hearing --

MS. DAILEY: And real quick, just to be sure they'll be happy to talk to you all day about what they're doing independently and never close the loop back to their interactions and the information we need about the SOC.

DR. PHILLIPS: Okay. Thank you. There is one

area I'd be very interested in hearing from them and it's not listed on these pages and the big picture is you look at the VA, its unified; it has commonality at every level. Whether or not what their thoughts would be related to having the WTU's on the one joint Command? You know, have a model that's similar; that's apples to apples. Right now, I mean, I know it's controversial and there'll be a lot of discussion about it, but I'd be interested in hearing at least from them, either officially or unofficially, would it make their job easier? Would it make their life easier if they had all the commonalities that the VA has.

MS. DAILEY: Are you talking about the in terms of having a joint forces Warrior Transition something.

DR. PHILLIPS: One single Command for all the different services, they all move over to one single command and everything is filtered through that one single command. Again, I don't want to be tarred and feathered, but --

GENERAL GREEN: You won't be tarred and feathered. The difficulty becomes -- so, all right, I'm guessing that some of that comes from the Congressional language right now about joint unified medical command and whether that should be a single entity to interface with the VA, etc. But part of the problem in terms of what

we're dealing with the wounded warriors is the benefit side of this. And so when you're talking about transition from DOD to VA, there's a whole -- there's, you know, more than 50 percent of what's going on is not about the care that they're receiving; it's about the transition of benefits.

And the transition of benefits is something that resides not in the medical, but in the A-1 side of the house. I say A-1, but the personnel side of the House. And so when you talk about doing a joint oversight, for instance of the casualty care, it sounds as if that would make a lot of this much more straight forward, but then you will encounter fairly quickly the differences in what happens to a soldier, airmen or -- I can hear who I left out -- the Navy, the

LIEUTENANT COLONEL KEANE: Marine.

GENERAL GREEN: Sorry, I should have mentioned them first, of course. But I mean the point I'm trying to make is that a lot of what's going on with the differences between the approach has to do with trying to get them back into the culture of the Marines, or back into the culture of the Army; back into the culture of the Navy or the Air Force. And the decisions on who's able to stay are really dependent upon the personnel systems, not the medical systems. So I'm not certain that you could go to a, so for instance, a joint wounded warrior command -- I'm not sure

what that would even mean.

DR. PHILLIPS: You know, I certainly understand that. This is been discussed in side bars obviously, and I would just be interested in hearing what the folks in the SOC think about something like that. I know -- again, I -- certainly, I understand all those different issues. But if you have one target and its bi-directional, again, not to distract from the services, and you know, one might argue that if you're out of the Marines, or out of the Army, boy I really want to get back in. You know, I'll do everything I can to recover and move things along. So I would just want to understand their overview because they've been doing this for a number of years. Wouldn't it be easier for them to function at every level, if there was one area that they could talk to and one standard paperwork and so forth?

GENERAL GREEN: And there's lots of ways to envision it. So do you basically put Warrior Transition Units and the Warrior Transition Regiment and the Wounded Warrior Two program under the joint staff, for instance? So there's ways that you could link it up. They don't necessarily have the resources because that's not necessarily the way it's been executed. But you could try to put something like that together and the tricky part is now back to where I always start, which is, okay, who does

it apply to? So the person who has a combat injury, the person who has a non-combat injury, the person who has a temporary profile that may well be able to -- I mean, how far do you go and put them into the joint function? If you didn't define that, it's very hard to now and try to create something new. Go ahead, Mac.

MASTER SERGEANT MACKENZIE: The -- it is actually two separate things. And that's, if you're retaining a guy on active duty that does come into the personnel system within special ops, it's actually completely different because within supporting from an additional angle, but the problem and I see where Dr. Phillips is going with this, is that if you take a soldier, a Marine, a sailor, an airman, a coast guardsman and their all lined up at the door, and they're all amputees and they're all transitioning to the civilian economy, why do continue to make it so difficult that every one of those guys sees the light at the end of the tunnel in a different way because there's no standard for how these benefits and how this stuff is actually relayed to these individuals to reintegrate them and help them continue on with normal life.

If that's the choice. I think the population that returns to active duty is -- is so small that that can be handled on an individual service basis. The overwhelming population, especially in, you know, the

critically wounded, ill and injured folks; it's the same results. I mean, we've captured some of that data in these different facilities we go to; what's your percentage of people that have returned to active duty and who have been retained on active duty and that percentage is very small.

But yet we seem to be catering or not taking that big step based on the small percentage versus the large percentage who really need the help. So I think it's still open for discussion or looking at -- at that route.

DR. PHILLIPS: You know, one of the things I've been impressed by is I think it is to me grossly unfair to the line units to, I don't want to say be burdened, because it's not a burden -- but to have this extra added duty and personnel physically within their command even though they're in a WTU. And they have to interact with them. And the tracks are their mission and I think in some respects this is tracking for the mission of the WTU's. And then I was also thinking in terms of future. Hopefully, when we get out of these conflicts and we downsize we'll have a solid, unified command system that can address the continuing needs. Again, I -- not to debate all the issues, I was just wondering if it would be possible to ask these folks what their thoughts would be on that.

GENERAL GREEN: Yes, there is no objection on my

part of asking. I guess, I'm trying to help understand the doctrine in terms of how we do things. And so the problem within the services is that our joint headquarters tend to be planning and is certainly where the combatant commanders execute all of their authorities in terms of how are we going to execute the forces. But when you go and actually do the job, it's all passed through the services. So the financial systems, the personnel systems, everything is service based.

So now when you decide you're going to say wouldn't it be better to do that jointly, you have to deal a little bit with the fact that you may not have a joint system that does the personnel or that does the financial accounting or that does all the small pieces that are currently done by the services, because when they established our joint doctrine back in the eighties, they decided that everything would be executed through the services. And it's usually very temporarily things that are done by a JTF or by a joint headquarters.

Almost everything is executed through the services. And so, although, I can use the medical since that gets a lot of press, there's certainly no difference in the care provided to these folks; Army, Navy, Air Force, or whether the patient is Army, Navy, Air Force, or Marine or whether the provider is Army, Navy, Air Force, or

Marine. The care itself is the same. The resourcing and everything that comes down to that care, is all right now comes through a service.

And so it sounds complex, but when you go to war, it actually works. So how do you, how do you kind of make this all come together? Perhaps there is the right, the right time to create some of these more joint entities to manage this. And maybe a very a good question to ask these folks because of their frustration with differences in resourcing and differences in communication about these things. But realize that when you talk about it, its not something that happens just overnight. There's some doctrine and some things that have to be put together in order for folks to execute in a world that's not overseen by the services. Carl?

GENERAL HORST: Sir, I think that's a great point and I think if you take a step back and look at the population of wounded warriors within the respective services, what then follows for a joint organization is what is the appropriate service contribution to that joint effort based on the population that's there. Again, it goes back to resources.

And to your point of our doctrinal approach to joint operations whereby each combatant command has a respective service component that's done for a reason. And

I'm not sure that part is broken. I don't think, I'm not sure that there's real value going into a joint construct because it will still boil down to what are each of the respective services contributions to that joint entity and what is the population of that that will drive that.

GENERAL GREEN: There may be another data point that would be valuable in this and that is what percentage of the people who go through the Wounded Warrior Transition Units or are followed in the wounded -- what percentage of them actually come back to duty? Because again, you don't necessarily want to create another scene by taking them from a service run program to a joint run program and then back to a service run program. Right now, it goes from a service run program and if they aren't able to be retained, they go to a VA program. So if you took them from a service program to a joint program to a VA program, that sounds like you necessarily be putting a seam in there. But if they come back from that joint program to a service position, you're actually creating another opportunity for seams in the system.

MS. CROCKETT-JONES: Let me just point out too, that there seems to be a connection between what you cited earlier in defining who is in and how many return to duty. Because we see really different numbers at the CBWTU's who have a very -- who have a very focused definition of who

gets in based on their -- you know, support systems, their, you know, general personal attitudes and their medical acuity. But that return to duty is highly, seems to be connected to defining who, the definition of who gets in and the timeline. And so I think that before we, I think that there's a progression perhaps we'll be making over the next few years. And I think that you're right to think that the definition might be really a core.

DR. GUICE: One of the concerning things I think that as we are starting to see is the sense that if you're in a wounded warrior whatever, that it's pejorative. And I think that's - that -- that's a trend that I think is unfortunate and probably is something that needs to be highlighted and you know, how do you get rid of the stigma of being put in one of those places and then, I think that's may be a little nugget that's a new twist to all of this that we were unaware of before.

GENERAL HORST: One of the other challenges we are faced each of the services have been directed to reduce total end strength. And so if we have a population residing in a wounded warrior type organization, then the question comes, do they count against the end strength? And in this age of diminishing resources and downsizing of our services, the argument then comes if I have ten thousand army wounded warriors in my program, will I then

have to eliminate ten thousand healthy warriors to get to my congressionally mandated end strengths? And we'll get into a real discussion about how quickly we expedite through the Wounded Warrior program or how quickly we move them someplace else from an accountability standpoint.

So I think we have to be cognizant of the environment that we're operating in here of a southeast trend line for end strengths and a north east trend line for admittance into wounded warrior programs. And I think they are at odds with one another when it comes down to the discussion of end strength. And so, to move it into the joint arena, I think would only further complicate the challenges we have and then to the point of into the joint wounded warrior back to the service or out to the VA. I think we may be creating an additional challenge to the overall system by going that direction.

GENERAL GREEN: All of this said, okay, we're not trying to restrict you from asking the MNR's, whether this would be easier joint and should it be a single system or not. But I just don't want -- as we talk here, I don't want you to walk in naively thinking that joint simply means that it would be a single system. Joint would mean in the way we do joint today that essentially you're establishing something additional to what the services are doing now. So it's not that it necessarily decreases the

bumps and those numbers of place -- it typically as you try and seek unity of command in a joint, it means that you're establishing something new.

MASTER SERGEANT MACKENZIE: And I think that's the reason for bringing it up in this forum to make sure that when we do go sit in front of these members, that we do have the general concession of what it is we're talking about and how we're looking at things from the whole Task Force versus rolling in cold individually or just a group of two. But -- I just as we think about this stuff, I just want to throw a token of thought into the pool. You take a military member within the service that is processing out and you take a special operations member from that same service, you say joint is too difficult to do. I guarantee you that special operations is going to know everything he needs to know going out the door. Who's guaranteeing that the other guy does? And that's just a thought to throw into the pool.

DR. PHILLIPS: Well, maybe I should just ask what will make your life easier and then talk about it.

GENERAL GREEN: What would make your life easier? I mean you, you could also argue, you know, that it could be done through a single service and have -- so the most robust Warrior Transition Unit system is probably through the Army right now. And so it should, basically,

you manage all of these people through a single service system until they get to a point where they can come back. Now that's a little different way, it's still joint. And so can we make that happen?

Mac, I understand what you're saying, we haven't briefed yet on the soft side of this in terms of what they're doing. So I'm not sure all that of us can say that I appreciate your guarantee until we actually went and visited the Air Force, I probably would have told you I thought we had a pretty good system, too. And then we found all the holes in terms of resourcing of the Air Force system. Let's find out about your system. Okay?

GENERAL HORST: And I think that's a good point. An example, the Warrior Transition Unit at Walter Reed has got 59 Marines in it. Fifty-nine. So you ask the question why are they at Walter Reed and the army Warrior Transition Unit -- why are they not at Bethesda or whichever else I'm sorry. It gets back to the point that General Green makes is maybe we designate one service as a lead agency for all of this -- as the approach to joint, which, under the joint construct.

When you look at a -- at a joint force land component commander, we allocate resources from the other services to the army guy or maybe a marine, or but in this case because of the population, it tends to be army because

of the population, the density of the population and the resources available.

GENERAL GREEN: And if we talk with the Marines who basically have that relationship with the Navy we would find out that it works really well, right?

LIEUTENANT COLONEL KEANE: Yes, sir. General, I believe those Marines, the 59 Marines at Walter Reed, they're all under the wounded warrior program, they're just at Walter Reed. So they all have Marines tracking them from the Marine Corps. But they're not in the WTU.

GENERAL HORST: Yes, but the warrior Transition brigade has had command over them at the WTU and there are marine LNO's there helping out. But there's an army colonel there driving their program.

LIEUTENANT COLONEL KEANE: Yes, sir, that will all change once their Naval medical center, the new Walter Reed.

GENERAL HORST: That army -- that warrior transition brigade is presently commanded by an army colonel. On the 27th of August will pop up at Bethesda.

GENERAL GREEN: Steve, we're with you, do you understand?

DR. PHILLIPS: I have thick skin.

MR. REHBEIN: The -- the issue that General Horst raised just a minute ago regarding man power and end

strengths is that an issue that would be appropriate to raise with these folks as to just what their plans are as they try to meet these lower end strength goals? How they are going to balance the wounded warriors, the wounded, ill and injured with active duty?

DR. GUICE: I'm a little concerned that if we start going down that way, we won't get to where the researchers need and where we need to be in terms of is there some sort of, you know, our legislative mandate is right there. It's not to assess how they're going to work with the end strength and how fast IDES can process people. But it is really to answer that question and I think the more we kind of stray out of that, cause we just -- we don't have much more time with this round and I think you may be in thinking prospectively for next year in how you want to lay things out. Put that on a to-do list or a tickler. But for this, I think we really need to get to the heart of the matter here.

MR. REHBEIN: That sort of --

GENERAL HORST: I'll offer that just as we --

MR. REHBEIN: That sort of thing would come up under number five, new issues.

GENERAL HORST: Dave, I offer that from just simply from a standpoint of situational awareness. As we go out and conduct these interviews, we have to have

situational awareness of the environment that we're operating in and the -- these respective man power folks, that's an issue that they've got to deal with. So whether we talk about it they're thinking about it in the back of their minds. We just have to understand what their operating environment is and what the expectations are.

MR. REHBEIN: Well, I bring it up from the standpoint of we all hear of anecdotal evidence of folks that have been discharged before medical treatment was really over. And if this sort of pressure comes too bear because of end strength decreases, then you'll hear more of those kinds of stories and I'm just concerned about that; that's all.

GENERAL HORST: I mean, it's a very, it's a very simple question. If you have cut ten thousand, and you've got ten thousand of them that are wounded, non-mission capable and you've got ten thousand that are fully mission capable, the argument is where you going to invest your resources? Okay. Not -- again just a reality.

DR. GUICE: The thing I -- we haven't had a chance to go around and think about it, but in terms of the medical care, many active duty are receiving their appropriate medical care at a VA polytrauma or even at a VA facility somewhere else. So it almost just what should be a seamless the transition of that medical care since

they're already in those venues. It's just a matter of when you give them the paper that says you're no longer on active duty. So I think that's part of this. But it does mean -- I think we do need to visit that, we talked about it initially is since we do have active duty members within VA facilities, how is that working?

And if they have to go back to a MTF, you know, how is the service maintained they're tracking those individuals and their responsibility while they're in VA facilities. And how do those, again those transitions or hand offs happen, should someone be in a VA facility when the papers issued?

MS. DAILEY: Let me backtrack real quick also. The three topics that were selected are, recovery care coordination; disability evaluation system; and information transfer were selected at our last meeting. These are key topical areas that the SOC has dealt with over the last few years. They had the mandate to set up and establish the recovery care program. You've seen it working out there. They also have the mandate to set-up the -- the integrated disability evaluation system.

Congress was -- Congress was engaged in that because Congress came to the table saying may be you should wait and hold until we are absolutely sure that the VA is ready. And it's a joint initiative on the SOC's part to

move forward with the integrated disability evaluation system. There is now -- as the systems stand up, there is push back that it was precipitous movement to do the integrated disability evaluation system. And this is one of the reasons Congress put this topic on your table was the -- the movement forward on these issues that are a joint decision, but not really be a joint decision.

So I just want you to have some awareness as you try and move forward with crafting your argument to Congress that you've looked at these issues and you've asked the players about how they address these issues.

GENERAL GREEN: Just one final thing to kind of -- and has been brought up several in discussions earlier this morning, and I'm going to use Suzanne's comment about TBI and PTSD in terms of how they are being treated sequentially. One of the things with the integrated disability evaluation system is that it doesn't start until you've reached maximum medical benefit.

So if you think about what you've heard on your visits from the folks they get there to the point where they have maximum medical benefit and then at that point it's decided that they're not going to be able to stay on duty. And then the next thing you have is a bunch of very impatient people who have reached maximum medical benefit who are now caught in a medical system -- I'll say medical,

but the transitioning system, that the standards for the IDES is currently 295 days, okay?

So you're really in limbo land after you've reach maximum medical benefit. So one of the questions and I'm not sure if it's for the MNRs, but for us to consider is should all of this be sequentially done? In other words, could some of this be done in parallel? Whereas you get started with some of the early steps that would be required for the IDES and now when you reach that maximum medical benefit you simply tip the scale and finish off what hasn't been done in the integrated disability evaluation system. And at least to my knowledge right now, folks aren't talking very much about that because of the concern about any effort to shorten what's really required for maximum medical benefit, which is truly probably a medical decision.

So, as a doc it concerns me that some of our guidance over the years has changed. It used to be certain conditions that required you to identify to the medical evaluation board as soon as that condition came up or within 90 days, you were supposed to do that. And nowadays the guidance is much more lenient on that. There's no longer a specific, I'll use one that you're an insulin dependent diabetic; it's no longer required that you submit a medical board at the 90 day point. It's when the person

has reached maximum medical benefit. Well, if you're working on their insulin for a year or two, you may or may not submit the medical board. Okay. Think about that, well, in that case if the person is functioning, and you know, well, who knows.

But on the other hand, so you've got somebody who now has got a double amputation, and one of the reasons I asked earlier about any data that shows what the normal recovery time is -- is can we predict that someone who has a double amputation when they're going to reach maximum medical benefit because could you make it so that their disability system is ready to hand them what they need on the day that they reach maximum medical benefit, which would basically decrease all of that frustration with now here I am, and I can't go on and get another job or I can't go do the next thing because you still in a system that says I can't.

So one of the early things that was done by the SOC was to look at TDRL, and kind of step away from TDRL, which was a system that allowed people to go into a temporary disability while they were getting the recovery and the maximum medical benefit. So all of these things are things that we need to be cognizant as we think about this. And so when you talk with the MNR's, it's kind of artificial to talk only about the 295 days without talking

about the may have been two years, okay, that led to the maximum medical benefit before they started the next two year process. So it's kind of a weird system that we've got right now and I don't know how, how to address that exactly. I don't know if that's something we need to bring up to the MNR's.

But I think it's important that you folks realize we do these sequentially, which I think is somewhat problematic. And they're going to want to talk to you about the IDES at this thing and the IDES starts after they've gotten their medical in large part. I mean, they will continue to have medical needs, but they've reached a point now where they're saying, okay, that's the best -- that's what we can do for you with the technology available today. Now we're going to put you in the IDES system, does it has to be sequential? Denise, on the stuff going to the MNR's, okay with this that we're taking do you want us to just stick with the five questions that are here?

I mean I'm trying to get a sense of what you're saying. Is this going to further the research to go after it just this way and these other things are less formal questions cause it saves everybody a lot of work if we're not trying to give you what are going to be the standard questions. If you really only want to ask these five. I mean, I'm getting a very clear sense from that you that we

need to stay fairly focused?

MS. DAILEY: I'm going to add in I think -- I think what -- where's my notes -- sorry, sorry, sorry. I'm going to add some of the discussion that we had here. So I will rejigger this and give it back to you all going in. I do and am concerned that it's one hour, there's going to be their staff in there, our staff in there and we need to try and stay in this effectiveness of the transition between the SOC and the VA lane. If you want to hear about the programs, and you've heard about a lot of their programs. I can bring them to the table on a different topic.

But we need to discuss about what they have to say about the senior oversight committee and their interactions with the senior oversight committee. So I apologize, if you're -- if there were other broader expectations, but we need to try and keep it in that lane.

Now, let me go back to my tab and I did put down expectations of who should be in the wounded, ill and injured. That I added as a sixth question and I might have moved my notes here, and warm hand off -- warm hand off and I think that's about, what have they done well independent of SOC activities, that one I didn't role in there, sir, because we're chatting about we're getting information about what their programs are. I didn't want to put that one in there. Right now I'm in the camp of expectations of

who should be a wounded, ill and injured and a warm hand off.

MASTER SERGEANT MACKENZIE: Did you get the accountability for information transfer?

MS. DAILEY: Good, accountability for information transfer, that really puts us at eight. And I'm not all that excited about information transfer because we're talking about commands transferred down. The topic we have here, information transfer -- and I'm pretty sure remembering this correctly the electronic files, going across the VA. That term information transfer had to do with the electronic medical process?

DR. GUICE: It also information transfer broader includes the personnel and it really is the information needed by both agencies to operate under the way we manage our personnel. It's about VA understanding the personnel information as well as the health information from DOD and for DOD to understand -- particularly for the guard and reserve when they're mobilized again, nuances and how they manage these bits of pieces of information.

MS. DAILEY: Okay. So on the information transfer concept, I'm not trying to delve in at the MRNA level as to how they are transferring information for remaining in the service; that's a service issue. If my information transfer thrust has to be towards holding them accountable

for the information they need to transfer to the VA, because that's the mandate and how does SOC ensure that that type of information for their transfer to VA, whether it be medical, whether it be benefits, or both; it folds back into that warm hand off also. Are we on the same sheet? I know you would like the information for their continuing of service, but I need this to be an interagency discussion.

DR. GUICE: But I think that's what we were talking about. It's not the services it's about all the information, what's available through the VA benefits and services, I think that's what we're talking about. Not just coming down through the service to the service member and how that does it, I don't think that was the issue. But it was this big pool of information that we all know and have at our figure tips, but yet somehow all this information is not going down.

In the example is that in Florida no one knew IDES, it was just a deer in the headlights. We've worked on an extreme lining evaluation system and ask anyone in the SOC, and they can explain it. That information is not going where it needs to go and what choices they need to make. I think it's that level of dissemination, the SOC has oversight of; how are they making sure that information about those get disseminated and who's accountable when it

doesn't. Isn't that what -- Mac, isn't that what we were trying to get to?

MASTER SERGEANT MACKENZIE: Yes, that is correct.

MS. DAILEY: Okay. Good. I got it. Okay. All right. We're going to have lunch in -- lunch is served in seven minutes, let me give everyone a break, like I said, we have all the things to talk about, but lunch is in seven minutes. Now I have to -- we are not in this room for lunch, ladies and gentlemen and my staff is ready to take you to the lunch room and so, who's taking everyone to lunch and then we will get you -- you need breaks, so -- so who have I got out to lunch? Who's out to lunch?

GENERAL GREEN: All right, folks. If we can go ahead and get started. First of all, welcome back, okay. I'd like to direct your attention to Tab D in your books. Our next set of briefings and panel presentations is by the Wounded Warrior Care and Transition Policy Office. I will point out that we have looked at the military service level programs and installation level execution of the service programs. And today and tomorrow, most of the panels and briefings will be presentations of programs and initiatives at the DoD level.

Mr. John Campbell is the currently serving Deputy Assistant Secretary of Defense for Wounded Warrior Care and Transition Policy. He was appointed to his current position in 2010 and is himself a Marine Corps veteran. He's held numerous positions in financial, business, and veterans organizations, including founding My Vetwork, an online social network for service men and women, veterans, and their families.

His office published policy and provides operational support to many of the non-medical care programs the services have briefed you on and you have subsequently seen executed in the field.

So, Mr. Campbell, thank you and your staff for time today, and we will pass it over to you, sir.

MR. CAMPBELL: Thank you, General, appreciate it. And, ladies and gentlemen, it's a privilege to be here today to provide some insight into what my department, the Office of Transition of Wounded Warrior Care and Transition Policy is doing to improve the lives of members and their families and caregivers.

Our mission is to ensure that wounded, ill, and injured, and transitioning service members receive high quality care and seamless transitioning services through

proactive leadership, responsive policy, effective oversight, and interagency collaboration.

I'll be joining the briefing today by some of my direct reports. The first will be Special Assistant Koby Langley, who will be speaking on strategy and outreach. He'll be followed by Phil Burdette, my principal deputy who will be talking about program and budget. He'll be followed by Director Brett Stevens, who will talk about the IDES and transition assistance policy. And finally, Director Bob Carrington, who will talk about the recovery care coordination program.

This (inaudible) mission, our programs are designed to create high quality service, member-centered care and transition experience. Ultimately we're here to make sure that service members get what they need when they need it. And we are a relatively new office, having been stood up in 2008. I've served, as the General said, since July 2010, and report to Dr. Clifford Stanley, Secretary of Defense for Personnel Readiness.

The Office develops policy and conducts oversight of three programs, which I'm happy to read you through. This is the organizational chart, which I think most of you have seen already maybe. The only addition is the fact

that the Strategic Oversight Committee and the Executive Council operations are now run by Joe Materia, now report to us.

But these are the three programs over which we have primary responsibility. The Transition Policy is really meant to improve the transition experience for our service members and their families. We do that in collaboration with DoD and the Department of Labor and Veterans Administration, connects -- which connects service members and their families leaving active duty through pre-separation counseling, benefits briefings, employment assistance workshops, individual career coaching.

As part of the IDES, that is meant to provide faster, fairer, more equitable treatment for our service men and women through a single set of medical exams under VA protocols and also closes the benefits gap, which was clearly a problem with the legacy IDES.

Next is the Recovery Care Coordination Program, which is one where we provide recovery care coordinators, 146 of them through 67 locations across the U.S. and in Germany. Those coordinators are highly and jointly trained by DoD and in service wounded warrior programs. They are assigned and supervised by the programs.

We work on the comprehensive recovery plan with them, and the clans (phonetic) of the different bases are responsible for implementing those plans.

And finally, strategy and outreach. It is a program that we have where we have a number of different web portals, natural resource, directly working with the VA on that, as well as e-benefits, TurboTap, and warriorcare.mil, all programs for transitioning service members and for wounded warriors to give them the information that they need.

We also have proved the outreach and communication to service members, families, and other stakeholders, as well as media monitoring and analytics.

That's just a general overview. My colleagues will take you through it in more detail, exactly what it is that they do to improve the lives of service members and their families. And I'll start with Special Assistant Koby Langley.

MR. LANGLEY: Thank you, sir.

As Mr. Campbell mentioned, the mission for the Office -- the current strategic mission is ensure equitable, consistent, high quality support and services for wounded warriors and their families. The Office does

this through effective outreach and interagency collaboration policy and program oversight.

The Office effectively has three overarching goals. It's easiest to bucket them into three. The overarching goal is to become all things to the wounded warrior so that if there is an issue related to wounded warriors, the Secretary of Defense, the Deputy Secretary of Defense, and Dr. Clifford Stanley can actually reach out and touch this office to get answers to some of those questions.

Now, this is matrix support. We obviously don't have complete control over all of the wounded warriors programs across the Federal government, but this is an effort to become the central point of contact within the Department of Defense for all things to wounded warriors.

The things that we do specifically are to improve care and services for our transitioning service members. We also improve the transitioning experience for our service members. And lastly, we connect people to resources through effective communications and resources.

What you see in front of you is a list of our current strategic priorities and initiatives for the office. These are near term initiatives and near term

strategies to make sure that we become all things to wounded warriors.

I'm not going to talk about all of these strategic initiatives, but I will highlight a few of them to give you an example of what this office is currently doing and what it hopes to do into the future.

The first one under improving transition experience for all service members. The Transition Assistance Program is, as most people already know, approximately 20 years old. It's currently undergoing a significant redesign with the Departments of Labor and Departments of Veterans Affairs.

Specifically, we hope to transform the Transition Assistance Program into a program that is a military life cycle event. In other words, you're not receiving information about your benefits and services that you may need or may need to help plan for your transition upon transition, upon the receipt of your ---214, or 90 days before that, or a year before that. Instead, those benefits and services should be available to our service members prior to that time and through their entire military life cycle. That's what we hope to do.

In addition, we're looking to deliver the

Transition Assistance Program information in a more consistent fashion for the current demographic of service members. Specifically, we're looking to move out of bricks and mortars delivery systems and move into a blended delivery technique. And when I say blended delivery, I'm talking about not only the classroom environment, but also the online environment. We can do that through delivery of virtual online experience and counseling services, and we could also provide the information to service members in an online platform and deliver it to them when they need it and how they need it.

Improving care and services to our wounded warriors and their families. We do a lot in this area, but I do want to highlight one thing in particular. We're currently working on developing a warrior athletic reconditioning program. As many of you, currently in Colorado Springs, Colorado, the war games are occurring with the U.S. Olympic Committee. The department -- excuse me -- the Office of Wounded Warriors Care and Transition Policy provided important resources to the pre-training regimen of those service members. Specifically, we provided them with equipment and resources to assist them in their competition.

We hope to expand this partnership and look more specifically at innovative technique and ways to engage transitioning service members and wounded warriors, more specifically, in -- by providing them additional support through athletic reconditioning and other types of services.

Effectively connecting people to resources means effective communications. We understand that we have a long way to go in this, but we do have an obligation and responsibility to ensure that we're effectively communicating the resources and the benefits and the services of the Department to our transitioning service members and to our wounded warriors.

These are our three primary goals, and these are our initiatives. The following briefings will talk in a little bit more detail about our programs, and you'll see that each one of our programs and initiatives are aligned with each one of our program offices.

Specifically, I do want to spend some time talking to you about how we effectively connect people to resources and how we hope to improve that process.

If you can envision the service member and all the different ways that we can touch the service member.

Some of the more innovative ways that we're hoping to reach the service member are through new media outreach. So, for instance, in the past eight to 12 months, we have filmed a suite of new media outreach activities. We now have a blog, which was once a one-page 2008, non-static website. It's now an interactive page of conversation between wounded warriors, stakeholders, and service members about our services and benefits.

We're also now on Twitter. You can follow John Campbell -- Mr. Campbell here -- as well as our office on Twitter. And we have approximately 170 followers, and this was fielded in the last three months.

We also have a Flickr account. We also have two Facebook pages. The first Facebook page is brand new, warriorcare.mil. The second Facebook page is the Transition Assistance Program Facebook page. That Facebook has approximately 4,000 users, and it averages approximately 15,000 user sites per month -- user hits per month.

As most of the panel members understand, NDA 2008 directed that the Office stand up the Wounded Warrior Resource Center hotline. That 1-800 hotline is a collaborative partnership between our office and the

Department of Military Care -- excuse me -- Military and Community Family Policy.

That particular hotline fielded approximately 3,000 calls last year. Those calls are transferred directly to the wounded warrior commands, the respective wounded warrior commands and respective wounded warrior programs within the Department of Defense.

We fielded approximately 10,000 outbound calls. What that means is that once a case was referred to the 1-800 Center, approximately 10,000 calls went to resolve some of those issues. More specifically, there were 2,000 cases that were opened and closed last year through this call center. The primary issues that were discussed and addressed in the call center were healthcare, military benefits, and VA benefits,. Respectively.

I'm going to talk about the National Resource Directory last, but we also all obviously have a VA and DoD benefit site, ebenefits.va.gov. That benefit site is a part of the overarching objective to create seamless transition between the Department of Defense and the Department of Veterans Affairs. More specifically, your Veterans Affairs benefits and services that you may be entitled to as a transition service member, you can now

access online through e-benefits.va.gov.

The Department of Defense has made that site 100 percent accessible to all service members, all transitioning service members. And you can online and you can find out what services you may or may not be entitled to under the Department of Veterans Affairs. This is a new initiative. We hope to make that site a little bit more duty centric and VA-centric, and more serviceable for service members. I will say that that average -- the current average usership of that site is approximately 100,000 per month visit www.ebenefits.va.gov.

I spoke a little bit about TurboTap -- TurboTap.org. I'm not going to spend a lot of time talking about TurboTap.org because Mr. Stevens will speak extensively about where that's going. But that particular website provides valuable resources about the transition assistance benefits for transitioning service members.

GENERAL GREEN: I count six or seven websites on the page. Are they all interlinked? Can you get from one to the other by going to one and finding all the rest?

MR. LANGLEY: Yes, you can, and you can do it in a variety of different ways. So, for instance, if you went to warriorcare.mil, which is our central blog -- the

average is approximately 15,000 hits per month -- you'll find our link to ebenefits.va.gov. You'll find a link to nrd.gov, and you'll find a link to turbotap.org.

MASTER SERGEANT MACKENZIE: A couple of questions for you, sir. First of all, when you started talking about all these outreach and support and outreach programs, the first part of your sentence was you're doing all this hoping to reach these guys. Do you have any effective plan in place to validate how much of the wounded, ill, and injured population you're actually reaching?

MR. LANGLEY: Sure. So, through new media outreach and analytics, you can actually engage the number of service members that are actually visiting the sites. More specifically, the principle mechanism that we are using is the National Resource Directory. And I can tell you today that there are 16,000 users -- registered users for the National Resource Directory, and that resource directory was stood up to provide information and services, both Federal, local, and state for recovering service members.

Now, that number of usership has actually increased. It's actually doubled in the past year. And we will continue to do effective outreach to advertise the

National Resource Directory with the Department of Veterans Affairs to make sure we reach as many wounded warriors as possible.

DR. TURNER: Mr. Langley?

MR. LANGLEY: Yes, sir.

DR. TURNER: While we're talking about your measures of success, that sounds good for the effectively connect people to resources. What measures of success, or, if you're going to cover them -- I'm sure you'll get to it -- the improved transition experience and improved care in services, do you have measures of success metrics in place for those as well?

MR. LANGLEY: We do, and so each one of those strategic initiatives is or will be mapped to a very specific performance plan. These are all initiatives for this year going forward, and, more specifically as it relates to transition assistance, Mr. Stevens can speak to those.

MASTER SERGEANT MACKENZIE: The one more question I had along the same lines of the first question I asked you, the -- you know, when you talk about, you know, ebenefits.gov, you know, you got 100,000 hits. Well, how many of those are actually wounded warriors, you know?

You've got 170 followers on Twitter. How many of those are actually wounded warriors? I mean, has there -- have you put in place a way to identify that you're not getting gee whiz people just checking this out, and you're actually getting to the wounded, ill, and injured population?

MR. BURDETTE: I'm Phil Burdette; you'll meet me in a minute. This is a central issue that we have struggled with a little bit. Let me give you the two schools of thought in how we're approaching it.

If you follow the Apple experience recently with the iPhones, people in America get very upset if you suddenly are surreptitiously tracking them, so to speak, of where they are or what they're doing. So, we have a careful balance here as to who is hitting the websites. I'm relatively new to the program. One of my first worries is, frankly, that I had contractors that were hitting N, N, N, N, left and right to make sure that my numbers were trending in a direction that they would like to see to further support websites. So, I ask the same questions you do, and we've all asked those questions.

The balance we're trying to find is to not be invasive towards the service members and not do this ease loothing (phonetic), if you will, to figure out who's

hitting the websites where it's overly heavy handed, but also to get a good idea of who the customer base is.

And here are some approaches we've taken. If the call center -- when they call into the call center, we have very good diagnostics on that, an excellent diagnostic. And where we can and advertise to the people hitting it, hey, will you tell us more about yourself, we do, but we don't want to be too heavy handed about that.

A good lesson we've learned is with McFamily, Marine Community Families, their suicide lines. When they put in you had to stay (phonetic), you start fitting in some discriminating factors about yourself -- I'm an active duty Marine, I'm 27 years old -- they found everybody was clicking off almost immediately and not connecting to those resources. Probably two-fold there. A, they don't want to give up a lot of information about themselves. B, they just want to get info, want to sort of remain anonymous.

So, that's the struggle we have. We have the same types of questions you are, so I guess I would sum it up by saying where we can learn about our populations, we absolutely are. But we're also keeping some intentional distance between who's clicking on them so that that person can remain anonymous as they hit the site.

MASTER SERGEANT MACKENZIE: And that's as a wounded warrior. Okay. I got no problem telling -- you know, logging into something as a wounded warrior if I have an identifier, you know. It's not to keep other people out or from going and looking at these things and providing, you know, constructive benefits. It's all make us better by getting people who aren't involved in it. But as a wounded warrior, it's good to know that the stuff -- the resources I'm looking for, the people that are trying to take care of me and write policy on me, are writing policy based on wounded warrior, not -- you know, and things are being supported because we're supporting a wounded warrior, not just the general population of contractors, or inquisitive people, or that kind of stuff. Do you see what I'm saying?

So, if it's -- I guess what I'm getting at is if it's effective for the wounded warrior to gather that information, that would be more important than effective for people to access the site in general.

MR. BURDETTE: It is I think, and that can be big enough to do both for them. And while you don't have any problem, you know, saying, hey, I'm a wounded warrior, there's a lot of people, especially with the non-visible

injuries, that are very hesitant to say, hey, I might be having some PTS, or, I might be having TB, I'm not sure. So, if you set up any artificial walls or even try to learn demographics about who's visiting your site so you can tailor it better, you find them clicking off and not going through it on the site.

So, it's a balance. We're trying to get it right. We'll continue to do the best we can with it. But your point is well taken.

MS. CROCKETT-JONES: I have a question for you. Can I just ask, is there someone in the structure for the average service member in a transition unit, cadre, nurse case manager, SVAC, someone that you think -- consider to be the specific dissemination point for these websites and this information to connect people to them, or are you relying on their networking abilities to find them?

MR. LANGLEY: So, we're still actually developing that strategy -- that best outreach strategy. The majority of these tools have just been launched within the past year.

I will say there are two schools of thought, just like Mr. Burdette mentioned earlier. One is to disaggregate the information or to free the data. So, we

had a really interesting session with several very high profile new media folks that do this for a living. And they suggested, for instance, that we look at ways to disaggregate the information within the social networking community as opposed to centralize the database. So, that's one way. Another way is to drive everybody to one central database or one central site.

So, there are multiple ways to reach our audiences. I don't think that you can necessarily choose one or the other. In terms of where the information comes from, the information, the authoritative information, should always come from the departments. And to the extent that we can control that information and disaggregate it as necessary, we do do that.

So, a perfect example is the National Resource Directory. So, the National Resource Directory, for example, actually doesn't host any particular information on a server, so to speak. But what it does do is it connects those users directly to the resources. So, it's a portal of sorts. That's one example.

If you look at the Facebooking community, for instance, a lot of the information that's provided there on our turbotap.org Facebook page or on our warriorcare.mil

Facebook page also doesn't own the information. But we connect the users to the information that they might need.

So, we're continuing to evolve that strategy. We're going to make it better. I will tell you that my personal belief is that you can never own a particular space in this new media environment. You need to disaggregate information and you need to push the information directly where service members are receiving it and how they're receiving it.

MR. DRACH: Koby, excuse me. On your previous slide, or actually the first or second slide, you have three things that I want to ask. What's the difference between the virtual online TAP pilot and TurboTap? In looking at your redesign of TAP, are you looking at the ACAP report from West Point that they did? And your Peer to Employment and Education pilot, is that in collaboration at all with the APO of the armed forces?

MR. LANGLEY: So, Mr. Drach, I'm going to allow the program officers to talk directly about their strategic initiatives, if that's okay.

MR. DRACH: Great. Thank you.

MR. CONSTANTINE: I've got a couple questions for you on some of these programs you have up here. For

instance, Assist the Military Spouse Employment Program, is that just for wounded warriors who are still on active duty, or is that for those who separated as well? And what do you do for them?

MR. LANGLEY: So, MSEP is a good example of one of those programs, and that's an education program for spouses of service members.

The partnership that we have with military community family policy is an important one. We see ourselves as an amplifier of their central mission, which is to make sure that family members of service members and family members of transitioning service members receive the information that they need.

What are doing specifically to connect wounded warrior families to resources? So, there's two things that come to mind. First is a transition assistance program, and I'm going to let Mr. Stevens speak a little bit more about that. But most f people -- I shouldn't say most people don't realize, but a lot of people probably don't realize that the Transition Assistance Program is fully accessible and fully available to all transition service members' spouses.

Another thing that comes to mind in terms of how

we're assisting military spouses is the current ongoing efforts that we have to make all of our benefits and services, where applicable, allowable and open for military service members. So, transition assistance is a great example. All of those benefits are available to them. MSEP, which is an employment program for military spouses are also available to wounded warrior spouses. And there are other several other initiatives that military community family policy has for military families.

MR. CONSTANTINE: Do you really have spouses who are going through TAP?

MR. LANGLEY: Yes, we actually do have spouses that are going through TAP. And I really don't want to steal Mr. Stevens' --

MR. CONSTANTINE: Yes.

MR. LANGLEY: -- but I assure you that he'll come back and talk about how spouses use the TAP program.

MR. CONSTANTINE: And also, on there you have GOG veterans homeless policy. What role -- I mean, obviously it's a huge priority to Secretary Shinseki of the VA. But what does your office have to do with that?

MR. LANGLEY: Sure. So, the actual Interagency Council on Homelessness is a multi-department council that

involves at least 12 Federal departments. We're part of that process as well. One thing that we're specifically doing in that arena is ensuring that when BRAC sites are BRAC'd that service members have available resources to them to make sure that their new home situation is adequate, and if not adequate, it can actually be supplemented and augmented through various different programs and subsidies by the Department of Defense. That's one very specific thing that we do for -- to make sure that we're addressing homelessness.

The homelessness strategy has not published yet for this year, and we hope to look at other ways that we can assist transitioning service members to ensure that they don't -- that they do not fall into the category of most at risk for homelessness. Some of those initiatives may ultimately reside in the Transition Assistance Program. I would say probably the bulk of them will probably reside with our employment initiatives, and Mr. Bob Carrington can talk about some of those employment initiatives. If you have a job, you're not going to be homeless.

MR. CONSTANTINE: Thank you.

MS. CROCKETT-JONES: Can I try one more time on my question? In general, service members who are in

transition units receive information and guidance through a few specific people, through their cadre or their non-medical case management, through their medical case management, usually a nurse case manager, or sometimes they receive information through the SVAC centers.

As you're developing these programs and connections and websites, which one of these would you say is most likely -- what you envision for the connection to guide your -- the service member to these websites, or are you relying on that aggregate, you know, existence out on the web to filter down to them sort of organically?

Because in general, our experience as we go around to installations is that there is usually a person that a service member turns to for information, or a place like the SVAC. Sometimes in a few cases, it's been like a document, like the -- keeping it all together.

But is there -- of those roles, which are integral to the WTs, who would be the person that you think is most suitable to disseminate the information from your office to the service member?

MR. LANGLEY: Sure. So, I apologize that I didn't understand your question the first time. I would say clearly the recovery care coordinator and the recovery

team. That would be the -- that would be the resource that I would hope would connect a recovering service member to these resources when it's appropriate for them to -- not when it's appropriate, but when they're in the place in their recovery to receive this information and to utilize it in an effective way.

MR. BURDETTE: And let me add that it's a push/pull. I think it's how do we -- do we push information or do service members and their families pull it? I think you can't put all your eggs in that basket. That's the great answer. But we've got to have a really wide net on this. It's got to be the recovery team. It has to be the squad leader. You visit a warrior transition unit, you ask them, how do you learn how to get help? My squad leader. If that squad leader is not equipped and doesn't know -- and to the general's point, if I have seven websites, one of my big goals here, we got to map to one website.

For me, the jewel is the NRD, which Koby is going to talk about here in a minute. But we've got a jewel website that connects to everything else, one, maybe two places, and everybody who touches a wounded warrior or a member in transition or their family has to know, we will

start up the NRD and we can branch from there.

DR. GUICE: So, I think the fundamental question is, what's your marketing strategy to reach your targeted audience?

MR. LANGLEY: Sure. So, the marketing strategy is evolving, but I will say that ultimately it will touch them where they're most likely to receive the information. I see it, just like Mr. Burdette mentioned, in multiple different places. So, the first place would be with the recovery care coordinator. Another touch point would obviously be with the family member, so through other sites that the Department of Defense hosts that touch upon members. And, most importantly, in social networking sites. We know for a fact, for instance, that over 50 percent of the customers that we service receive their information on Facebook. So, if we're not there, they're not receiving the information.

DR. GUICE: So, a year from now when this task force asked you how effective you were with your marketing strategy, you will be able to tell us how the information got disseminated, and the resulting uptick in users from your various websites as a result of your strategy.

MR. LANGLEY: Absolutely, yes, ma'am.

So, I really do want to get to the National Resource Directory, and I know I'll have to go through it quickly.

DR. PHILLIPS: Just one question and you may answer it as you go along.

To step back even further, what processes do you use to develop your strategies and programs? Is it historical information? Are you getting direct feedback from the community you serve, surveys, all of the above, or some things.

MR. LANGLEY: That's a great segue into the National Resource Directory. So, we're going to take a slide turn and I'm going to take you through an example of how we do that. Next slide, please.

Okay. So, the National Resource Directory, and to answer your specific question, the National Resource Directory conducted a usability study most recently. And the usability study was a survey of actual users, of actual wounded warriors and their family members, and they were asked to go through the site and given very specific instructions and questions about how effectively they were able to navigate the site, how effectively they were able to actually receive the information that they needed at the

site. That's one example of one of the ways that we make sure that the tools that we use are effective and the strategies that we use are effective.

A lot of changes came about the site because of that usability study. One most recent one that I thought was extraordinary was the inability of transitioning service members to look at the National Resource Directory on their iPhones or on their Droid or on their smart phone, whatever that may be.

So, we got a great team and put some smart heads together and created a mobile version of the website. And that one change, that one small change, by using customer feedback from wounded warriors turned the usage rate from approximately 40,000 or so per month to 100,000 per month as of last month. And that was approximately about a month or so process. That's just one example of some of the things that we do. And we'll continue to conduct, you know, effective customer feedback and outreach to improve our programs and processes.

I do want to talk a little bit about the National Resource Directory. The National Resource Directory has approximately 15,00 resources on it, and when I say resources, we're talking about governmental, state, and

local, and Federal -- both Federal, state, and local, and non-for-profit resources that are on the directory that provide a number of different resources for service members in the major categories that you would imagine, things like education, things like housing, things like employment.

The current registration of the National Resource Directory, you can actually go on to the National Resource Directory, log on and register yourself on it, and you'll receive regular updates about new resources. That usership is approximately 14,000 users -- or excuse me, 16,000 subscribers -- 16,000 subscribers as of this year.

One of the strategic initiatives, and you asked, sir, about our strategic goals, for last year it was to improve the usership of the National Resource Directory by 35 percent. We're at 110 percent of that goal right now.

A couple of other statistics. The National Resource Directory to date has provided approximately 225,000 usages of the state, and it sounds a little -- just hang on with me here. So, for instance, if you are a governmental official in the state or if you're just a regular blogger in the social network, and you want to know what resources are on the National Resource Directory in your local communities or in your state, well, our great

web development team put together a very simple, one click process where you can go on to the site, you can click it, type in your information, say what state you want to get information from. And then export that small, I would call it a mini website, into your page.

So, for instance, if you're a Federal official, we recently into and did an outreach campaign on Congress and asked members of Congress to take that information, plant it into their page so that local government officials can actually use this information for their constituencies. So, that's just one example -- multiple different examples.

We're really running out of time. I will say that right now our monthly usership is approximately at 100,000 per month; that's doubled in the past six months.

MASTER SERGEANT MACKENZIE: One thing, just food for thought as you look at your effectiveness and how you're doing this.

MR. LANGLEY: Yes, sir.

MASTER SERGEANT MACKENZIE: Many of the site visits that we've done to different facilities around the country talking to specific focus groups had no idea what the National Resource Directory was. So, as you push these numbers in your number of people that are logged in and

checking out this site, take a look at how this is being trained and disseminated to the wounded warriors because we're not finding -- from wounded warriors and their families and their caregivers, we're not finding an effective connection between them and your website.

MR. LANGLEY: Thank you, sir. We hope to improve it in the future.

MR. BURDETTE: I really can't wait for that question next year because I know that the response is going to be different. And I know that as well as a neophyte to the program.

My name is Phillip Burdette, and I serve as Secretary Campbell's principal deputy. And I can tell you, I absolutely echo what you say, because I open and close every town hall with, have you heard of these things that we're investing in? And as I talk about our programs and budget section here, I want to really emphasize to you that we are connecting priorities from Secretary Campbell and under Secretary of Defense Stanley with our resources and our people and our dollars behind it. And then we've got metrics of the effectiveness of the tail end of that to make sure that those investments were smart, make sure they're in the right areas, and that they're serving our

wounded warriors and our communities.

We talked about marketing strategy a little bit, too. I promise you the NRD will be the jewel and that central point, and that NRD is going to be much more well known in the year ahead, both from a marketing strategy and a usage point. But 90,000 hits a month, you just can't argue with that, but I want more hands to go up in the town halls when I'm out there, too.

I don't have the loan portfolio to speak with you a little bit today about. I do want to emphasize a couple of things that we do programmatically and strategically.

I joined this team after coming in and helping to stand up the Department of Homeland Security in 2003 and the Transportation Security Administration in 2002. I mention that because I think it's an important point of emphasis. I see many parallels here between an agency or an outfit that was stood up in the wake of such an emotional and tragic situation as the Walter Reed episode of 2007. The passion and the spirit of the people that lead these programs and work day in and day out to make them realities, I find unparalleled. And it's wonderful to bring the lessons I learned there to this outfit and to help drive Secretary Campbell's vision. A couple of them

that I'll speak to at a high level.

You've got to match your resources with your priorities. You've got to organize correctly. You've got to be adaptable and change. And those are all traits that I see us reflecting in day and day out.

Our org chart is good. It is also responsive. A couple of things that we'll talk about on the budget line here are the Strategic Oversight Council and the Joint Executive Council, which have just come in house, which is just an organizational change that had to happen. Dr. Stanley recognized that, and on recommendation of Secretary Campbell, made that move. So, they are back in house. I think that's a wonderful addition to our team. It lets us focus primarily on the important lines of action that those bodies undertake and make sure that they're driving real results for wounded warriors.

I showed both budgets in the slide back here just to show you where we invest the money. And as the metrics and measures of effectiveness are spoken to by the program directors, who I'll hand the microphone to in a moment, those are good questions. Those are things we ask week in and week out. Are our priorities lined up with our investments, lined up with our results? And where they're

not, we turn the ship and we reinvest in other things.

Mr. Langley has a tough portfolio in new media. Where do we invest next? Where do we go to next? Is Flickr still a good investment? Are our tweets working? One of the measures that we used, Mr. Campbell recently returned from 10 days in Afghanistan. Watching his Twitter membership climb and the people watching him on the web, seeing him tweet from inside theater, was remarkable. And you know that has an impact on the community. When we saw that, we recognized that's a great investment; we need to stay with that. So, that's how we utilize and track and make sure that those are good investments.

Our request in '11 was \$79, \$81 in '12. We actually executed a little bit smaller than that. I'll point to a couple of big pieces of the pie. Am happy to take your questions at any point on it.

The Transition Assistance Program, which Mr. Stevens will speak to, gets a lion share of that money. So, we hand that to the serves and then they execute. The measures of effectiveness in that and the campaign plan for that that he'll speak to we're excited about. Next year's appearance at this table, we're going to have some great data on how that has really improved. A terrific

collaboration between labor, between the VA, and between the DoD. That's great stuff as far as that goes.

I'm going to save us some time and go to the next slide for the 2012 budget. And then we'll move to slide 13 on metrics.

I included a couple of the high level metrics here to show you in the telephone books of data that reports that roll out of the Pentagon and onto Capitol Hill and other places. These are some of the metrics that we track. I included here for your perusal and consideration just to say that these are things that we're held accountable for. These are things that we report to Undersecretary Stanley on.

They are high level. They are evolving, and it's my intent to add more to this sheet, not to delete, and then to manage it at the local level with aggressive metrics that include meeting our timeliness goals and IDES, that include meeting our enrollment goals and IDES, and then also with the recovery care coordination program.

I think I'm going to stop there pending any of your questions, and hand it over to Mr. Stevens so that we can spend the lion share of our remaining time talking about programs that deliver for wounded warriors.

MR. CONSTANTINE: I got a quick question for you. It sounds like you allocate a lot of your resources to the new media. Do you have people to (inaudible) full time?

MR. BURDETTE: We do, and I think not enough. If you look at the chart, it's like \$1.8 million for both years, and on an \$80 million budget, that's not enough. And when you take a business approach to it, if I've got 90,000 or 100,00 people searching for resources on the web, and I think my slice of the pie is too small on that frankly.

We do have a team. They're super talented. They're in the room with us today. Karen helps lead that team. They're available 24/7. We were e-mailing last about updates to the site until 11:30. They care. They're passionate. I think we need to invest more in it.

MR. CONSTANTINE: I agree. Certainly what's going on now and including the future. What we've seen across the board from the service level on down of real deficit in that field. Do you support individual services having a more robust budget for that kind of stuff as well?

MR. BUDGET: I think it's a team approach. Historically the money in this \$40 million or that we passed through those services has just been a hand off.

Here you go, how's it going? We have active relationships with the program managers that run TAP. We need to have a stronger relationship with them. Where are you supplementing? What are your measures of effectiveness? What are you delivering as an Army that the Marine Corps could learn from and lean into?

The testimony this morning, I was surprised that Deputy Secretary Gould and Deputy Secretary Lynn weren't asked more about TAP. They are in sync on let's deliver a refined, better program.

The TAP, I was startled when Secretary Campbell and I started working together that his TAP experience coming out of Vietnam and mine coming out of the Desert Storm is the same as the service members that we meet on the road when we meet them. That can't happen. And the strategic plan, and Mr. Steven will talk about it, speaks to the new client and new customers that we're dealing with. They're new media. They're savvy. They want to learn before deployment what's the end of the deployment hold for me when I get out and go back to Peoria, or Des Moines, or San Diego.

The virtual TAP which delivers electronically, the lifetime delivery of that I think is a step that we have to take, and it's a step in the right direction.

MR. CONSTANTINE: Thank you.

MR. BURDETTE: You bet. Thanks. I look forward to your questions throughout. Mr. Stevens will take it from here.

MR. STEVENS: Next slide, please. I'm Brett Stevens, the Director of Transition Policy for the Office of Wounded Care and Transition Policy. And I'm going to go through the history of the Transition Assistance Program and some of the things we're doing to enhance this opportunity for our transitioning service members.

The Transition Assistance Program was basically congressionally mandated about 1991, and resulted from the need to basically provide separating service members pre-separation information concerning benefits and some direct employment assistance as they transition from military service.

The two DoD directives that were borne from the legal requirement to start the program are noted on the slide. Those documents are dated 1993 and 1995, and that's why we've taken a pretty strict -- pretty strong measure to

enhance what we're doing, and I'll talk about that throughout this particular presentation.

As Mr. Campbell said and Mr. Burdette alluded to, we've got some initiatives under way to strengthen TAP and reinforce its relevancy to the audience that we are here to serve.

Service members should have, and we're providing them with, knowledge, skills, and abilities to empower them to make informed decisions, and to be more positive contributors to their civilian community as they transition back from active service.

One important thing to note is the TAP program was designed to provide that information to assist the service members in their transition and point them to resources relative to that transition effort. Next slide, please.

You may already know that there are four principal components of the Transition Assistance Program, the first being mandatory, that everyone transitioning from military service will undergo pre-separation counseling. And this is about a two -- two and a half, three hour effort of one-on-one where the individual service member gets a wealth of information about the various resources,

and also information that affects their transition, such as information about financial counseling, information about participation in the following workshops -- VA benefit briefings, disabled transition assistance program, or any other thing that would be impactful for them.

They're also encouraged to undergo or to start an individualized transition plan. Based on the questionnaires of the survey, a checklist that the individual is briefed on, and the checklist -- out processing checklist that the individual goes through has a number of things in terms of licensing and certification, apprenticeships.

We point them to such things as troop to teachers or teachers' aide opportunity. We talk to them about Federal employment opportunities. We talk to them about state employment agencies that they can go to in terms of receiving additional assistance. We talk to them about education and training and, in addition, about what some of their future benefits would be when they transition to the Department of Veterans Affairs.

In addition to, as I stated, pointing them towards enrollment and participation in the voluntary components of the Transition Assistance Program. The first

I'll speak to is the DOL TAP employment workshop, and this is a two and a half day workshop done by the Department of Labor. And this is to specifically provide employment assistance where they start to develop resumes, they're working on job searches and interviewing skills. And also, this particular time, they're learning about how to either further refine the translating of their military service into civilian occupations. There's a number of key tools that the individual service members are afforded to that help them in that particular transition process.

The next is the VA benefits briefing. Again, it's voluntary. It's a four-hour briefing. Yes, sir, I'm sorry.

MASTER SERGEANT MACKENZIE: Can I just ask you a question real quick? Two things actually. First of all is, what is the reason behind the disparity and the amount of time invested in the service member, whether they're active duty or guard and reserve? And, number two, under the current climate where a lot of our guard and reservists are completing years of active duty service, why is it they're not able to get the same benefit as the active duty service members?

MR. STEVENS: Let me answer your first question in terms of the difference. And you look at the slide, on the right hand side of the slide it shows where the demobilizing and deactivating reserve or guardsman, they get about a four-hour composite of the pre-separation counseling, the employment workshop, and the VA benefits briefing. This particular briefing for them is done at demobilization where they have a total of about five days, maybe seven days, as they're demobilized coming in from theater. This is the time frame we're TAP is delivered.

Now, we do have follow-on support with regards to their access to information and resources. The question being asked right now actually is, can you extend their demobilization time when they come out of theater past that five days, and what is the cost of that in terms of not just dollars, but just how would that then be delivered? That's what we're looking at now with regards to, is that something that we can approach the reserve components to undertake.

Your second question, again, I'm sorry?

MASTER SERGEANT MACKENZIE: The second question is, is the difference now in this current environment where some of our guard and reservists are serving for five, six

years, you know. They're just like an active duty service member in the fact that they don't have a job to go back to, you know. They have nothing in their community. They're just like an active duty guy trying to transition out, but yet they're still categorized in the same way as if they've done a six-month rotation and they're just going back to their normal job.

MR. STEVENS: And that's another thing that we've been looking at with regards to the reserve component on how we can effectively provide that transitioning experience for those specific types of individuals.

Unlike the person who mobilizes of 180 days, may have been employed previously, and now is going back to employ, we do have a number of our guard and reserve members who have long-time service, and like an active duty member, should have that same access to the transition process. So, it's working with the guard and reserve component to set those -- to get those things in place so that they are able to take advantage of those type of opportunities.

MS. DAILEY: Master Sergeant MacKenzie, if they've been serving as an AGR or they've deployed and come back and they're part of an installation, they're getting

full Transition Assistance Program benefits. They can roll into the TAP program. They can roll into the DoL today. So, that's not -- they're taken care of if they've been on duty that long.

MR. STEVENS: I took your question as those individuals who may have had a long affiliation with active duty, but not a continuous affiliation, someone who may have been on orders for a year, come off a little bit, and then go back on orders for quite a bit of time.

MASTER SERGEANT MACKENZIE: That is the direction I was looking at because we do have a lot of guys that, you know, are not necessarily at the same duty station for that number of years, you know, multiple sets of orders or back to back sets of orders, not a continuous set of orders. That was the question, because it seems -- I was familiar with what you said, Denise, and that when you're on the same installation, it's -- you're treated just like an active duty person. But it's interaction with a lot of guys that do -- do a set of orders for a year, and then they come back on another set of orders at a different location, et cetera, et cetera. And you did address that.

MR. STEVENS: But as long as they're on continuous orders, Denise right. They will be able to go

through the transition process as an active duty member would. Yes, sir?

COMMAND SERGEANT MAJOR DEJONG: I think where the biggest change in the guard and reserve on this is if you have a soldier who's assigned to a warrior transition unit on an active duty post, they are treated like an active duty soldier with the amount of time invested into them.

I don't see the same on the CVWTUs to where they're just out processed from just a guard unit drilling while they're getting their care. The out processing time is not the same, but those soldiers still are in the position of not being able to go back to wherever employment they may have had prior to. So, that may be something that you want to look at putting into is that different transition. Do you have any further information on that?

MR. STEVENS: Looking at what the Department of Labor is doing, don't have the specifics, but there's some catchment that we believe we can make for those individuals as well, not just referring them to a disabled vet outreach program or to a leader in the state employment, so that they're picking up those types of resources there to include VA benefits.

But that is one thing we definitely need to take an aggressive on, ensuring those types of individuals and those community-based warrior transition units, or those people not at an installation have the same opportunity, or at least an enhanced opportunity, to have that experience. And that's why we're also enhancing our online capability with a virtually enhanced TAP and also enhancing the TurboTap website, also assist them as they transition.

DR. GUICE: Brett, I have a different question. With the high unemployment numbers for young veterans, how are you assuring that these courses are effective into providing them the resources that they need? Are you doing any look backs to see how many become employed after they leave these programs? Are you asking those departing members to feed that information back to you? I mean, we're all struggling with this, why is it so high and what can we do about it. You're providing -- well, DoL is providing these employment workshops. Are they effective?

MR. STEVENS: To answer your question, we don't have the exact -- we don't have exact knowledge of how effective the Transition Assistance Program is with regards to connecting someone with employment because we don't have currently a survey tool that follows them six months, nine

months, 12 months out. However, starting this November, we will have that in place through the Department of Labor.

They're revising their DoL workshop to where they will have follow-on coaching and counseling to include follow-up with service members at discreet points to include when they become employed so that they can make that connection to see how effective was that transition experience with regards to pushing or allowing that individual to seek employment.

Continuing with the presentation in terms of the next -- VA benefits briefing is another voluntary component, and this is a process to where the individuals in four hours get the information about VA benefits as they relate to their service-connected experience to include home loans, compensation through the disability process, any VA benefit that the individual would be entitled to based on their military service.

Finally, they have what's called the Disabled Transition Assistance Program. This program is specifically identifying those individuals who have or believe they have a service-connected disability at which they would get more in-depth information about VA disability benefits, and to have an opportunity to learn

about the Vocation, Rehabilitation, and Employment Program that they could take advantage of to assist them in rehabilitation towards a new occupation or occupational training towards a new career in civilian life.

Following these mandatory and voluntary opportunities, individuals also receive individualized coaching and counseling. And these are one-on-one sessions with the transition program manager to include a number of individual sessions, workshops, and clinics on a variety of topics that the individual has wanted more information. And the next slide I can tell you a little bit more about how effective those have been.

DR. GUIDE: Actually, Brett -- go ahead, Ron, and then I have a follow-up.

MR. DRACH: Just a question -- quick question. As you point out in your slide, all except the pre-sep counseling is voluntary. Senator Patty Murray introduced a bill last week. Have you been asked for your position and/or have you established a position on Senator Murray's bill?

MR. STEVENS: We actually went to the military departments last week to get their input in terms of the -- their opinion on respect to making the Transition

Assistance Program mandatory for all departing service members. I'll get to this specifically on my next slide.

But what we hope is to get their input and to provide a cogent response back to Congress with regards to our position or our opinion with regards to the elements of TAP as it is and what it would look like under a mandatory environment, and maybe to include where then it should be placed. And I'll talk about that in a couple of slides from now.

MR. DRACH: Excuse me. Can that be shared with us when it's official?

MR. STEVENS: We can do that.

COMMAND SERGEANT MAJOR DEJONG: One real quick difference, again, the guards side versus active duty side is -- the VA briefing on the active duty side, it is given by an veterans benefits administrator. On the guard and reserve side, you've got it as a veterans benefit administrator or a military service. And from what my experience has been with the military service giving it out is you've got that classic barracks lawyer that thinks he knows the system, thinks he knows the ins and outs, but really doesn't. And a lot of soldiers are getting confused, lost in the system, or just giving up on it all

together because they're not getting the correct information.

Looking into actually having veterans benefits administrators doing all of it may give the truth out to a lot of the soldiers on the guard and reserve side.

MR. STEVENS: And that's a good point. We'll take that to the military services, or actually the guard and reserve who are conducting the transition for their service members.

DR. GUICE: Could you tell us how many actually take advantage of the individualized coaching and if there's any feedback on how effective the individual transition plan was and developed through that process?

MR. STEVENS: I do have some statistics on the individual coaching. Going to, I guess, two slides ahead, ma'am, we do get into a little bit of data with regards to individualized -- okay, we're already at that slide.

When we're looking at the individual coaching and counseling, the very bottom of the left hand side, we've got about -- actually, if we look at the very top of the slide, we have 1.3 million demands for TAP-related services. And this includes individuals as they go through

the various pre-separation counseling. That's counted as we go through the various other voluntary experiences.

But then you get down to the bottom of the slide, ma'am, and that's where it's directed to your question. As we look at -- we've done another 475,000 demands for element of employment assistance. We've done another 11,000 additional workshops or seminars that 130,000 people participated in. We've had another number of 229,000 individual one-on-one coaching assistance. And the service member provide -- or the services providing the base level TAP provided about 221,000 hours of assistance in addition to putting down the pre-separation counseling.

And what this involves is individuals coming back for additional information or assistance for educational assistance, finance assistance, maybe to include some additional support with resume writing, follow-up for some of the other components of TAP that they had taken mandatorily or voluntarily where we re-engage with them.

And back to a question of how many spouses participated, we had about 14,000 spouses actually participating in components of the transition assistance process to the tune, I think, of like 2,500 actually got

job employment assistance with their own needs as their service members transitioning out.

We do encourage spouses to participate in the transition experience. What we're trying to do is gauge on how we can improve the number of spouses participating, along with the service member, because I said about 162,000 people actually went through components of the Transition Assistance Program on the active duty, and we only had about 13,900 spouses actually participate.

Yes, sir?

GENERAL HORST: Do you have any metrics as -- in terms of how this is manifested job productivity wise on the back side? Do you have a feedback mechanism that says out of all these folks that have gone through the program, X number have secured jobs? Any success metrics there?

MR. STEVENS: We don't have success metrics. And I said earlier that we will have those starting in the fall of this year through the Department of Labor. They're the primary agency that tracks job assistance. But we hope to have that in place when they release their new transition process for their workshop, because that will be part of that element in terms of a follow-up for this.

GENERAL HORST: I think that's an important step because you can go through the process, but if it doesn't yield any benefit on the end --

MR. STEVENS: Absolutely.

GENERAL HORST: And success begets success.

MR. STEVENS: And we're also looking at that in terms of the unemployment compensation rate from the military departments, and I think that's one of the big drivers and the overall unemployment rate with individual service members leaving military service.

GENERAL HORST: Okay, good. Thank you, sir.

MR. DRACH: First question, when in the process is the v-met (phonetic) actually -- when is the transitioning service member made aware of and given his or her v-met?

MR. STEVENS: That is done during the pre-separation counseling. That's one of the elements that the service member goes under. And for those of you who may not understand the v-met, it's the basically the verification of the employment -- excuse me, verification of skills and employment and training that all service members receive when they go through the transition process. Very critical document because this document

actually is a good source document for the service members to not just catalog their military training, their education, and skills. It also is a great document for them to use to verify these same skills to potential employers, as well as using this same document and possibility of having them apply for credentialing, certification, licensures should they have to validate what experiences they have.

So, this is a very key document. Each service members receives it, and they start that process when they do the pre-separation counseling.

MR. DRACH: Just a comment on the upcoming tracking system. As you see on the employment workshops, 128,000 attendees. The only people that will be able to be tracked through this new system are those that actually go to the state workforce agency and register. And as we're seeing, a lot of transitioning service members and veterans are not going to that system. They're getting their employment assistance somewhere else. So, if they don't register with that system, DoL will not be able to track them.

DR. GUICE: I have one follow-on question.

MR. STEVENS: Yes, ma'am.

DR. GUICE: Looking at the pie chart for the distribution of funds within the office, over 50 percent of it is TAP services. Can you tell us what parts of TAP are being purchased?

MR. STEVENS: The services that 50 percent provides is the salaries for the military departments to actually conduct the individual training for their TAP. It's distributed out, you know, proportionally to the military departments. But that 55 or 57 percent actually goes to the military departments to actually operate the program.

MR. CONSTANTINE: Brett, did you say that when a reserve unit comes back, they demobilize completely in five days?

MR. STEVENS: Well, the time it varies. Generally, it's like five days, four, maybe seven days for demobilization as they go through the process. Now, they don't just do transition assistance. They're doing a turning in of the weapons. They're doing some of the medical examinations. They're taking all those other military mission things that kicked them up to bring them down basically during that demobilization process. We are

a very small portion of the time that they're allotted during that demobilization or deactivation.

MR. CONSTANTINE: Yeah, I understand that. In my experience as a reservist is it's been more like two or three weeks because, again, it was a few years ago, but there was no way we would bring these Marines back from Iraq and let them go back out in five days. There was a certain cooling off period (inaudible) more.

You talked about moving TAP to a military life cycle process. Can you tell me what you've done so far to -- they're not waiting until the end of their career to find out about your services?

MR. STEVENS: Yes. And one of the things on this slide actually is the career decision tool kit. And we launched that in August of last year. And basically, this is an interactive online -- or actually there was a CD you can pop in your computer. Ability of the individual to receive basically transition assistance at their own pace at their own time.

This is an opportunity for introducing assessments, teaching and also a training tool designed, again, to assist the service member plan for transition. It asks questions that actually gauge the readiness or

understanding of the individual service member as they go through various components of this, i.e., financial preparation, career planning to include resume writing. The types of questions that this particular tool kit asks or similar to what would be conducted in the view and in the DoL workshop, but not to the depth that maybe at the DoL workshop

With this tool was designed to is to assist the guard and reserve members who wouldn't have that full component of the transition experience allowing them to take this weeks, months, before their deactivation and get a head start on their transition process.

We think this is a very dynamic tool. It's about -- we've distributed about 350,000 of these. We've distributed them even to the overseas environment in theater, so if there's some down time or as they're preparing to rotate out, pop in a CD and kind of look at what your transition needs are. It's great for the spouses as well. They also get a flavor of what types of things that they can look at and try to gauge as they're getting ready for the transition.

So, that's one of the initiatives that we've launched, and we're trying to make enhancements to that

career decision tool kit as we can to make it even more robust and interactive. Available at turbotap.org. You can just click on into it and just start -- and start the process.

MR. DRACH: Male Voice: Excuse me. Getting that and tying it back into the VMET, when they start accessing the career decision tool kit, is the VMET available on there? And, if not --

MR. STEVENS: You can access the VMET through TurboTap.

MR. DRACH: Okay.

MR. STEVENS: Through TurboTap.

MR. DRACH: The second part -- getting back to the VMET again -- it's provided, you said, at pre-sep counseling.

MR. STEVENS: Yes.

MR. DRACH: Have you considered or will you consider getting it to them some time earlier in the process, because when they're getting ready to be discharged and getting through that process, they've got a gazillion things on their mind. And if the VMET is not current, are they going to go back in and update it? Probably not. So, if they get it maybe six months early,

just to make sure that everything is on there -- all the criteria and all the stuff that they've taken.

MR. STEVENS: And that's a good point because generally what we're trying to do is hit the individual through transition, especially the pre-separation counseling, at least 90 days before they transition. Members have an opportunity two years prior to their retirement and a year prior to their separation to begin the transition process. So, as soon as they come to the transition counselor, we give them that opportunity for the VMET to be completed.

So, let me quickly to another area here, and that's the virtual learning opportunities that we also started --

GENERAL GREEN: Can I interrupt you?

MR. STEVENS: Yes, sir.

GENERAL GREEN: I just want to make certain, because this will probably be a follow-up issue for you folks next year. So, how long has TAP been active? I know I did, of course, almost seven years ago. So, how long have you been offering TAP services?

MR. STEVENS: Since 1993. Actually the legislation was passed in '91.

GENERAL GREEN: Okay. So, since '93, and basically you're spending now \$44, \$45 million a year if I see this correctly on this.

MR. STEVENS: And so, I'm assuming that there's been a growth to whatever you've spending each year. And the measure of effectiveness that you're giving us in terms of whether or not it's been effective is the Department of Labor survey that requires people to register with a state agency. The survey that the Department of Labor that you're talking about using as of December as your measure of effectiveness is actually something that requires registration with the state?

MR. STEVENS: We've had the other measurement was actually a goal in place, sir, that 85 percent of the individual service members would complete pre-separation counseling in the required time frame. But there's recently been a taking that we are starting to conduct those types of surveys and measures so that we can show the effectiveness of this program.

This started in about November 2009 when we had a specific offsite with the Department of Labor, military departments, and some other agencies, we collectively came to say how can we make sure this program is meeting the

needs or relevant for the individual service members? Part of that, sir, is metrics that are being developed and deployed so that we show the effectiveness of this particular process. And that's why the Department of Labor, Department of Veterans, and we also are undertaking enhancements to this particular process to include measures that we can say how are we doing.

GENERAL GREEN: Okay. I just want to point out that if you're going to use a survey that the Department of Labor is requiring -- that require state registration in order for you to use that survey, I would assume that your TAP course will incorporate that registration in some way.

MR. STEVENS: It will be discussed during their DoL workshop, yes, sir.

GENERAL GREEN: Okay. But you actually have 17-, 19-year history of offering these services without knowing whether they've been effective or not.

MR. STEVENS: Noted.

GENERAL GREEN: Okay.

MR. BURDETTE: And, General, I think it's well taken. This used to be housed in another places in OSD and it was also the Office of Secretary of Defense. It has come in house. We're asking the same kind of questions you

do. When Mr. Carrington speaks about another employment initiative, we grade on whether we got a job for that service member at the end. And you don't have to register with DoL or anybody else. We're going to track whether we intercepted you early in the process and got you a job. So, that's how we're going -- metrics on effectiveness on that.

For the first time, now under Mr. Campbell's leadership, now that we're writing the checks to the services for TAP, we're bringing them to the table and saying, what are you buying? What are best practices? Are you talking to the other services about what you're doing? What are you supplementing it with, because the \$40 million doesn't get you home in a lot of cases. And why are you supplementing it? Is it facilities? Is it trainers? Is it curriculum? So, those types of discussions are going to happen and the checks won't be written until we get better, I think, granularity on what we're buying.

GENERAL GREEN: And I just want to make certain that you understand that when we ask next year on the 21st anniversary of the program if the measure of merit is with the Department of Labor survey, I would hope that you'd

have people registering with the states to where we'd have some results with the Department of Labor survey.

MR. BURDETTE: I think that's a part of it.

GENERAL HORST: Isn't that a compelling argument then to make this mandatory rather than voluntary?

MR. BURDETTE: And I can tell you as we prepared the Deputy Secretary to testify this morning before the Senate, that was a discussion we had until late in the evening last night. And I can I think summarize in this forum the feeling is, let's build a great product first that meets the needs of our service members, and let's watch them flock to it. So, Secretary Gould on behalf of the VA has said, hey, mandatory. He's excited that VA has created a better product. Secretary Jefferson at Labor has created a great product. They want us to make it mandatory. We're thinking about that, and we're near the edge of that decision point. That's elevated to the highest levels in the Pentagon.

GENERAL HORST: Okay. I think if you're writing a check, you have the right and potentially the obligation to mandate it, not ask them to amend if they weren't mandated to mandate it.

MR. BURDETTE: You bet. I think, first of all, we have the right -- or the obligation to make sure it's a great product, to make sure that the check we write downstream, that we check up on and make sure it bought a quality product for some formals. If we're using a mandatory tool as a hammer, that's probably the last piece of the tool kit we need to take out. The best one was a great product, but then at the end of the day, we make sure that the service members think it's great. We think it's great. And mandatory is a part of that tool kit. I'm with you, General.

MR. STEVENS: Quickly going through the remaining portions, we do have that virtual learning opportunity, which is a webinar based opportunity that we've been offering since March. We've had about ,000 registrants. It's offered about three times a month where we go over various opportunities for them to get more experience with writing resumes, acing interviews, et cetera. So, we're getting some success with that.

The other is we've talked about a virtual enhanced TAP redesign of the TurboTap website, and that basically is we're now moving from a blended delivery of TAP, not just a brick and mortar classrooms, towards the

end of a military life cycle with the advancement of the tool kit, with the webinars that we're offering. We're also redesigning the content of our TurboTap website to make it more accessible, to make information more available during the military life cycle. That's the approach we're taking.

And as Mr. Campbell and Mr. Burdette alluded to earlier, we're trying to make TAP a military life cycle, not an end of career event. We're giving that opportunity earlier for individuals to draw from experience and to get those resources at a much earlier time.

We've talked about the VMET document in terms of where that plays and how that's used, and so I don't think I need to go any further with that.

Let me quickly transition into another program. Next slide, please.

GENERAL STONE: Before you do that --

MR. STEVENS: Yes, sir.

GENERAL STONE: -- I wonder if we could come back to the statement that we're going to decide success before we write the check. I wonder if you can share with us your success criteria that will give the organizations receiving those checks, whether they reach pass/fail.

MR. BURDETTE: I think the ultimate grade at the end, General, is to have a job. If you have a service member that leaves --

GENERAL STONE: So, do you have metrics by which you evaluate percentage of employment or success in employment, which you have shared with the recipients of this, that will allow you to decide whether to write that check or not?

MR. BURDETTE: Well, deciding whether I write the check, I'm not going to hold ransom over the money. These service members need a transition experience, and this buys real transition experiences for the people. What I want the services to realize is we have a collective obligation to deliver the best we can and hold ourselves accountable for how we spend the money.

GENERAL STONE: Okay. I agree with the holding accountable. I understand what you're saying. But I guess I'm asking you, do you have metrics that you've published that require them to live to a success goal?

MR. BURDETTE: I think collaboratively we need to establish those metrics.

GENERAL STONE: So, the answer is no?

MR. BURDETTE: The answer is today no.

GENERAL STONE: Okay, thank you.

MR. BURDETTE: You bet.

MR. CONSTANTINE: I have a quick question to follow there. It kind of offends me a little bit that you say you wouldn't wait for a great product before you do that because, guess what? We have service members who are getting killed every day. They're not waiting around. We have (inaudible) injured. They're not waiting around for this. So, what you're saying is we mandate (inaudible) to do all sorts of stuff. A lot of times because we think -- someone thinks it's good for them. But we're not going to do that here even though we have -- you yourself said that suicide is -- if you have a job, you don't commit suicide. So, we have suicides through the roof. We have unemployment through the roof. We have all these horrible things out there, and we're not going to mandate they go through probably the most beneficial programs that make up TAP.

And I don't understand why. The Marine Corps makes it mandatory in any of those services. But why? Why -- and you're in the transition policy. It's not the job of the Marine Corps or Army to think about these things.

That's part of the job -- that is your job. And so, why are we kicking this can down the road?

MR. CAMPBELL: Well, let me just say that we have heard this argument a number of times. There are members - - obviously in the Department of Defense who agree with you. We just have to push a little bit further in what we're trying to do to get all the information to make sure we're making a correct decision. The best decision.

I mean, one of the issues that we find -- that I find personally as I go around is I look at the Air Force. The Air Force is not mandatory, but they have an exceptional success rate going through TAP. And we're trying to get our arms around exactly why that is without making it mandatory.

We will take your comments and your interest and your strong beliefs and views back, and we'll move forward on it.

MS. CROCKETT-JONES: What are the down sides to making it mandatory?

MR. CAMPBELL: Pardon me?

MS. CROCKETT-JONES: What are the down sides to making it mandatory?

MR. BURDETTE: The Deputy Secretary asked me the same question in prepping for this testimony, and also services directly. And if I could summarize what they would say is, if it's a bad product, why would I make it mandatory? So --

MS. CROCKETT-JONES: Okay. That's not an answer, though. If it's a bad product, why do you have it at all? I mean, why even have people volunteer to do it.

MR. BURDETTE: So, that's why see you the Department of Labor, who has revamped theirs completely, the VA which has revamped theirs completely, and why our strategic plan to revamp our piece of it in a collaborative life cycle approach that's electronic and brick and mortar, delivering now the pieces of it, including the career decision tool kit that's --

MS. CROCKETT-JONES: I get it. I just -- I know that you think that you gave me a reason -- a down side for it being mandatory, but I did not hear a down side for it being mandatory. I heard a reason -- a potential reason for not making it mandatory, but unless you're also saying that TAP is a bad product -- so, I'm just hearing a disconnect. And I get your position, and I'm not going to press it further. But I'm just -- I have not actually

heard any valid reason for it not being mandatory unless you want to also stick by the TAP is a bad product.

MR. BURDETTE: I'm reporting the feelings of the services -- don't make it mandatory. The Marine Corps makes it mandatory. The Navy makes it largely mandatory with the declination option. The services that don't make it mandatory feel like if there was significant value, they'd make it mandatory, A, and, B, service members would attend it.

MS. CROCKETT-JONES: So, it's their decision. Okay, I get it. Thank you.

DR. PHILLIPS: This is just to follow-up real quick. Do we have any metrics then to differentiate between the mandatory versus the voluntary so that we could possibly make a future decision?

MR. STEVENS: With respect to --

DR. PHILLIPS: The different services, some make it mandatory, some make it voluntary. So, I'm wondering if we're able to measure outcomes from both sets.

MR. STEVENS: We have some outcome measures as regarding to like unemployment compensation from those individual services that are mandatory versus voluntary. We have usage of individual components of the like the DoL

workshop, how many people are going to those things. But not to any further finite -- and that's what the discussion is between the military departments to get that type of data before we say this is the reason that we're going to take the approach we are.

DR. PHILLIPS: Thank you. I mean, obviously if the mandatory was 110 percent better than the voluntary or vice versa, it would be easier to make a decision.

MR. STEVENS: There are a number of dynamics going to it, and I'll just be real quick. In terms of age and the number coming out of the military, it's lower in the Marine Corps than it is in the Air Force. The type of experience they've had prior to or during their military service, what would be the driver for them to participate in certain components of the transition process.

If I can go to the next slide, please. Yes.

TRACK 7

MR. STEVENS: The Integrated Disability Evaluation System, you wanted a brief update of really what this program -- where we are with this particular program. And I'll take you through that now.

As you know, we started the pilot in 2007, and we have since gotten permission to make the Integrated

Disability Evaluation System a worldwide model. And that is to be done by September of '11.

We think the pilot -- excuse me, the Integrated Disability Evaluation System has distinct advantages over the previous Legacy system in that it's a more efficient system using the examinations derived from the Department of Veterans Affairs.

The participants in the system to the tune of 78 percent thinks that single source disability rating and outcome is fair for them. It's a faster system. Even though we're at 394 days currently over the goal by almost 100 days, it's still faster than the IDES -- I mean, excuse the Legacy process at about 540 days, where they're receiving their benefits from VA faster.

They think it's a better system compared to the Legacy system where 68 percent of the participants perceive that the receipt of the VA benefits prior to their departure or shortly after their departure from active service was a good thing. And it's definitely more transparent where we're providing disability outcomes from both departments to the service members to make a more informed decision prior to their departure from active duty. Next slide, please.

This slide depicts the world wide roll out of the Integrated Disability System, again, by the September time frame. This year we'll be at approximately 139 installations by the end of September to include the overseas. Right now, we have 78 locations participating at IDES sites, and that comprised about 74 percent of all entry service members coming to the disability process. Next slide, please.

MR. CONSTANTINE: Brett, did you 85 on the previous slide -- 85 percent of active duties think that IDES is transparent and a good system? What was that?

MR. STEVENS: What this slide -- what that statistic notes, sir, is in terms of the transparency of the process, the individual that's the key in this process is the PEB liaison officer, the person responsible for transmitting how the process works, staying in contact with the service member, and explaining that particular process. The 85 percent derived from -- that's that satisfaction rate of individuals in their PBELOs and their ability to transmit the information, stay in contact, and assist them in the process.

MR. CONSTANTINE: Frankly, I'm surprised that it was that high based on what we've seen. How did you come up with that number?

MR. STEVENS: Well, the number is derived from a number of questions that we have been asking service members since the start of the pilot actually. We had about 10,000 individuals come through. We do have quite a bit a number of respondents to our surveys. And where we ask them direct questions about their experience with the PEBLOs, the knowledge of the PEBLO, the assistance of the PEBLO, your understanding of the process. That's where we derive that. Now, there are some other factors where you may be alluding to that. They may not as high a satisfaction rate with the process.

MS. CROCKETT-JONES: Is that a survey conducted at the end of the process?

MR. STEVENS: It's conducted throughout the process. Key points following the medical board, following the physical exam board, following their transition, and that's where we get the data.

DR. GUICE: I have a question about the length of time. I'm sure you were expecting a question about length

of time because it has continued to increase as the roll out across the country has proceeded.

What are the drivers of that increase in time, and what are you doing to mitigate and change that dynamic to get it back to what you projected it should be?

MR. STEVENS: We look at some of the drivers, ma'am, in terms of the -- early on in the IDES process or the pilot process, we had a lot of people come to it pretty quick with regards to their medical conditions. We now see a little bit more complex medical conditions. We're looking at maybe two referred conditions with nine claimed conditions by the service members. So, we're seeing a little bit of difficulty in terms of that with regards to now we're assessing people with more maybe complex and more conditions as they go through the medical phase.

We also are looking at some issues with regards to inherent to the process in terms of staffing. So, we know that we have some issues at certain points within the process that the military departments are dedicating resources to, such as the medical evaluation board phase. VA is looking at providing additional resources to their areas where maybe the rating phase within the process. And we're also noticing, too, that something that we didn't

look at and maybe account for was the increase in individuals taking transitional leave, also accounts for the time that the individuals are in the IDES process.

So, on average if we're looking at 84 days of transition leave, we're looking at a little -- about 100 days of maybe ME processing time, and some of those factors, ma'am, that would indicate that we do have some outliers that we really need to work on, and the services are undergoing plans to do that.

GENERAL GREEN: I have a question that's a little different in scope. Have you done any analysis of length of time from time of entry perhaps until time of initiation of an MEB? So, can you give us any data that would tell us the average time before, say, a single amputee started the MEB process?

MR. STEVENS: Sir, I don't have that data as part of the disability process, and i would have to go to our health affairs organization to find out are they tracking that information, sir, before service members refer into the process, how long have they been in treatment. I don't have that data, sir, from the event of injury. The next slide, please.

This slide talks about the campaign plan that we're undergoing this year through 2014 with regards to efforts to enhance or improve the integrated disability evaluation process. As I've stated, we're going to have a roll out of this process by the end of FY '11 to all military personnel entering the system. We've also completed an update of our expedited catastrophic injuries for individual service members. If they voluntarily want to go through an enhanced or a faster process through the disability.

And also, too, as I've mentioned, we're looking at making some immediate improvements, more senior commander involvement in the process, and also for accountability, and also staffing and resources.

On the short term, we're looking at actually a process in how we can minimize or reduce the time individuals are in the Integrated Disability Evaluation System, looking at the structure of the particular process to see if there is a way that we can bring down the time for individuals transitioning through this particular program.

So, we hope to have that developed, briefed out, and hopefully if we have success with that, to implement it starting in 2012.

We're also having some long-term strategies for the IDES reform, and this is a more strategic look in terms of is this the right way to do disability within the two departments. And so, there's a team looking at that. And once they are done with their deliberations or work, they'll brief that out to see if we have success in maybe looking at even a long-term reform of the Disability Evaluation System.

DR. GUICE: One of the things I think I'll share with you that we observed on some of our site visits, it not only doesn't the service member understand what IDES, but his immediate military people around him, for instance, the cadre, the CBWTUs, they can't explain it either. So, that may be a strategic communication issue that you may want to tackle fairly soon.

MR. STEVENS: And thank you for that point, and we are -- we've started to push out more strategic communications, starting in December of last year, about the IDES, how it works, who it affects, and how people process through it.

MR. CONSTANTINE: Brett, I want to point out two things. One, you just said you're going to do a study later this year or next year on determining if this was the right to do it. Yet with TAP, you're waiting until you have a perfect product before you implement it.

Second, you -- I remember getting briefed when I worked on the Hill in 2009 about the same things about how complicated injuries are today -- unit snipers and IEDs. We've known that since '05 and '06. Why is that still a reason why it's taking so long? We know that our young men when they're coming in with seven or eight reasons at a time.

MR. STEVENS: One of the complexities of the disability process is as -- even though we have individuals with more complex injuries, we are also finding that we are maybe to about eight percent of the individual service members going through this process are actually returned to duty. Some of them have very catastrophic wounds or injuries. So, we really are having a more scrutinized approach, I believe, in terms of assessing individual service members, their medical conditions, and their effect of the individual's ability to remain on active duty. So,

those are some of the things that we're looking at as it relates to this process.

But in terms of the complexity of the process, we're also looking at can some of the things that are making this process cumbersome in terms of time be eliminated so that we can make the process go smoother for those individuals who are experiencing this, because 394 days, as you know, is a very lengthy time for someone who believes that they are ready to leave military service.

GENERAL STONE: So, if we just put more resources against this process, is this a viable process? Is that what you're saying?

MR. STEVENS: We think, sir, that this process is a viable process as it relates to -- or, excuse me, compared to the previous system that we came through. The integration of the departments in terms of the coordination of getting benefits to military service members immediately following their discharge from active service we think is a good thing.

What we're looking at is, is there any way to enhance that particular process, maybe even marginally, to where we can even make it better?

GENERAL STONE: So, what -- are you working to time them? Is there a time goal that you have that you're working against?

MR. STEVENS: We do have a time goal, sir, that is less than 295. And once we've completed the development of what we think as a viable model, that time goal will be able to be realized -- or, excuse me, not realized. We'll be able to come and speak in terms of this is a time goal that we think we're going to meet with the new process.

GENERAL STONE: And, therefore, you are not seeking legislative relief to dramatically change the system?

MR. STEVENS: In the short term, no, sir. In the long term, legislative relief will probably be required because we know to really get down to a time frame, we're going to have to look at the Title 10 and Title 38 authorities in terms of some of the length of times or some of the things that we're going to have to overcome in order to fully reduce the time individuals are in a disability process.

DR. PHILLIPS: We know there are a number of sick and ill and wounded, or sick and ill, that are in the

system, but have never been down range. They seem to have been recruited with a preexisting condition. Do we differentiate between those folks, or are there plans to manage that differently?

MR. STEVENS: We currently do differentiate. There are individuals who have a preexisting medical condition, and if it can be validated that the military department did not further aggravate this military condition, these individual are discharged with what we call separated without medical benefits. However, with the legislative changes, that we now have a shorter period of time in which we can evaluate an individual to determine if they have had a preexisting medical condition to where we would be able -- not would be able to -- where we through the physical evaluation board would determine that this condition was not further aggravated by the military.

So, we don't have many individuals coming through our process with preexisting medical conditions that weren't aggravated by military service.

DR. PHILLIPS: Is there a process or is it in your purview to try to identify those individuals, pre-recruitment and improve the recruitment standards, or is that -- are we talking beyond the mission?

MR. STEVENS: I think that would be an item for the recruiting military service members. We know they all go through MEBs processing. They do that entrance examination. How thorough is that and is that meeting the needs? But I think at the back end, if we're collaborating with those individuals and not a tremendous increase or a spike in the number of individuals with preexisting medical conditions, I'm not sure exactly what further enhancements they're going to make to medical screening of individuals coming in.

DR. PHILLIPS: I was just wondering if this is an issue, and you hear a lot of sidebar talk that it can be, and whether or not we can advise and bring it to their attention that there is an issue related to pre-conditioning and being recruited by the military.

MR. STEVENS: The number of individuals, and I'll have to go back and check the statistics of, again, pre-separated for preexisting medical conditions, the threshold for that. If it's not a high indicator of where we're having individuals and we can't keep for various reasons, I would say there probably wouldn't be a need to enhance the MEBs processing.

DR. TURNER: Could you give us an example of some of these preexisting conditions that you've seen?

MR. STEVENS: We may have an individual who may have had some, should I say, a traumatic event in terms of where they're maybe having a bout of depression or something that that then further manifests initially on military service injury as they may be going through basic training. But a better example actually would be someone who has maybe an orthopedic condition that would be -- they would then have a problem and immediately on military service with that same condition. Laxity of a joint or something like that. That is, they're entering military service, that reoccurs or manifests itself again. I can't really give too many specifics on that because it's, again, something that we don't necessarily have a large number of individuals with preexisting medical conditions that we're now turning out.

DR. TURNER: Do you think there's any value in tracking those with the metrics, or do you have those?

MR. STEVENS: I think we do have. I just don't have that information here. I'd be happy to share that back with this particular task force.

DR. TURNER: If you would, I'd be interested in seeing that.

MR. STEVENS: I will do so.

COMMAND SERGEANT MAJOR DEJONG: Sir, real quick. What has been looked into as far as working the MEB process along with -- in concert with the medical care, because what I'm seeing a lot of is soldiers that you know, where there may be an injury or an illness that you know is probably going to disqualify them and they're going to be medical boarded at some point in time. And we've got enough history and enough data that we can probably come pretty close to figuring out what those are and at least classifying them. And working those soldiers together in concert through both processes instead of -- I meet a lot of soldiers that are frustrated because they're treated for a heart condition for 12, 16 months, and they're ready to get out. They know that their military service is done, and then they say, well, now you've got the MEB process, and you've got at least another 365 days here.

And what has been looked into as tying those together and coming up with a classification of injuries and illnesses that may or may -- that may fit in? And if it goes for the best part, we can stop it.

MR. STEVENS: What we are looking at is how we can enhance some of the information already contained in the medical record to expeditiously pull it out, process it. To simultaneously do a -- we actually do simultaneously do those types of things because as an individual is going through a medical board, they're still receiving treatment.

But there's a point in time when the physician says you must be referred for the decision on whether or not you're able to continue military service. That's when the record gathering starts.

We're looking at processes to where we can expedite the gathering of that information, the processing of that information, so ultimately to move that quicker.

MR. CONSTANTINE: Brett, also some statistics show that -- this is kind of piling on Dr. Phillips's comment that 80 percent of the folks in the WGTUs have never been down range.

You know, do wounded warriors get expedited processing compared to the ill and injured?

MR. BURDETTE: In the Army Warrior Transition units, 87 percent of them have deployed, and that's a

10,000 -- about 10,000 to 22 people just in speaking about the Army numbers there. So, 87 percent have deployed.

The Secretary of Defense has charged us through the SOC with the VA to say, let's find a way to -- and the definition for wounded warriors, as you all know, complex medical care of 90 days or more gets you into a warrior transition unit.

Many Americans, the Secretary included, are sort of surprised sometimes at the number of injuries that did not occur in theater, combat zone, combat related. So, with the caregiver legislation, combat zone, combat related seems to be a good threshold.

The Secretary has charged us with saying, find a way to care for everyone, absolutely. Find a way to find combat zone, combat related people and make them more special. Make sure we're really saying, you stepped into the breach force, you went into theater, you get something extra.

In house we're calling that platinum benefits. It's a difficult task. It get thorny almost immediately because the minute you have a motorcycle accident of a two-time OEF deployed person with a Purple Heart and you're not allowed to get platinum benefits? It gets hard.

We have smart people working on it through the SOC. We're just not there yet, but that's an intent.

GENERAL HORST: I would be interested to see your numbers because obviously I'm an Army guy, and real close to the wounded warrior program. And I personally supervised two warrior transition units. I'm not sure that I agree with your numbers in terms of wounded in action versus ill and injured. I think the numbers are a little bit different.

MS. DAILEY: I don't think that's what he said. You said that 87 percent of them have deployed.

MR. BURDETT: That's what I said, 87 percent have deployed.

MS. DAILEY: Not been injured in the deployment, but they have deployed.

MR. BURDETTE: Yes, 87 percent of the 10,000, 22 -- very close on the numbers here -- have deployed as U.S. Army soldiers, no doubt.

GENERAL HORST: Okay.

MR. BURDETTE: General Corelli is adamant on that, and will chase you down the hall and make sure you get that right. So, I don't quote that off a paper.

That's -- he's got that seared in my memory. And I'm happy to share with you the data by name if you'd like.

MR. CONSTANTINE: Well, how many WTUs have combat-related injuries? What's the percentage of that?

MR. BURDETTE: So, we have data that's largely representative. I'm going to say that it's about eight percent, and I need about three percent on either side. It's about eight percent combat zone, and it's about 21 percent -- I need three points on either side -- that's combat related. Combat related, as we were using in the caregiver legislation is, if you're an NTC and you get hurt. So, a realistic injury that's related to training for combat, combat related, that's about 21 percent, eight percent in theater combat zone.

MR. CONSTANTINE: So, only 30 percent are combat or in zone are combat related.

MR. BURDETTE: Correct. So, if you wanted to marshal our current population, about 12,460 wounded warriors across the services. About 30 percent of them we think -- I need some flexibility here -- are combat zone, combat related.

I know we're real tight on time, but if we could get it to Mr. Carrington to talk about Federal Recovery

Care Coordinator Program. I appreciate your indulgence and your questions.

MR. CARRINGTON: I'll quickly go through the Recovery Coordination Program. It's a relatively new program established in November 2008 by DoD to provide non-medical care coordination across the department.

The Wounded Warrior Act essentially is a law that establishes part of the NDA 2008 that provides for recovery care coordinators. These RCCs, the law prescribes that they're assigned to recovery and service members and their families' that they use a comprehensive recovery plan to focus on meeting the needs; that they attend standardized DoD training, their supervision and also their proper case load ratios.

That was followed by another DoD directive type memorandum in January 2009 and followed by Department of Defense instruction which codified the policy in December 2009 that essentially set the policy for the services to implement and run their wounded warrior programs. Next chart.

Again, services run their programs, so they hire, place, supervise, and utilize their RCCs based on how they assess the recovering service member population. And it's

more than just case load ratios. It's also the complexity of the needs of the recovering lawyers and some of their family issues.

Our guidance is 40 cases per RCC. Services obviously, place additional RCCs in populations where they have larger needs or greater numbers of wounded warriors.

Services track the numbers, caseloads based on number of cases, how many of those service members return to duty versus transitioning out to be veterans, how many cases they closed, understand that you can transition to veteran status and continue to have needs in a comprehensive recovery plan so that would still be considered an open case. And the RCCs would continue to work with the now veteran and their family.

The metrics spoke a little bit about that earlier. Quite frankly, you measure compliance based on what's the percentage of recovering service members that are assigned an RCC? What's the percentage of those RCCs that are actually DoD trained? And what's the percentage of recovering service members with an active, comprehensive recovery plan? If you're doing well in those statistics, then you're in compliance with the law.

Services also measure satisfaction of the recovering service members and their wounded warrior programs. For example, this morning I read a report from the Marines that reported that over 70 percent of their Marines are satisfied or very satisfied with their recovery care coordinators. Next chart, please.

There's 147 recovery care coordinators in 69 locations across the United States and in Germany. The Army uses 170 advocates in their Wounded Warrior Program, and likewise they're also assigned based on what I described earlier. Next chart, please.

A little bit about the DoD training that we provide. Essentially, it's a one-week, more than 40 hours obviously, of comprehensive standardized core curriculum training to teach the RCCs some roles and responsibilities of being an RCC. Conceptually how to develop a comprehensive recovery plan and also develop that plan on an automated system. Some practical experience, and also a whole lot of standardized training modules from program leads from across the government, such as the Department of Veterans Affairs, VBA, VHA, program leads, Social Security Administration, to give the high level in depth knowledge to the RCCs so they're better prepared to go out in the

field and have a good understanding of what these different programs are.

Likewise, we teach them about PTSD, suicide prevention. We spoke earlier -- they also get a module on the National Resource Directory, so they're aware of that and what it provides to the recovering service member and their families.

DoD training is assessed, reviewed, and updated quarterly. At the last training that we conducted in January, 83 percent were extremely satisfied with that training.

And then the services provide the follow-on 40 hours or one week of their service specific training.

A point to make is the Army is now again sending their advocates to duty training, so they're bringing their program back into compliance with the law and duty policy. Next chart.

A little bit about our RCCS, quite frankly they're highly qualified. Eighty-three percent of them have served in the military, 72 percent of them are retirees, 99 percent -- almost 100 percent -- served in leadership positions of senior NCO and commissioned officer

levels. Forty-six percent of those served more than 20 years in a leadership position.

DR. PHILLIPS: I have a question, please. Is there a certification given to -- after the completion of training?

MR. CARRINGTON: There's a -- they get a certificate, but they also get continuing education credits. A lot of these RCCs have backgrounds in social work or counseling, and this training augments the skill set that they already get hired under.

DR. PHILLIPS: And for the military folks, that fits in with an MOS -- with their primary MOS.

MR. CARRINGTON: We trained -- essentially the vast majority of RCCs are contracted employees. A few of them are government employees and some are in uniform.

DR. TURNER: Yes, sir, and do you require yearly or recurrent training to maintain certification?

MR. CARRINGTON: We are just starting. We've programmed the money, and we are just starting a plan to have a formalized refresher training, if you will, for the RCCs that are currently serving out in the field.

DR. GUICE: Can I have a point of clarification? The certification is that you've completed the RCC

training. It is not a recognized certification such as a social work certification. So, I think there may be a misconception. It's that you've completed the training. Is that correct?

MR. CARRINGTON: Just completed the training.

MR. DRACH: I looked ahead real quick. I didn't see it. But what is the average case load for the RCCS, and what is the worst and the best? What is the lowest and what is the highest?

MR. CARRINGTON: I went out to Colorado Springs and met a brand new January trained RCC working for the Air Force. And she had 33 cases loaded in the RCP, which is recovery plan software solution, actively working those cases. If you go out and talk to another RCC that's been in the field for a year and a half or two years, they're going to tell you and me that they have a case load of maybe 150 or 200. And then as you delve into that, you'll find out that their caseload active is something less than 40.

They may be staying in touch with veteran services members or service members that are still in uniform on a six-month or 12-month basis.

The services run their programs based on service culture, philosophy, size of population. Services feel like they're a Marine for life, for example. The Army Wounded Warrior Program will always stay in contact. Their advocates will always stay in contact, so their population is both in active duty and a veteran population.

DR. GUICE: Again, a point of clarification. The span that you said where an RCC might have 150, that is not what we heard from the services when they gave us their RCC ratios.

MR. CARRINGTON: You have to be very careful how you ask the question in terms of our active cases versus cases that are on kind of a maintenance level, if you will if they check in occasionally.

MR. CONSTANTINE: I see that over half of the RCCs don't have a college education. What is the criteria you look for when you're hiring an RCC?

MR. CARRINGTON: The criteria we look for, and almost all of them have some college experience or degree. We look for educational experience in the field. We look for people that previously served. We look for disabled veterans; 65 percent of them have gone through the process that these service members are going through with the VA.

Sixty percent of those deploy to combat; eight percent are wounded. So, we try to get a population that has experience, educational background, and a clear interest in working in this non-medical care coordination field. Next chart.

A little bit about what our RCCs do in the recovery, and rehabilitation, and reintegration phase. Right off the top, they consult and collaborate with the recovery teams. Each service does it slightly different, but a recovery team would essentially be a doctor, a nurse, a squad leader or a section leader, and a recovery care coordinator. They would also add to that team other appropriate individuals at the right time and place and manner that would contribute to that service member's transition.

They do this to ensure that the recovering service member and their family have access to medical and non-medical services and resources.

The next thing that they stress and focus on is a comprehensive recovery plan because I think we've all come to an agreement that if you have a plan that's going to cover your recovery, rehabilitation, and reintegration or transition to civilian life, focusing on that plan and

establishing goals, establishing what you have to do to meet those goals, and then ensuring compliance with that, but also having flexibility to modify and change that plan as things change during the rehabilitation and reintegration phase.

The RCCs facilitate an efficient, effective, and smooth rehabilitation and transition back to active duty. They're there being the one point of contact -- the coordinator, if you will, for all the different providers, managers, case and care coordinators that are out there.

They support the assessment, identification of family needs. We stress that the family is an important part of that recovering service member. And there's a lot of resources thrown toward the family. We want to make sure that they're -- they know about them and they can coordinate the access of those resources. Also, down in the state and local community level.

And lastly, they coordinate and monitor the non-medical services across this continuum of care documented in the comprehensive recovery plan. Looks for gaps or intervenes when necessary and assist in the coordination of delivery resources to that service member and their family. Next chart.

In late March, we had a wounded care coordination summit. Quite frankly, the goal of that was to look for best practices across our service programs and all this as a department strive for excellence.

We had four chartered sub groups that focused on these four different topics -- education and employment. We've talked a little bit about earlier today.

FRC/RCC collaboration, that's a relationship with the VA's federal recovery care coordinators and our own program. Like I said, documenting best practices and wounded warrior family resilience.

These subgroups identified 31 different recommendations. Some have already been executed, and the remaining ones are being worked across the Department.

MR. DRACH: Excuse me, could we get a copy of those 31 recommendations and the current status?

MR. CARRINGTON: Absolutely. The last chart.

We've talked about this. I just want to make a couple points. We've used successful transitions, are key to the reintegration of the recovering service member, the wounded, ill, and injured and their families. And we've taken some initiatives within WWCTP, new initiatives. And I'd like to talk about two of them specifically.

We spend a certain amount of time and money on these because we view them as critical to the successful reintegration of that veteran.

The first one, Operation Warfighter. To be quite -- essentially it's internships for recovering service members while they're still wearing the uniform. So, conceivably you could do your rehab appointments in the morning and then go out to be transported to an internship site off base, and either learn a new skill or broaden your resume.

The second one is education and employment initiatives. It's a program, in short, to get veterans into Federal jobs. And we start this while they're on active duty. So, we start the process to identify the skill set, their interests, what jobs are available, and get them into it.

Quite frankly -- and we talked about measures and metrics a little bit this afternoon. The best way to do it is you track the numbers that are placed into internships or jobs.

And currently, there are over 400 wounded warriors that have been placed in the education and employment initiative. We hope to see that increase to

about 2,500 a year. Secondly, there's over 400 Operation Warfighter interns placed right now that are active in that program.

This concludes the formal portion of my presentation. And I will be followed by some -- closing comments by Mr. Burdette.

COMMAND SERGEANT MAJOR DEJONG: Could I ask one question real quick? Sir, part of what you said and part of what you recapped in this summit was capturing best practices. I've kind of come on to this taskforce at a late stage, but from my history within the National Guard, how much time is spent in the guard bureau of capturing best practices, because best I can tell right now, multiple states are doing multiple different things. There's not a whole lot of mandates for states to do anything.

And as we look through this presentation, we're cutting their reintegration time down to five or seven days. There's not a whole lot of talk of possibly extending that. And a lot of the information that's put out there is voluntary based on that, based on the recommendations to not mandate it. And then cross that with the number of congressionals fielded nationwide for families of guard and reserve soldiers that are stuck in

the system, can't get their questions they want, so they start fielding congressionals.

I'd like some hard numbers on that as far as -- as comparing the number of congressionals and complaints filed and then going back to looking at mandating some policy and some regulations as far as time periods and the amount of information and how it's given to the soldiers, and cross reference those to see if we can make a change there.

MR. CARRINGTON: Actually you ask a very good question, and you make a rather valid point We've employed the guard and reserve components in ways we never imagined. We haven't changed the laws, regulations, and policies. And one of the recommendations that came out of the best practice subgroup was, and I'll read it to you, "Conduct combined review of laws and regulations to ensure same level of care for wounded, ill, and injured reserve component members on and off active duty." So, we want to ensure that whatever the active component has, that the reserve component member gets that same level of care. And I think if you did that, then the congressionals and complaints and things that you referenced, you'd see those go way down because we'd solve the problems.

COMMAND SERGEANT MAJOR DEJONG: Absolutely.

Thank you.

MR. CONSTANTINE: Robert, you mentioned the Veteran's Employment Initiative. I'm not really that familiar that program yet. But have you seen that it works? And also, if it has, have you seen it working specifically on severely injured wounded warriors who have a higher unemployment rate than everyone else?

MR. CAMPBELL: I didn't speak to the Veteran's Employment Initiative. I've talked to E2I.

MR. CONSTANTINE: -- to say hire vets I think is -- if it's not, it's in Mr. Campbell's Senate testimony. Under the VEI program, it says, "Veterans of the public may access the VEI's helpful website at fedshirevets.gov."

MR. BURDETTE: Here's what we -- when we survey the landscape of how do you connect a transitioning service member to a job, and when you go out and you talk to VA and you talk to Labor and you say, what do you have, what do you have? So, this slide at the end is the landscape, and we want to drive it with Secretary Jefferson's leadership to that national jobs portal, not just to connect with OPM. If you go to OPM today, usajobs.gov, if you're a vet, there's a little star at the bottom right. It takes you to

Federal jobs, a really good tool. But how do you connect with General Cortez at Microsoft who wants to hire 100 wounded warriors like this month? And then how do you make sure that you've done the building blocks for those veterans to make sure they have clearances?

Operation Warfighter, those 400 people in Federal opportunities right now, 20 percent of them go on to keep that job that they had. The other 80 percent oftentimes take a letter of recommendation from the FBI back to St. Louis, Missouri, and that's gold there and really helps them connect. And we track that on how you do that.

The E2I Employment Initiative, where we, instead of the speed dating at a job fair that you have a base, post, or station, and you just throw a resume in front of - - at a table with a blanket over it, you do a real assessment of that individual beforehand, and what the company needs, and you connect those two, and then you track yourself to it. That's what E2I will do, add some science to it as far as that goes.

And you've got to point at the President's initiative on veterans employment where a GS-15 is at every executive agency now trained to help a Federal hiring manager. When I was a Federal hiring manager in my last

job, I knew the right thing to do. I wanted to hire a disabled vet. I wanted to hire an OEF veteran. I didn't know how to do it. Now, you have a GS-15 at Homeland Security where I used to work who teaches that hiring appointment person how do you do this. How can you quickly get to the veterans, and you want to do the right thing?

And the results are startling. The USDA and their 17 member agencies have tremendous success on it. I met with Ray Decker, who leads this effort for OPM, and I spoke to all of the 15 who came together at a conference and said, how are we driving vet hiring, and how are we connected to our wounded warriors for that? That synergy - - this isn't just a slide with 10 separate disparate things into one. It's working, and it's happening, and we're tracking the metrics on it.

GENERAL GREEN: Gentlemen, I need to cut us off. We're about 30 minutes over, and so I'm afraid I'm going to have to cut off the questions for right now.

I want to give you a chance for a quick summary, but I think it's fair to say that no one in the country has focused on trying to get this right in your office. And so, we do appreciate that. We appreciate you allowing us

to speak with some candor here as we ask hard questions. And we appreciate your coming back with tough answers.

But, please, sir, over to you.

MR. CAMPBELL: Well, I guess this is a pretty sobering experience for me. And I realize that we don't have the metrics. I realize that some of these programs haven't really been changed in a number of years. We're in the process of moving that forward. It's taking us time to get some of these things. We want to be held accountable. Certainly Dr. Stanley and I both strongly believe in collaboration with this taskforce, with the media, with Congress. We really want to get it right, and we want to do what we can.

And realize there are some things out there, like mandatory TAP, that are difficult for some people to understand why we don't have it. And we want to drive that to a conclusion that everybody says, yeah, that's the right way to go.

We're committed. We think we're doing some thumpings that are good. We think the media -- digital media that we're exposing, we will expose this summer is going to be exciting. We realize your report will already have been started to be written by then, but we'd still

like to, you know, show you what we've got to demonstrate our commitment to what we're really trying to achieve here.

So, we know that in a year you'll hear a different story, and hopefully you'll find it more satisfactory than you have today.

GENERAL GREEN: Well, Mr. Campbell, I thank you and your team. Please understand we are a five-year group, and so we will be talking with you again, okay?

[Laughter.]

GENERAL GREEN: And with that, we'll take a break. Thank you, gentlemen.

MS. DAILEY: Ladies and gentlemen, if you have a seat -- can I get you in your seats, please? I'd like to leave those back doors open, so, for my staff. For my staff, I'd like you to leave the back doors open. We have individuals who might be overflowing into the hall, and with that in mind, we'll leave those doors open.

And with that in mind, I would like the panel to ensure you're speaking loudly and into the speaker system because that will allow those individuals who are standing outside the door to hear your presentation.

Okay. So, we're still pulling some chairs

together. That's good. But, again, we do have some people who are standing at the back or standing outside the door, so using the microphone and a nice loud projection will help our people standing outside the door capture everything that's going on.

GENERAL GREEN: Okay. I apologize for the temperature. We're working on it to see if we can get a little more air conditioning in here.

If you'll please go to Tab E, okay? Just to recap, Congress directed the taskforce to review the establishment and effectiveness of the four DoD Centers of Excellence. In January, the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury gave us their presentation. And today we'll hear from the DoD/VA Vision Center of Excellence presented by the Center's Executive Director, Colonel Doctor Donald Gagliano, Deputy Director Dr. Mary Lawrence. Dr. Gagliano will also be presenting for the DoD/VA Center of Excellence for Traumatic Extremity Injuries and Amputations.

As current director, Dr. Charles Scoville is retiring, and Colonel Cathy Gates is the interim chief. The Auditory Center of Excellence -- I'm sorry. Colonel Cathy Gates is the interim chief. Auditory Center of

Excellence is also presenting, and Lieutenant Colonel Packer, who is the current PDY in Germany until the 5th is represented by Colonel Gates. I apologize.

We'll begin with Colonel Donald Gagliano's presentation and the Vision Center of Excellence. And please take this away. Thank you.

COLONEL GAGLIANO: Okay. Good morning -- good afternoon, everyone. Bad start. I'm Colonel Don Gagliano, the Executive Director of the DoD/VA Vision Center of Excellence, and I'm accompanied here today by Dr. Mary Lawrence. She's the Deputy Director and is from the VA. And we'd like to first thank the Recovering Warrior Task for the invitation to present the status of the Vision Center of Excellence.

The purpose of the brief today is to address these questions that were posed by the Recovering Warrior Taskforce. And the first is, what is the status of the Vision Center of Excellence? Who are the customers of the Vision Center of Excellence and how well utilized is the Vision Center of Excellence? And finally, what prevents a higher utilization?

And this slide sort of highlights the status. I'd like to begin by providing some background information

on the establishment.

In the recent conflicts of Operation Enduring Freedom and Operation Iraqi Freedom, we've seen a new array of injuries, most notably an increased number of head and neck injuries when compared to previous conflicts. And, more specifically, ocular injuries resulting from many small fragments generated by improvised explosive devices.

In recent published reports, eye injuries account for approximately 13 percent of all battlefield injuries with approximately 4,000 cases of significant traumatic eye injuries reported between 2004 and 2010.

It's estimated that 82 percent of serious traumatic eye injuries are caused by glass and glass fragments. And in the 2006 report, it was estimated that 22.5 percent of all evacuations were because of battlefield related eye injuries alone or in combination with other bodily injuries.

Another significant change in recent conflicts is the high prevalence of traumatic brain injury and under -- and the high prevalence of visual dysfunction that is seen with traumatic brain injury. Recently it was reported that for moderate and severe traumatic brain injury known as TBI, the prevalence secondary vision damage is as high as

76 percent in TBI patients.

Often, visual dysfunction is the most disabling consequence of TBI. So, in June 2008, Secretary Gates highlighted the need for increased research for TBI, vision restoration, and prosthetics. In the NDAA 2008, the Secretary of Defense was directed to establish the Vision Center of Excellence to address the issues of traumatic eye injuries and visual dysfunctions associated with traumatic brain injury.

The VCE was directed to collaborate to the maximum extent practicable with the VA, as well as institutions of higher learning and public and private entities, both nationally and internationally. And in addition, the VCE was specifically directed to establish a defense and veterans eye injury and vision registry for tracking patients and performing longitudinal outcome analysis.

The VCE has been -- is being developed as an integrated organization and is jointly funded by both the VA and the DoD. Approximately half of our current staff of 13 personnel come from the VA.

In May 2010, operational oversight of the Vision Center of Excellence was delegated to the Secretary of the

Navy and was further delegated to the Navy surgeon general in November 2010.

The mission of the Vision Center of Excellence is to continuously improve the health and quality of life for members of the armed forces and veterans through the advocacy and leadership in the development of initiatives focused on the prevention, diagnosis, mitigation, treatment, and rehabilitation of disorders of the visual system. This track's pretty much exactly as what's in the public law.

At the core of the Vision Center of Excellence mission is vision readiness, both for the battlefield and for reintegration back to civilian life. The vision of the VCE is to link patient care with the necessary vision research and the registry information that will enhance readiness, improve health, and provide the best possible quality of life for our service members and veterans, who suffer from vision loss and vision dysfunction.

The VCE is currently housed in temporary space. However, in the fourth quarter of 2011 -- we've been waiting for about two years for this -- the VCE will occupy two new locations. Clinical headquarters will be co-located with the Ophthalmology, Optometry, and Refracted

Surgery Center in the New Walter Reed Military Medical Facility on Bethesda.

An imbedded function at this location will be a vision care services patient outreach and education center that will be available for service members, veterans, and their families who have vision dysfunction in their service members and veterans. This space is in close proximity to other VCE collaborative partners, which include the National Intrepid Center of Excellence for Traumatic Brain Injury, the Uniformed Services University, and the National Institutes of Health, specifically the National Eye Institute.

Space and environmental limitations had restricted the number of personnel that we could place on the Bethesda campus. And for this reason, the second location was identified in Crystal City. This space will be used for administrative personnel in providing programmatic and operational office space more specifically for the operation of the registry.

It was chosen specifically it's because it's in closed proximity to the Defense Centers of Excellence for Traumatic Brain Injury, and it is co-located with the National Center of Excellence for Telehealth and

Technology. This will allow -- this has allowed for shared connectivity, shared network operation, and will further provide further opportunities for collaboration and integration with traumatic brain injury and telehealth programs.

Now, you see the terms up there "virtual" and "distributed." To maximize efficiency and to stay closely linked to the point of care, the VCE is being developed with regional offices, distributed across this virtually linked vision care services network of the DoD and VA. It's not really well defined. It's a virtual network. And our goal is to provide a construct that will allow us to serve four primary functions: to facilitate vision care coordination, point of care research coordination, provider and patient education coordination, and, finally, information data management coordination.

Currently, there are two regional offices that are planned, one in the western region which will link Madigan Army Medical Center and the American Lake VA Medical Center, and one in the National Capital Area, which will link the Walter Reed National Military Medical Center and the Washington VA Medical Center.

As mentioned earlier, the VCE is being developed

as a partnership between the Department of Defense and the Department of Veterans Affairs. And for this reason, governance is provided by the DoD and VA Health Executive Council and Joint Executive Joint as shown on this governance chart.

VCE customers extend from the end to the battle space through the entire continuum of care across the DoD and VA. And this includes support for veterans, support organizations. We've closely linked with one in particular, the Blinded Veterans Association, which you'll hear more about in the next slide.

Although we're small and still in development, the VCE services are extensively utilized. And we serve as the principal DoD and VA advisor for all vision related issues. In addition, to linking of the VA and DoD vision rehabilitation services together, there are several other VCE sponsored reintegration and rehabilitation programs that I'd like to highlight.

As noted in the first bullet, all soldiers found unfit for duty by a physical evaluation board are eligible to apply for a continuation on active duty, continuation on active reserve program. This designation provides soldiers with an exception to policy which allows them to remain in

the Army, even if they have significant physical limitations. This allows soldiers to continue to serve to meet their career goals as well as support the Army through their leadership and combat experience.

While up to 75 percent who have experienced extremity amputations are able to remain on active duty, only a few who have experience in ocular amputation or severe vision impairment can remain on active duty. There are a few -- there are several soldiers who are currently on active duty who have severe vision impairment, but not many. And the VCE is working to support this program and to try to find ways to enhance performance of the visually impaired in support of their continuation on an active duty program.

As noted in the third bullet, the U.S. Paralympics provides sports programs for those with disability and vision impairment. But the programs for the visually impaired are relatively new and they're not well developed. As note in that bullet, the VCE has established an MOU with the U.S. Paralympics to support the use of sports and physical activity as a means to enhance rehabilitation and reintegration of the visually impaired.

Peer mentorship, peer support have been shown to

be one of the most effective means for vision rehabilitation and reintegration. And as noted in the fourth bullet, the Blinded Veterans Association Operation Peer Support, which is one of the newest programs of the BVA, connect combat blinded veterans with World War II, Korea, and Vietnam, and newly blinded veteran who have been wounded in Iraq and Afghanistan.

The VCE has been in support of peer support for the last three years and continues to support that program. It's one of the most effective programs for the visually impaired peer support programs.

In addressing the fifth bullet, unfortunately recent Department of Labor statistics highlight the devastating impact of vision loss and vision impairment unemployment, reporting that 80 percent of those over the age of 16 who are legally blind are unemployed. As noted in the fifth bullet, VCE is currently initiating a state-supported pilot program in Texas, which has the second largest veteran population in the country, to relook the Veterans' Employment Education Programs in an attempt to enhance employability and reintegration of our visually impaired veterans.

I listed to the last presentation and will

continue -- we'll connect with ongoing programs in Secretary Campbell's office and try to bring a little bit more focus for the visually impaired to those programs.

Everyone who has spent time in combat knows that the criteria for an urgent evacuation is potential for loss of life, limb, or eyesight. In an effort to enhance battle field management of eye injuries, the VCE participates in the weekly Joint Theater Trauma System Worldwide Case Management Review Conference. Our participation in this has saved multiple lives from being lost through enforcement of the use of eye shields and the Battlefield Eye Injury Clinical Practice Guidelines.

In addition, the VCE is working closely with the Military Combat Eye Protection Program and is actively promoting the use of protective eye armor to reduce the incidence of eye injuries, as you see in the top slide in the second -- a picture and the second picture. It made a significant impact. Prevention is our objective if we can effectively execute it.

To enhance the quality of care, VCE has initiated a vision care specialty base worldwide teleconference that is based on the JTTS model, and it links providers employed in the theater with those that Landstuhl and CONUS. This

is the first specialty case review conference that has been developed. And although it's only in its fourth iteration, it has very effectively identified opportunities for clinical performance improvement. We're going to continue to expand on that and use that tool both for educating our providers and for finding ways to improve our clinical care capability.

VCE has been actively engaged in promoting necessary vision research and has been instrumental in more than doubling the DoD funding for vision research over the past two years. Currently there's about \$72 million in DoD funded vision research.

As the director of the VCE, I chair the Interagency Vision Research Scientific Steering Committee that is responsible for prioritizing the vision research gaps and selecting the vision research proposals for funding. We're trying to focus priorities on those issues that we know need an immediate solution in an effort to promote translational solutions and bring those to bear on the battlefield and those who are visually injured. In addition, we are currently coordinating the publication of a five-year research gap analysis and research strategic plan for vision research.

The VA currently has three vision research centers of excellence focusing on the development of implants and artificial means to restore vision, and new techniques for vision rehabilitation. And through the VCE, we've been able to link the DoD and VA research community, both participating routinely in VCE sponsored vision research symposium.

I'd like to show this slide to demonstrate the extensive reach of the Joint Vision Research Program. These researchers have all been one year into their process. Each one of these is addressing a high priority area, and it not only extends to some of the premiere institutions in the country, but also premiere institutions in the world. You'll see two projects that are being conducted in Israel and the U.K.

In the NDAA 2008, it was directed that the VCE establish a joint vision registry to provide quantitative data, clinical data for longitudinal analysis of eye trauma and vision impairment. And the Joint Vision Registry is in development and is currently in pilot stage, and is ahead of schedule. And the project manager recently was awarded the DoD Quality Champion Award for her work on this vision registry.

The Joint Vision Registry will be the first -- and I want to repeat the first to jointly combine clinical data and the DoD and from the DoD and VA into a single repository, and will also provide a federated framework for all centers of excellence to use for their registry requirements, which will enhance efficiency of operation and also provide the ability to share information across their specialty communities of interest.

This is my last slide, and this is a tough question: What prevents higher utilization? It's hard to word this without being negative, so I'm going to try.

While the VCE has had good success in developing and integrating programs, there are two things that would facilitate higher utilization. And those are listed here. That is -- the real strength of our program has been the integration of VA and DoD in -- throughout the process. As I mentioned, Dr. Mary Lawrence is the Deputy Director. She's from the VA. About half of the staff for the VCE is from the VA. We are integrally linked not just in words, but in action.

However, a joint culture is really key to success, and continuing to promote that joint culture will provide opportunity for the VCE to further lead efforts and

effectively lead efforts to develop -- for the development of joint policy, joint procedures, joint programs. So, wherever you get your care, it will be on the same -- to the same standard and the same policy.

We mentioned earlier that we have a joint governance model that's really critical and key to our success to keep that accountability to a joint organization that will allow us to execute as a joint program.

The second bullet highlights the need for resources. It would be remiss if I didn't come to this taskforce we need more resources, and it really is true. We are in sort of a deadlock now for hiring actions because of the staffing restrictions, and we're trying to work through that.

We have been able to gain a foothold as the primary interface. Coordination of all eye and vision care matters in the DoD and VA, but we really need a little bit more authority in that regard. And one of the areas where we are weak -- two of the areas we're in terms of funding is in the sustainment of the registry and additional funding needed for vision research. I highlighted that we've pushed the program along over the last two years, but we had the highest scientific score of any organization in

the history of TAATRC on these proposals that we've reviewed, and more than 60 percent went unfunded. And so, we have a great opportunity with additional funding to really push the science along and translate some solutions to our soldiers.

Well, this concludes my brief, and I'd like to again thank the Recovery Warrior Taskforce for the opportunity to present on the VCE today.

MASTER SERGEANT MACKENZIE: Okay, a couple of questions. Let me first relay the fact that, I mean, helicopter flight engineer severe traumatic eye injury 2004. And I want to -- what I'm asking for is some input for how do you see this.

You mentioned a lot about involving civilian community in research. What level of involvement are you having with the extreme expertise in the civilian community as far as performing and procedures? And the reason I ask this question is because in 2004 I was told by a military surgeon that I was going to lose my eye, referred to one of the top three retinal surgeons in the country, and I still have my eye. That surgeon specifically came out and said, why is it the military only asks us information and never asks us to do the work?

So, how is the Vision Center of Excellence, in working with the civilian community as far as performing these incredibly difficult procedures that we may not have the expertise at this time to do?

COLONEL GAGLIANO: Right. As you know, a lot of the decisions are made locally. And as I mentioned in the case review process, that we're starting to integrate to get a better understanding of who has what capability and what capacity. And that's really what we're undertaking as well.

I don't think there's any inhibition to refer. I've been in the system for a long time. I'm an ophthalmologist, a retina specialist, as is Dr. Lawrence, and I've never had an inhibition to refer to a clinical expertise if that requirement -- if I were faced with that requirement. So, I don't know if your question is why wasn't the referral done because somebody said they couldn't refer. I would be willing to say that that probably wasn't true, and I see you shaking your head. So, I actually would like to answer that by saying, I don't think that I've come across any component in the system where a referral to a capability that was better than the capability that we had in our system existed.

I will say that we have some of the best trauma surgeons in the system who have more experience than anyone else. And, in fact, it's the civilian sector that looks to us for that expertise. We're about to undertake -- developing a program that would be exportable to the civilian sector to help them learn about our experiences with the management of our ocular trauma because we have the most experienced personnel in the country, in eh system., having dealt with eye trauma -- high level, very complex ocular trauma over the past few years.

GENERAL GREEN: Let me ask a related question, Mac, and then you can come back at it.

So, can you give us an idea of how you intend to use the registry? For instance, is it going to be used to get people into rehabilitation programs so that they can proceed more quickly? Example being that we found in some of the experimental protocols where you're trying to do a combined with new technologies, they have to be adequate in terms of their skills and being able to function in a room, basically daily self skills.

And so, are you going to try and get people through a system faster to get them to a rehab site and get them through the rehab site? And then, secondly, to tie it

back to what Mac is asking, have you worked with the American associations that basically have the best experts in the world to create some of the linkages to come back, so that we're talking similar to what the DCOE has done in terms of TBI and that way, and just trying to find out who are these people that have exceptional skills, that we may want to send those difficult cases to. How will you use the registry?

COLONEL GAGLIANO: Yes, sir. To answer the first, the registry will be used to track patients and will have a capability for us to perform cohort analyses on unique characteristics of specific groups of patients that will help us look at outcomes for interventions that have been performed.

So, the second part of your question -- and, oh, by the way, this is a web-based tool that will be available to all providers in the VA and DoD, so it's not just going to be a headquarters tool. It will be a tool that will be distributed across the entire system.

If we execute the registry properly, everybody who has taken care of a patient or a group of patients will not only see the health care information from both the DoD and the VA that will be entered, but other elements of

information that may relate to their rehabilitation and reintegration programs. In other words, it's not a replacement for the electronic health record. It's an expanded view of what's going on in the individual that brings in social issues and looks at other components of the outcomes that will allow us to do exactly what you're talking about, which is getting the right person to the right place as quickly as possible.

We'll also mention that in the National Capital Region, we have brought a -- the VA rehabilitation resources to those recovering warriors that are in the military hospitals that at an earlier point in time to accelerate that rehabilitation process, as you suggested. When we first started, we realized it was very sequential, and we've tried to make the process more concurrent so that you can get rehabilitation care while you're waiting for some of your other treatment to be completed, or even while undergoing extremity or prosthetic rehabilitation. So, that's been very successful. In this region, it's a good example of what I talk about, the regional coordination centers and one of the functions that they'll be performing.

There was another part of your question that I

wasn't sure I --

GENERAL GREEN: The last piece is how are you linking worldwide experts into your system to try and, again, get those cases that need that special emphasis or a little bit more than what we have found in the standard care available to our patients?

COLONEL GAGLIANO: We have over the last three years have met with the majority of the worldwide experts in a forum called the Association for Research, Vision, and Ophthalmology, ARVO. I've presented at this meeting a kickoff presentation, and we started with a small room. And this last time we did the presentation, we had to go to the major ballroom because there was interest with the Vision Center of Excellence, and we're trying to nurture that interest.

We then met for the next three days every 15 minutes with representatives from institutions that come by and tell us what they're doing, what they can do, and now do we link with them. And we follow up with that and encourage them to be participants in our program.

That picture slide of all of the researchers was partially generated through that forum in the first year that we executed that program. It's been very successful.

We've also held two symposiums. We hold one symposium in Boston called the Military Eye and Vision Trauma Research Symposium. It's sponsored by the Harvard and the Mass General Hospital at the Schepens Research Institute. This is the fifth upcoming in September 2012, which would just complete (inaudible) for -- will be the fifth iteration.

We have had representatives from every major academic institution at that meeting in the past two years, all of which have come to talk about what they're doing for these specific areas of interest, the management of a blast eye, the management of ocular motor dysfunction associated with TBI. These are some of the topics that we have in that meeting. And we just completed our first off year meeting on the West Coast at the Smith Kettewell Institute, which is one of the leading research and eye care institutes in San Francisco. Again, an international symposium bringing together the world's leaders. And our hope is to use that forum to address the issues more specifically related to visual consequences of TBI and the other forum in Boston, more specifically related to traumatic eye injuries.

GENERAL GREEN: My intent, and I'll pass it off,

but just so that you understand, you folks have been in existence -- came together as a team when?

COLONEL GAGLIANO: I was appointed in November 2008, and was alone for -- well, I had a deputy. But we have been officially in existence since November 2008. And there was some difficulty in understanding the appropriate allocation. So, the official designation was really in November 2010 where the governance was defined and the operational support was defined.

GENERAL GREEN: And so, my only message is that this group will be looking at these types of issues over the next five years. And so, we'll be looking for outcome type data. So, please do be thinking about not just the research and the number of symposiums, the number of people you've hosted, but how you're planning on shortening rehabilitation time, if that's one of your goals, how you get people to the right -- all the things that would constitute positive outcomes from having a center such as this. I'm very familiar with the delays in terms of what happened. So, thanks, Don.

DR. PHILLIPS: Just a quick technical question on research. Are you involved at all in any of the research related to restoring vision of people who lost their eyes

with putting electrodes on the visual cortex and using camera systems? Is that part of what you're doing?

DR. LAWRENCE: We actually participated in a program Friday a week ago that was sponsored by the Food and Drug Administration and National Institutes of Health on looking at outcomes or end points for vision prosthesis. And they had industry and academia all coming together in the Vision Center of Excellence. I gave the opening talk, and that's to try to get the researchers that are coming up with vision prosthesis -- four big one right now, and come up with end points that might actually get them across the hurdle of FDA approval. And so, we are very, very intimately involved in that.

DR. PHILLIPS: I've seen patients that have been restored to 20/200 with camera systems and so forth.

COLONEL GAGLIANO: I don't know if people caught that, but Mary gave the keynote opening presentation at that meeting. This is, I think, a significant representation of where we've moved in our -- in the view -- interagency view of our role in vision rehabilitation and restoration.

DR. TURNER: Colonel Gagliano -- excuse me -- on the developing joint policies, procedures, and programs up

here on your slide, I'm just going to drill down a little bit on what General Green said.

It seems like you've done an absolutely superb job of building the head of this animal. And its heart is like the working end. How -- what kind of policies do you think are necessary to get this disparity of expertise solved at the working end down at the rank and file guys? Do you propose like a clearing house or some unity of command or referral system? What are your thoughts on this?

COLONEL GAGLIANO: You hit right on it. There is a clearing house model that we'll probably follow. And then there are joint clinical guidelines in best -- we'll say strong practices. And what's the other term? Well, there is a guidance model. We have actually started a working group on the ocular exam for -- in traumatic brain injury. There is a very interesting set of publications that highlight that in closed globe apparently non-injured eye, there are evolving and emerging vision dysfunctions. And in order to catch these at the earliest possible time, we are starting to take the baseline that the VA has worked with in terms of a common clinical exam and implementing that across both the DoD and the VA so we can have the same

procedures.

DR. TURNER: Again, brilliant research. How do you propose to disseminate that, if I could just hammer you just a little bit on that point?

COLONEL GAGLIANO: Yeah. Well, we're still working through that, I'll have to admit. We have -- I don't think we have the solution. However, we have some thoughts on it. Mary.

DR. LAWRENCE: Well, thank you very much. We -- the VA has a required ocular exam with very specific elements for every patient that's been admitted to the poly trauma rehabilitation in patient. Every single patient, whether they've had an eye injury or not, gets one of these exams. It's very comprehensive.

What we're looking at is patients that are outpatients that have had TBIs. What do they need in terms of eye exams? And we have a work group that's coming together in August to help actually come up with elements that patients will need to have done to them by eye doctors in the system.

So, it's very specific. It's right down to the level of the patient, what needs to be done. And we are working very closely with VA and DoD to come up with

algorithms of care.

One of the issues with traumatic brain injury is that there isn't a lot of peer reviewed literature or research that actually says what's better or what's not better. What are the outcomes if you do treatment X or treatment Y? And we need to have that research to come up with true clinical practice guidelines.

We can come up with some things before we can get to a CPG or clinical practice guideline. We can come up with what's called clinical guidance, and that's sort of a white paper or -- and it gets together all the experts in the field, and coming up with what is sort of best practices. But it's just consensus. There's no peer reviewed literature to show it. So, we need to combine getting the experts in the field clinical guidance with research, and then we can always go back and revise the clinical guidance.

And that's what -- that's how we're approaching these new and difficult eye and vision injuries and dysfunctions related to traumatic brain injury.

GENERAL STONE: What barriers are there to the development of those algorithms?

COLONEL GAGLIANO: Yes, sir, thank you. And I

think that tied back into your question is, once you develop this, how do you get the system to comply? How do you measure compliance? How do you ensure that it's agile enough to adapt to new changes that have been identified? And I think it ties into that last slide, is the joint culture of the whole system is not very strong. And we're breaking a lot of barriers in terms of the joint culture.

So, we know that there is a joint clinical practice guideline working group. As a component of the HEC, we'll probably work through them. How effective they have been to disseminate joint policies and joint guidelines is a question that we haven't fully gotten answered.

So, I don't know that there is a good system that exists. I will know that one of the things we want to try to build into our registry is some alerts that will allow people who are tracking will have some information available to them so that at that point of care, they'll be able to have some new information that might help and assist them, or provide them with a reference to what -- this is kind of a thought -- kind of a real time reference. So, you need to be aware of this guideline and this -- with a patient with these findings and these clinical --

MR. DRACH: First, I'd like to compliment you on your efforts to establish a registry. I think that's very, very important. But, secondly, the question is, have you had any interaction with the University of Pittsburgh's research headed up by former Brigadier -- or retired Brigadier General Gail Pollock and her tongue sensor?

COLONEL GAGLIANO: Extensively. And, in fact, in the last award of the defense related Medical Research and Development Program, that project, that specific project, was funded to continue. The weakness of that project was they didn't have a good training at part of the program, and if that gets implemented, then we may be able to get this past the FDA approval if it needs to be FDA approved, and then get that available.

But to answer the other first part of it, yes. There's a lot of great research being done at the University of Pittsburgh. Joel Shuman is the chairman of the program. He's the one who hired former Major General Pollack. And he and I have spoken on several occasions, and I think --

DR. LAWRENCE: He was on the faculty with him at Harvard.

COLONEL GAGLIANO: Right, so we're very linked

with him.

MASTER SERGEANT MACKENZIE: One of the things I wanted to quickly clarify was, you know, first of all, it wasn't -- my question was not to say that we didn't have good enough surgeons, because, trust me, the ophthalmologist in the green zone in Baghdad in 2004 is why my eye got saved initially. But what I look at with what you guys are doing here is the requirement of health care providers, both DoD and VA, to stay educated. And the reason I say that is because I'm a helicopter guy; I'm not a medicine guy, but yet I'm working as a liaison taking care of wounded warriors. And in the fall of 2010, one of my wounded warriors had his retina come detached. The chief ophthalmologist at the VA in Tampa stood right there after I introduced myself and told her what I was doing there, and told my patient that that retina could not be reattached because it was under oil, and I probably had mine done under nitrogen. This is six years later, and I was, like, no, my retina has been reattached three times under silicone oil. And then we had to put a referral in to get him out of there to get him to somebody to take a look at it.

Not that she wasn't skilled, she just wasn't

knowledgeable. So, with that, are you guys building into place an accountability of education to these providers to make sure that they're up to speed on these new technologies and these new things that are coming down the pike that you guys are creating this information for?

COLONEL GAGLIANO: Yeah. We struggle with that. It's not that we don't know what needs to be done. It's how to get it done. And we just recently hired the former consultant to the Surgeon General of the Army, who will be heading up the regional office at Madigan to lead our education and training directorate. We have six directorates, and that's one of them. And a part of his function is to do that.

Now, he's probably the leading knowledge expert on the use of simulation in training in vision care. And we want to capitalize on that and imbed simulation capabilities at various locations so that providers can have that. Just as you a pilot know that you go through the simulator to refresh your skills, that same concept is being built.

The DoD is probably the leading capability in the country for the use of simulation for teaching surgical skills in ophthalmology. And we want to -- and Rob

Mazzoli, Dr. Mazzoli, is the one who put that in place. We want to capitalize on his expertise, his knowledge, and his experience in that regard to try to bring that same thing nationally across the VA and DoD.

GENERAL STONE: Don, let me just chime in a minute because I think what we're hearing is a much broader question, and that is the frustration of the amount of time it takes all medical care systems to disseminate very good knowledge to the line, and for the line to integrate that knowledge. And we've seen that of more than a decade that it took for very good information on traumatic brain injury to be implemented in even assessment guidelines.

You and I operate in an owned system, and that owned system is not like the civilian health care delivery systems where people don't work for us. In that owned system, there's been an inability to implement algorithms, clinical practice guidelines. You must know that as you were discussing the need for more money for research, I've never sat in a room with researchers who didn't say they needed more. And I appreciate that, but I also appreciate the fact that the end consumer of health care deserves better than what we're delivering today in the transmission of that knowledge into real algorithms and enforced

clinical practice guidelines.

I'm not sure we're asking the questions to the right person because it's been articulated at the highest levels of the delivery systems for our networks. But your insight into this -- you and I also have measured our success based on where we exist on the briefing guidance of the latest American Academy, you know. So, for the opening speaker, we must've been doing something well. How many articles we may have written. And all of that is great, but it doesn't get to the end consumer of health care in an effective manner.

Do you have insight on how to move this great research faster to the end user?

COLONEL GAGLIANO: Yeah. I think what we -- that's the objective. And what we have tried to do to achieve that objective is to keep the program focused. There was no focused vision research program. Essentially it was just a fragmented program and all the different funding systems, and they were getting money, but not placing that money against priorities. There were five priorities identified in this last request for proposals. And all of those were graded against their ability to meet those five priorities so we could move the translational

component down in an organized and coordinated way. And that's the main way we intend to address this.

We're very fortunate that we -- I'm fortunate I guess that I also sit on the National Advisory Council of the National Eye Institute, so I get to see pretty much all the research that gets executed in the country -- vision related research. And the majority of it is either funded through DoD or NIH. And I use that tool to help see where there might be opportunities to come forth.

I want to just highlight one other question about getting the capability to the end user. Knowing that we have limited staff and it's been very difficult to hire people, we kind of took one part of this elephant to tackle, and that was the battlefield component of it. If we can prevent injury, if we can reduce or mitigate morbidity associated with injury, then that was what we wanted to start with.

We introduced the clinical practice guideline. We introduced and implemented and enforced, and it is an audit alert now, and if you don't hear -- if you listen to this worldwide case conference, you will hear every patient that comes through that has an eye injury has a shield placed over their eye to prevent further injury.

We've sent eye shields to the theater, so where they didn't have them so that we can ensure compliance with that clinical practice guideline and ensure compliance with that care, because we were getting eyes that were, in all good intention, that were -- has head trauma and were being bandaged even though the globe was open and it was non-repairable and something that might have been repairable. So, we've stopped that. And I can say to you that we've saved many eyes as a result of that because I listen -- one of the three of us listen every week to this and enforce that.

I would also say that recently been told that the single most complied with clinical practice guideline in that JTTS of the 31 that exist -- the Joint Theater Trauma System -- is the one for battlefield ocular trauma management. But I think that's because of our personal engagement and our weekly enforcement of the things that need to happen. Maybe there's a better way, but right now we're just doing sheer force of will and presence to gain a foothold.

MR. CONSTANTINE: Colonel, I was -- like Mack, I was injured (inaudible) 12 years later than he was. I

can't see out of my left eye due to a gunshot wound to the head. When I -- and most of my care was excellent.

When I was at Bethesda, I went to the ophthalmologist and I was first seen by an elderly gentleman who was a retiree who was a volunteer there. He did my eye exam, and I filled out on paper, and it asks you a bunch of questions. I came back a couple of weeks later, started -- I went to the cornea department, started doing the exact same process with the exact same guy. I said, this is silly. Don't you remember me? He said, yeah, but that was the for the general intake. This is specialized. It was obviously frustrating.

Well, my plastic surgeon was getting ready to leave to go to UCLA. He was fantastic -- Dr. Kumar. He put in the referral to Johns Hopkins, and I went there. The gentleman that was going to be my oral surgeon, who had already missed a couple of meetings we were supposed to have, called and left a message on my cell phone when he heard that, and questioned why I would want to go to Johns Hopkins and why I was taking that referral.

Also one of the eye surgeons that actually told me that the oral surgeon didn't allow other doctors in his operating room when he was in there, which I was very

concerned about because I injured obviously more than just my mouth.

When I went to Johns Hopkins, it was completely different. It was a totally integrated team effort. All the different doctors were there. When I went to the eye clinic, I was met by a medical fellow who took me downstairs, took about 100 pictures of my eye, inside my eye. I went up and saw the doctor. They pulled all the stitches here, and I immediately had a great feeling about what was going to happen over the next three years.

There was a vast difference between the two systems. I'll never know if the ultimate result would've been any different, but I felt very confident leaving Johns Hopkins, and I've only had great things to say.

I just wanted to know that -- and I was also understanding that I was very lucky to get the kind of referral, but you said that shouldn't be a problem. I just don't know if anyone really knows that they even have that as an option, or do most of our warriors are 18, 19, or 21, would dare ask for something like that.

Plus at Johns Hopkins, they're in the middle of a virtual battlefield anyway all the time in Baltimore. So, (inaudible) a long time.

You -- it sounds like you don't think there's a big difference between the level of care between our military facilities and other facilities. Is that accurate?

COLONEL GAGLIANO: I think that the care providers are skilled, and most of them have trained and have worked at these institutions that you're talking about. I was just in Baskin-Palmer at the University of Miami, the number one eye clinic -- eye institute in the country for the last two years. And we went there to review some research that they're doing for us. But while there, we met with military eye specialists who train in these civilian institutions and talk with the people who will say that the best residents or best fellows that they work with are from the military.

And so, I'm going to say, yes, I think our care providers are superbly --

TRACK 9

COLONEL GAGLIANO: -- trained and bring with them the civilian understanding of the management of these eye injuries.

Our systems that they operate in are a little cumbersome. You described a couple of things that were

more than just provider, that were the system. And that's a problem. And we're going to continue to work to make the systems the best possible. But it hasn't been designed that way initially, and there are many initiatives to try to move in that direction. So, I'll leave it like that.

MR. CONSTANTINE: Well, that's great to hear. I appreciate what you said about getting that civilian experience. I didn't realize that was a part of the resume. I'll go on to say that my doctor said I should get some glasses, so I followed up on that, but Tricare denied my claim saying that -- if I had glaucoma I would get it. But getting shot in Iraq wasn't as serious. But I did take care of that, but thank you.

COLONEL GAGLIANO: Thanks for the question.

COMMAND SERGREANT MAJOR DEJONG: Sir, taking this to the guard and reserve side, most of these -- you happened to catch three of us on the panel. Eye injuries are a long-term healing process. I've been dealing with mine since 2004, ended up in 2008 finally getting a corneal transplant, and then still continuing follow-up care.

With that being said, the follow-up care on the guard and reserve side based off of their location, is there a plan from your Center of Excellence to have

referrals nationwide as to the level of care based off of location of the soldiers?

COLONEL GAGLIANO: That's always been the plan, and we'll be able to track that better. With the registry and some of the registry information, we'll actually be able to pull cohorts based on zip code and information that's related.

We'll work closely -- you know, the system that exists is the Tricare system, and we will work closely with the Tricare system for those referrals.

I have to admit the guard and reserve component of it has probably -- it slips through the cracks more than others, and that's been a very important part of our awareness. And when we look at the registry and how we design the registry, it's our intent to try plug that gap and stop that from happening.

COMMAND SERGEANT MAJOR DEJONG: There's a lot of injuries that, like in my case it was an injury that was then fouled up by an infection, and an infection coming back. And then on the VA side of it, as soldiers, especially on the guard and reserve side, are trying to go back and file for things, there's a difference in whether they're filing for a traumatic injury and whether it's

actually being diagnosed based off of five or six years of care as to, well, this was an internal infection or an internal issue. So now, we're trying to place it into what case it is.

So, that takes me into the last part of my question, is the data for your registry, how much history are you guys going to try to gather through VA files or anything of past, and how far back are -- if you're planning on going back, are you going to go to try to build this database?

COLONEL GAGLIANO: The answer is yes. Our initial mandate is to go back to 2001 and then to go back to 1991 when we complete that. It's a very complex and difficult process because there's nothing that has -- most of our information is not stored in the digitized format, so we have to actually go back and review the records record by record, digitize the data, put it in a database, which is why it's taken two years to get us to this point. But once we do this, we're going to take this information back across both the DoD and the VA to begin with through 2001.

MS. DAILEY: Ladies and gentlemen, can I ask that we -- we still have two more vision centers to go through.

And we are -- we can afford more time, but I'd like to get on to the next center of excellence. So, we can send him questions down the road if we more, but we do need to move on to the next one.

GENERAL GREEN: If I could just help with some of that. We happen to have three people who have obviously benefitted from some of the ocular interventions, and so a lot of personal interest from the panel.

It is true, depending on who you listen to, that from the time a new innovation comes into medical practice to the time it becomes common practice, it takes somewhere between 10 and 14 years. That's across the system, not just the military. That's across the U.S. health care system.

And so, a lot of the efforts that are going into this now with registries and with electronic health records are to try and get to that level of decision support and tracking frankly that we can see the people who have these injuries have the right experts looking at it, and make certain that we're basically steering them towards the type of care that you folks were fortunate enough to find without having all that steerage each time.

With that, I agree. We need to kind of move on. And so, just kind of some background information. So, can you talk to us now about the Extremities Centers of Excellence?

COLONEL GAGLIANO: Yes, sir. So, as mentioned initially, I am presenting this on behalf of Colonel Scoville, Colonel Retired Chuck Scoville, who is the interim director of the Extremities Center of Excellence. I'm going to present the slides, but probably defer questions for the record, and so we can move at that.

We have worked closely together in all of the four centers of excellence. I will say Dr. Packer, the TBI and the vision, worked closely together, and we know that in any single individual, there will probably be elements of all four of the specific communities of interest.

And so, we mentioned the VA interface as being important. We also think the centers of excellence interface is very, very important. And we host a monthly meeting. We share resources. We're looking at common research strategies. And we're going to be sharing information across the registry, which is a part of why we're developing it the way we did.

Okay. So, the purpose of this brief is to provide information on the traumatic Extremity Injury and Amputation Center of Excellence, the EACE, and to address the same four questions that were proposed for the Vision Center of Excellence.

I want to highlight that this center is under the operational oversight of the Army, and that it was in the NDAA of 2009 whereas the traumatic brain injury and vision were in NDAA 2008. So, they have had a year -- their start is a year later than TBI and vision.

The current status of the Extremity Center of Excellence is that it's awaiting a concurrence from the Assistant Secretary for Health Affairs on the placement of the headquarters. The Army Surgeon General has recommended the headquarters should be in San Antonio. And once concurrence is achieved, they'll begin hiring staff. At the moment, the only staff in the Extremity Center of Excellence is the acting or interim director, which is Colonel Scoville.

They have been able to get into the budget a \$5.5 million per year for operational expenses. And that's currently in the palm. And one point that Colonel Scoville likes to make is that even though we don't have a center of

excellence for extremity and amputation, they've been doing this now for several years, and the existing three centers are functioning very effectively in meeting what he says are the requirements identified or highlighted in the NDAA 2009 regarding the Extremity Center of Excellence.

So, the metrics that they're using are those identified in three publications that are highlighted here, the *VA/DoD Clinical Practice Guidelines for Rehabilitation of Lower Limb Amputation* that was most recently published in 2007. The next step, the rehabilitation journey after lower limb amputation, which is in the *VA/DoD Joint Patient Education* book, and the textbooks in military medicine, *Care of Combat Amputee from 2009*.

There are three centers that -- in the DoD that perform extremity and amputation rehabilitation. The Military Advanced Training Center, otherwise known as MATC, which is in the National Capital Area at Washington, D.C. It's at Walter Reed. It'll be moving to Bethesda with the relocation. The Center for the Intrepid, otherwise known as the CFI, which is co-located with Brooke Army Medical Center in San Antonio, Texas, otherwise known as MATC North. And the complex in Combat Casualty Care Center co-located with Balboa Naval Hospital in San Diego, otherwise

known as C5. There are seven VA regional amputee patient care centers as well.

The research program that initiated some of this work extended through 2004-2007. However, no research has been specifically designated since 2007.

I'd like to look at this little picture here, and you can't really see it well. But there is an arm amputation with the prosthesis, the leg. And you can't see it, but Dr. Scoville, when he put this together also put the eye on there. So, he keeps reminding me that we really are linked, and that's encouraging.

I will say that's encouraging because there is a high incidence of eye injuries with amputations. We find that if the blast is large enough to cause an amputation, it will be large enough to cause an eye injury as well. So, that's not unrealistic.

There are five priorities that he has laid out. The first is the advanced amputee technologies, and this is primarily extramural research and extramural effort. The three that he has highlighted here are the "ruggedized" sea leg. This is one that can be used in deployment environment. It's currently in use, and it's being developed for those conditions, such as water and sand, and

to be resistant. The second is the prosthetic ankle device for running and for endurance walking. And the last is a method for oseo (phonetic) integration to prevent infections, and that's one of his high extramural research programs.

Priority number two is to establish an intramural research infrastructure. And each of the centers has a fairly robust research infrastructure, but I don't know that they're linked and combined, and that's a part of what Dr. Scoville is trying to get to. As you can see, there's been multiple publications, 35 research protocols, 10 completed data collection at BAMC, which is the CFI, and seven reviewed manuscripts, and five submitted under review. So, they're doing great work, and they continue to publish that great work. The same is true for the MATC and for the San Diego C5.

Priority number three is to develop high level functional outcomes. Outcomes measures is really the thing that I think all of us need to do, and this is one of his priorities. It is really a priority of the Vision Center of Excellence as well. Thank you for highlighting that.

They have -- one of the requirements for outcomes is to establish normative data. In the Champ study they

established normative data for clinical assessment of patients with amputation. And as well as second the second bullet, normative data for CAREN performance. I think there are only five -- pardon me -- CARENs in the country or in the world, and four of those are at the centers and one is at the National Intrepid Center for TBI. So, getting a set of normative data for the CARENs is going to be critical to measuring performance outcomes.

Last is the work on the advanced gate lab and the instrumentation that he has been working with.

Priority number four is to now link these intramural and extramural programs in with other partners that can help develop new solutions. There are several that he highlights that they've been participating in. The DEKA arm study, which was the Center for the Intrepid study in collaboration with DARPA, and the community reintegration instrument, which again the Center for the Intrepid test site studied to validate community reintegration to use an instrument that was developed by the VA.

The second main bullet identifies the major industry partners in the development of prosthetics. And they have been very engaged with providing functional

assessment of these new technologies as they emerge from industry. And it's the perfect place for doing that type of testing. And the last two address academia and military academic institutions and their integration.

Priority number five is, again, to become the world leader for CAREN. I guess that's not too hard when you're the only world owners of CAREN. But -- don't tell Dr. Scoville I said that, but this is really a very important tool. And we actually see this tool providing some opportunity in vision rehabilitation research as well. It's a very effective tool, uses projection and multiple measurements of movement and task identification. You can see here on the second bullet he was able to do some research on the effect of visual field loss and perturbations in the platform in the impact of visual field loss. And so, we want to continue to work with them on this CAREN instrument.

Who are the customers of the Extremity Center of Excellence? I think they're the same as what we described, recovering warriors, those with life threatening injuries, all eligible service veterans, the individuals who have -- already have extremity prostheses, and coalition forces. They've been heavily engaged in the care of coalition

forces around the world. And he also provides a fairly extensive training program that he engages with of providing training on rehabilitation around the world, part of the international program.

How well utilized is the Extremity Amputation Center of Excellence? It is -- in its development stage and itself is probably not well utilized. But the components of the system are very well utilized, as I think we showed here. So, linking the components of the system together is what -- part of the intent is through the Extremity and Amputation Center of Excellence.

He goes on to say that this problem is very significant. Eighty-two percent of all warriors evacuated from the theater have had extremity injuries, and that there is multiple ongoing research efforts, which you've heard about in his priorities and the work that he's been doing in those priorities.

What prevents higher utilization? The first is approval to exist and the location to exist, I guess. And so, awaiting that decision, awaiting the approval of the concept of the operation that's been in development for a little while. And I will say the data registry that he's working on will be linked into the federated registry that

I talked about for the Vision Center of Excellence as one of the communities of interest in that federated configuration.

Hiring of personnel is pending the first two decisions.

GENERAL HORST: Don, I'd like to ask the obvious question here. One, how long have you been waiting for a decision, and, two, do you anticipate a decision any time in the near term?

COLONEL GAGLIANO: It's been over a year I think that the decision on the approval of CONOPs and some of the -- I think it's been two months for the decision on the location. But the CONOPs is a little longer.

GENERAL GREEN: Actually weren't all these created at the same time, was it '08 or '09? Was it '09?

COLONEL GAGLIANO: This is '09, yes, sir.

GENERAL GREEN: Yeah. So, this was in the '09 NDAA to give you an idea. And the controversy -- I mean, I sit at the highest levels where these things are discussed. The controversy is over some of the comment functions. From the time that it first came out in the NDAA, the surgeons were in agreement that we should find a way to consolidate legislative support, conference support, those

types of things. But this is in the purview of health preparers. And so, those decisions, despite commonality from the surgeons trying to get these things placed, but yet attached to someone who could provide common services without duplication amongst the centers of excellence has been quite problematic getting a decision from health preparers.

GENERAL HORST: And, therefore, we do not move forward.

GENERAL GREEN: Well, the work continues. It's just that the formal establishment in terms of where. Even the registries are in some question. The ophthalmology residency, the ocular one, step forward and it started this initiative. But there is some effort to try and make the registries basically auto populate out of other databases so that we would identify people earlier and not necessarily have to do all the entry manually. But it is a problem some of the decisions as to where these things are and what the actual oversight will be. The oversight currently resides in health preparers.

MR. DAILEY: And why Congress asked us to look into it.

COLONEL GAGLIANO: That concludes the briefing. If there are any questions for the record? Okay. Thank you very much.

COLONEL GATES: Good afternoon. I'm Colonel Cathy Gates, and I am serving currently as the Interim Director and the Integrated Service Chief for Audiology and Speech at the Walter Reed National Military Medical Center. Unfortunately, the Executive Director the Auditory Center of Excellence, Lieutenant Colonel Mark Packer, is unable to here today. And I'm here to provide an overview regarding the Auditory Center of Excellence, and to answer those four questions posed by the taskforce.

The mission of the Auditory Center of Excellence is to heighten readiness and improve health and quality of life for service members and veterans through advocacy and leadership and developing initiatives focusing on prevention, mitigation, diagnosis, treatment, rehabilitation, and research of hearing loss and audio vestibular injuries.

The Auditory Center of Excellence was formally established 18 May 2010, a year ago today. And the Air Force has the lead for the Auditory Center of Excellence.

Again, the Auditory Center of Excellence, like the other centers of excellence, congressionally mandated per Public Law 110-417. And it indicates in there that the secretary of defense will establish within DoD a hearing center of excellence and ensure collaboration and sharing of information with the VA. And included in that is to develop a registry by directional data exchange to monitor and track hearing loss and auditory injury. Use of the data within the data registry will allow us to facilitate joint research and create best practice guidelines and clinical education.

The Auditory Center of Excellence has five major functional areas, as you can see: focusing on prevention, clinical care and rehabilitation, research coordination, global outreach, and information management.

The annual budget for the Auditory Center of excellence is \$12 million, and the formal governance is the Senior Military Medical Advisory Committee and the Air Force Surgeon General.

The staffing within the hub consists of one military, which is our executive director. That's Lieutenant Colonel Mark Packer. And in the hub we currently have three civilian personnel, one for

operations, administrative research, and we're currently working on obtaining a chief of staff.

The intent for additional hiring actions includes 29 contractors, which will be spread across the five major functional areas to support the Auditory Center of Excellence.

The products and services within the Auditory Center of Excellence will focus in on maximized hearing readiness and retention, coordinating standardized clinical care from the lowest level on up. We want to establish best practice guidelines, a joint access management of hearing loss and auditory injury data, and that's the data registry. And, again, our data registry will be modeled after the Vision Center of Excellence registry.

Also included will be educational outreach programs and facilitation and encouragement of hearing relevant DoD and VA research.

We within the Auditory Center of Excellence are really pushing on increased collaboration amongst the labs to ensure that relevant research is occurring within the area of auditory.

The status of the Hearing Center of Excellence, current actions to operationalize the CONOPs are under way.

Initial operating capability of the hub is 75 percent complete. Still working on trying to recruit a chief of staff. Four of the five directorate chiefs have been identified. We have a prevention plan that we're working on, and that is expected to be completed 31 August.

The items within the prevention plan, the recommendations, earlier this year we had a GAO audit of DoD hearing conservation programs, and the recommendations from the GAO audit are incorporated into our prevention plan. And we're focusing on better education and better tracking of our education that we provide. Included in there, we're also adopting best practices within each service to enhance our prevention program.

A strategic communications plan is being developed, and that is due out 30 September. And we also are working on a standardized hearing aid and cochlear implant purchase program policy. And that's due 31 December.

Also, we are upgrading our current hearing readiness, hearing conservation monitoring system. The DoD uses the Defense Occupational Environmental Health Readiness System for tracking hearing readiness and hearing conservation. Currently, that system requires to manually

enter demographic data. And the Auditory Center of Excellence is funding to get an automated demographic feed to eliminate that manual data entry of data, which will also allow us to have an easier sharing of this information with the VA.

The last thing that they're working on is establishing an MOA with the Medical Research and Materiel Command to adopt the use of their centralized IRB for sensory related clinical studies.

The customers are very similar to the other centers of excellence. Again, it starts with the service members, and the veterans, and line leadership. We want to ensure that we're providing them the tools and the information needed for them to make critical decisions related to force readiness and hearing readiness.

The VA sharing of data to ensure that the VA has the baseline audiogram and the termination audiogram data to help them with their VA claims and in the long term reduce the VA compensation claims.

Clinical providers. We're working on developing clinical practice guidelines and ensuring that that is a standardized practice across DoD.

Researchers We're looking at increasing collaboration and sharing information that's relevant to research.

And of course our customer also includes the other centers of excellence because we want to make sure that we have multi-sensory integration and awareness of what the other centers are doing.

And, again, our investors within the Auditory Center of Excellence consists of Congress, DoD, our research sponsors, focusing in on hearing loss and tinnitus data.

Industry. Our VA, our counterparts, so that we can have a single sharing of data.

And, lastly, the service members and our veterans. We want to ensure that we are providing best possible care and rehabilitation to our service members and veterans.

The HCE is a center for excellence as it is a network of capabilities across DoD and VA. Full operational capability is expected December of 2013, and it will include hearing loss and injury data captured and shared to the VA by directional feed of information. We also are looking at developing prevention practices and

education across DoD, standardizing those practices, and using the recommendations that were provided to us from the GAO audit; establishing clinical practice guidelines and tools that will be made available for health care providers, patients, and families; and focusing on advocacy for looking at the creation of a portfolio of relevant research within DoD and VA. And the Auditory Center of Excellence is going to be that center that's going to collect the information and ensure that that information is disseminated and shared with the research labs within the DoD and the VA.

Of course, the higher use of the Center of the Excellence is expected once we obtain formal approval of our concept of operations. And staffing actions are under way and will be completed. We have the funding available this year, and the CONOPs currently is in health affairs and awaiting review and approval by the SMAC.

The -- some of the outcomes and measures consist of the following: for prevention, our near term, again, as I mentioned, we're looking at developing that demographic interface with our hearing conservation and monitoring system to eliminate the manual data entry. One of the short term approaches with that interface is to allow us to

launch that worldwide and also to share that information with the VA.

We also are taking an initiative, a joint incentive fund initiative that is under way by the NCRAR in Portland, the Portland VA. And five Army medical military treatment facilities, they're establishing educational booths that will be deployed. We currently have one deployed at Madigan in Fort Bragg, and there's one in the VA in Portland. And that information is to help us increase education and awareness of hearing and the importance of hearing. And that initiative -- the plan is to deploy those educational booths to our five major medical centers.

One of the -- in the 13- to 24-month time frame for prevention is we really want to get the baseline DoD audiogram clinical practice guideline. We want to standardize that across DoD so that all of our service members obtain their baseline audiogram prior to their exposure to hazardous noise.

Clinical care. Focusing in on standardized hearing aid purchase program. Currently within the DoD, there is no standard in place. At Walter Reed, we currently use the remote order hearing aid entry system,

which is a VA system. And our plan is to deploy that across DoD. And the nice thing about this remote hearing aid entry system is it reduces the cost of the hearing aids, but then it allows us to track the hearing aid trends within DoD, but also within the VA.

The other thing that will be held next month is an MVAR training, military vestibular auditory rehabilitation training. This is the first training that is for audiologists to have a better understanding and the tools needed to provide vestibular assessments and rehabilitation to our wounded warriors as well as our other beneficiaries that have vestibular complaints. That's going to be held in conjunction with our physical therapist and our neurotologist, and that's going to be held at the NICO over at Bethesda in June.

The other thing we're looking at is developing asymmetric sensory neuro hearing loss guidelines. And so, those initiatives are under way.

More -- the 13- to 24- month time frame, we're looking at publishing the hearing aid policy regulation to standardize the hearing aid order and guidelines for DoD, and publishing trauma and primary care guidelines.

Global outreach. We recently had our joint DoD/VA audiology conference. That was in March, and that was very successful. We also had a fitness for duty conference in conjunction with the Joint DoD/VA Audiology Conference.

GENERAL GREEN: Kathy, if I can. Since you've given us the notes, you don't have to go over it quite so extensively.

COLONEL GATES: Okay.

GENERAL GREEN: Okay, thanks.

GENERAL STONE: Kathy, I wonder if you could stop for a second.

COLONEL GATES: Sure.

GENERAL STONE: One of the questions we ask is, the formation of centers of excellence, how much of the work that you have listed here, which is very extensive, would go on without the Center of Excellence? And how much exists today because of the formation of the Center of Excellence when you're not going to be up and running till the 13th.

GENERAL GREEN: Let me answer the first part, and then --

COLONEL GATES: Okay, sir.

GENERAL GREEN: -- you take the second part.

Okay. So, I need to add some clarity to what I said before regarding decisions on the COEs. The only center of excellence that received dollars up front from Congress at the time that it started was the DCOE. And there were very large dollars, in the hundreds of millions of dollars, for research that came in to the DCOE.

All of the other efforts, which came a year or two later in terms of the law, came without resources. And so, each of the services had to look at what's called an APOM year. But outside of the normal budget cycle, how to put dollars against these centers of excellence. And, more importantly, how to put manpower against these centers of excellence.

Initially because of the need for VA and DoD to work together, it was thought that they would all reside here in the National Capital Area. And then subsequently, as we looked at it, it made more sense for them to be placed where there was an aggregation of researchers and expertise. And so, then they looked across each of the services, which led to some of the delays.

Much of the work that's been done, and one of the things that Kathy is talking about, have been things that

are ongoing efforts by the Department. So, without the formation of the Center of Excellence, you are correct, this research and many of the things that are being done would continue. The advantage to the centers is that it aggregates that and brings it closer together where we might be able to actually shorten that time span from where the research is and where the evidence is to what's in common practice.

And so, the difficulty in terms of the organization based on it being outside of normal programming, not having resources, not having manpower. It's taken the Department some time to realign those things without interfering with other programs that are extreme value, such as hearing conservation that both DoD and VA have very long histories.

And then I'll let you, Kathy, talk to why it's important to have the center to aggregate this. I mentioned my opinion, but please.

COLONEL GATES: Yes, sir. Actually the Center has been a great asset to DoD audiology, VA audiology, as well as our neurotology community. The Center has allowed us to bring all of those professionals together and share information. There are a lot of great things that are

happening out there, but with the Center of Excellence and having Lieutenant Colonel Mark Packer as the Executive Director, has allowed us to share information and really move things forward. So, I would say that, yes, I'm very grateful that we have this Center of Excellence and that we're moving this forward. We're able to really push the clinical practice guideline from standardized how we provide services to our eligible beneficiaries.

GENERAL STONE: I appreciate that, but I think one of the things that we've recognized as we've looked at this is congressional mandates without resources do little to move us in an effective manner. And I think one of the advantage of this committee is we can help comment on some of those things that forces organizations that are already strapped to find mid-year reprogramming in order to facilitate what is a very good idea.

My wife often says I have great ideas rarely supported by my checkbook.

[Laughter.]

GENERAL STONE: This is an example of the same thing. There must be resources that come along with these great ideas in order to facilitate what we're trying to create.

COLONEL GATES: Yes, sir.

MS. DAILEY: And can we wrap here, ladies and gentlemen? We have got one more full briefing from a very significant program. So, I'd like to give the members a five-minute break. I'd like to very much thank the panel, all of you. We've got your briefings. We'll be back in about a year. Please don't change them. I realize your leadership is going to change over the next year, but this is our baseline, and we're going to hold you to it.

GENERAL GREEN: Nice job, guys. Thank you.

MS. DAILEY: Thank you.

MS. DAILEY: If I can get the committee members to reassemble. I know I have got this whip cracking pretty hard, but I appreciate your endurance.

DR. GUICE: All right. We'll go ahead and get started with the next briefing. This is Tab F in your binders, and this is the briefing on the Federal Recovery Coordination Program. You probably know this is actually my day job for a little bit longer.

And I'd like to introduce the panelists. These are all Federal Recovery coordinators: John Buckholtz, Verna Wells, Lisa Arnold, and Michelle Lee-Sing. And they

represent both FRCs at military treatment facilities as well as VA medical centers, and kind of the spectrum of our employees being nurses and social workers.

The Federal Recovery Coordination Program is a joint program. It was set up in 2007 through an implementation of a couple of MOUs by the Departments of Defense and VA. The program was set up with the intent of coordinating and accessing Federal, state, and local programs' benefits and services for wounded, ill, or injured service members, veterans, and their families.

We have a -- we are operating under a VA directive and a VA handbook. Both of those are available on the website if you'd care to read them. We report to the Joint Executive Council, the Senior Oversight Council, basically to Congress. We had a hearing just last Friday.

We've just recently undergone a GAO program evaluation, and the web link to that report -- that full report is in your briefing documents.

FRCP population and criteria. This was initially determined by the Senior Oversight Committee and includes the various categories that you see on the slide listed. Then in 2008, in the fall of 2008, under the guidance and direction of the NDAA '08, the Department of Defense stood

up a Recovery Care Coordination Program, and we had to determine kind of who was going to be in charge of what population. We came up with this particular scheme of how to manage the population.

Category one, if you think about it, these are merely triage kind of criteria. Category one are those individuals who really don't need much more than physician, medical care, support. These are people that are going to heal, maybe a little bit of rehabilitation, and then they're going to go back their military occupation.

Think of a simple fracture. Think of someone who has a normal labor and delivery. Those individuals are going to do fine. They're not going to need the complexity of services and benefits. They're going to need a little bit of care, and then they go back to duty.

Category three is the next most easy to explain. Category three are those individuals who really are severe, complex problems, both medical and injury. Those individuals you sort of look at and you say, probably not likely to go back to military duty. Probably more likely to leave military service than to return a civilian status.

And then the category two are those sort of people in the middle. You can see that around those

colored categories they are perforated lines, and that's to represent that it's really a fluid thing. Someone in a category one can suffer, I would say, a pulmonary embolism and quickly move down to a category three depending on what the problems -- subsequent problems are. And certainly category threes can get better and move into your category two, but that's just to indicate that there is some fluidity in these categories. It's not cut and dried.

The other thing to remember is these categories don't exist in any of our data systems. There's not a check box anywhere to indicate category one, two, or three.

Category two was to be assigned to a recovery care coordinator, the DoD program, and category three was to be assigned to a federal recovery care coordinator.

You can see on the bottom that that's where we list sort of all the resources that we thought needed to be in play for these individuals.

At the top, although we talk about recovery, rehabilitation, and reintegration, they're really not three separate things. They kind of happen simultaneously. So, it's a little bit hard to -- it makes for great slides, but it's a little bit hard to bend people into those categories because they overlap significantly.

Okay. A little bit about federal recovery coordinators. They're all clinical people. They all come to the program being master's prepared, nurses and social workers. They are hired and paid for by the VA. They are trained in VA, DoD, and private sector benefits and programs and services. They're assigned to their case load and to their place of work by the central office, which is in the VA central office here in D.C. And they work with clients, families, and anybody else to meet the client's needs.

One of the tools that we use is something called a Federal Individualized Recovery Plan, more commonly known as the FIRP. The FIRP is that goal-based tool that is task oriented to actually make sure things happen and that tasks stay on track to complete or meet someone's goals.

We use the veterans tracking application, which is our data management system. That also houses IDES. It houses some BBA information and a little bit of VHA information. And we use the National Resource Directory to look for resources for our individuals that we care for.

Well, I'm not going to dwell on this. Everybody knows how all this started. Of course there were lots of

investigations. The studies identified six common problems: complex war injuries, system barriers, multiple transitions, confusing benefits, information access, integration left to individual and family. The concept of care coordination specifically, the Federal Recovery Coordination Program came out of the Dole-Shalala Commission in '07.

Well, I think it's interesting to look back and say, well, if these are the six problems that all of these investigations identified, how does this particular program help to solve or mitigate some of those problems? Well, complex war injuries. Because FRCs are clinical personnel, they understand the potential complications and implications of the injuries and illnesses, and they're better able to coordinate the resources looking far down the road to predict what these individual will need and aligning them appropriately to deliver just in time care.

System barriers. A single point of contact is probably a better solution to aligning services and benefits between systems. We know we have a lot of case managers, but somehow there was something missing in terms of a unified approach to really cross the systems of care, including the private sector, and pull all of the best

resources together, particularly for the severe and complex wounded, ill, and injured.

We also know that these individuals, by virtue of our complex systems, undergo multiple transitions. They transition from Landstuhl to CONAS, to one of our many facilities here. They transition from inpatient to outpatient. They go from one military treatment facility to another. They go from one of those to a VA poly trauma center, and then they come back. And then eventually they transition to outside of the Department of Defense to the Department of Veterans Affairs and veteran status. So, making sure that we sort of mind the gap as these individuals make all of these multiple transitions, I believe is a real key to success in managing their care and benefits across our systems.

Confusing benefits. If you have a single point of contact that can help de-conflict some of the information about benefits, a single point can kind of manage those a little bit better using all the case managers to actually carry out the various activities.

Information access. Single point of contact provides better and accurate information. They certainly can validate the information that these individuals get.

You note here that they don't have to know it all; they just have to know to get it all.

The other thing that was a particular thorny problem was that integration and navigation of our complex systems was left to the family and the individual. They're just trying to heal and kind of adapt to what their new normal is. So, asking them to kind of figure our system of transition, and all the case managers that they come into contact with, and all the benefits, and all the resources that we throw at them, it just didn't seem to be quite fair. So, having a single point of contact to assist with really that integration and navigation of our complex systems, again, for the serious and complex injuries seemed to be just a better recipe for success.

FRCP active client demographics. We have several different categories of status within the program. One is active; that means you're enrolled. One is inactive; that means you've been enrolled and now you're no longer enrolled. One is a evaluate, which means you're referred to the program and we evaluate whether or not you meet the criteria for the program. One is a redirect where you find that someone who has been evaluated really didn't need the complexity of the services provided by FRCP. The

obligation of the program is then to refer them or redirect them to the appropriate level of resource.

And then we also have a category called assist, and those are those individuals who just need one or two things solved. People come to the FRCP program because they know these individuals can actually quickly solve and mitigate problems.

So, the average age of our active clients is about 30, and you see the range there. Most are men, which matches with the military itself. About 60 percent are on active duty, and you can see the distribution there. Fifty percent are single, 50 percent are married.

You can see there that we actually collect information on legal representative. Our individuals that we care for are frequently so complex and severely injured or ill that they can no longer care for themselves or their legal affairs. They have legal representatives -- powers of attorney, they have fiduciaries, they have guardians. So, with 40 percent of our clientele having to have a legal representative, it kind of give you an idea of the complexity of these individuals and what -- the population that we serve.

Eighty-four percent are affiliated with the

Wounded Warrior Program. GAO thought this was a little bit puzzling and thought that there might be some duplication. Actually, it's a requirement of the program. So, 84 percent is pretty good. The ones that aren't affiliated with the program are actually veterans who went through before the Wounded Warrior Program might have been established.

But we really value having that association with the Wounded Warrior Program because they can do things and reach back into the military that are really important for making sure that these individuals are well cared for.

Seventy-five percent are outpatient. Actually, it's not the same 75 percent all the time because our patients are frequently in the hospital, and then they go out of the hospital, and then they go back and forth. So, it's not -- well, 70 percent are generally outpatients. It's a fluid system because it's the multiple needs that these people have.

Seventy percent of our clientele have more than one thing wrong with them. We do track of the types of injuries and illnesses that these individuals have, and most of them are fairly complex. The ones that have a single problem are generally someone with perhaps

metastatic cancer or someone who has a very severe penetrating brain injury. So, they're very complex and severe injuries and illnesses.

We did conduct a baseline satisfaction survey. We value what our clients think of us, and we really want to make sure that we improve what we do. The key to that is a satisfaction survey. So, we conducted this last year, and you can see the results there. We tried to put it into context for you using the American Customer Satisfaction Index, and you can see that we sort of fit nicely in kind of the upper range of satisfaction.

We also use the Satisfaction Survey to clearly help us identify where we could do better, and we have identified several places that we know we need to improve, and we're working hard to make sure that we address those particular issues before we do our second satisfaction survey scheduled in 2012.

The caseload. People always want to know the caseload and ratios. So, here's that information for you. When I came to the program almost three years ago, we had 97 clients and seven FRCs. We currently have 727 active clients, 79 in evaluation and 33 -- average active client for FRC of about 33. We've helped almost -- a little over

1,600 individuals since the program has been in existence.

You can see that our average referrals currently are about 50 each month. When I came into the program it was about 25. So, we have grown in terms of referral. I think the pro to me -- it may be a soft indicator of effectiveness. But certainly if we weren't effective at what we do, if these people didn't do a good job, you would anticipate an increase in referrals. And that's what we've seen.

This is where they're located. So, again, I'm not going to read it to you; you can see that. We have a total of 25 approved FTE. We're in the process of hiring those additional three FRCs.

This is -- since we've asked about a CTP, I thought I'd better show you what a FIRP looked like. So, this an example of the FIRP. This is a screen shot taken out of our, not our active site, but our demo site so that it is not -- there's no PHI in it. But you can see the tabs across the top. You can see there would be a name. We have a case ID number so that we can sort things a little bit easier. And then there's a client information tab. If you clicked on that, that would be where all the demographic information would be. We have the FIRP tab,

which I'll talk about in a minute. We have our contacts tab, and that's where all of our points of contact for this individual would be. The case managers who are involved in the case, any physician, the spouse, the mom, the caregiver, whoever we need to contact, that's a way for us to kind of keep all of that information in a single location for the FRCs to quickly find and use.

The medical information, I told you we tracked kind of the basic wounds -- the illnesses and injuries. This is where that information goes because we are -- if you remember back to that SOC approved criteria, it had very specific types of injuries and illnesses that we were to pay attention to. So, we actually bend things according to that, so there's a roll up of how many amputations we have, and how many burns we have, and how many of this and that. So, that's where you'd find that information.

Locations. This is something that we've added. This is where the patient is today. These patients move around a lot, as I said. They're transitioning all the time to something. So, if an FRC needs to cover for another FRC and they need to know where is he today, they can go to this tab and see where he's currently enrolled for treatment either inpatient or outpatient, and the types

of clinics that he's -- he or she is receiving care from. It also includes a lot of address information, including a current address as opposed to the address of record, which is frequently not where they individual is.

Uploaded files. This is so that we can scan and store things such as assigned FIRP or any kind of release of information.

Now I'll go back to the FIRP. We've just done a complete redo of this. We recognize that really what you're doing -- if someone's got a goal, it's really just a series of tasks that the FRCs then monitor. If you want to run in the Olympics, you can kind of think about all the things that have to happen to get you to run in the Olympics. The FRCs will fill those in and begin to track them.

If you scroll down in any one of these things, you would find a series of tasks, who's doing the tasks, what they promise to do, and when they were going to deliver it. You can also see that we've got a red indicator there. We have the stoplight chart, which actually lets the FRCs know when something is coming due so they can quickly go in and see what they need to do for the particular case, who they need to contact in order to keep

things moving forward.

We are in the process of folding the FIRP into e-benefits, so our clients, when they log onto e-benefits, can see their FIRP. This, you can't see it very well, but that's kind of what it's going to look like within the e-benefits portal. We thought this would be a very clever way of delivering a plan to a client so that they can see it any time they log on to e-benefits.

Who do we work with? Well, this is just a short list of the people that we work with. All the different types of individuals who are involved in the care and providing services for or wounded, ill, and injured, and I think it's a pretty robust list. But those are key relationships for the FRCs.

All right. Now, if you think about what -- that slide I just showed you and those hosts of names, what the Federal Recovery Coordination Program does, and each one of those named entities is a bubble now. So, that yellow bubble is the interdisciplinary team. But the FRC piece, what we do, what the FRCs do, is they kind of watch as we all of those programs and services to the care of the individual through the recovery and rehabilitation, and reintegration.

And then the FRCs are there kind of providing support, making sure that if something drops, it comes back up right into place. And it was fun to make this slide, by the way.

All right. The questions you asked. How do we define success? Success is a smooth recovery. Success is when they achieve their goals. Success is if someone moves to inactive status because they say, we've got it, we're good to go, we can take it from here, but we'd like to know that you're there if we need to reach back. And we make sure that they know that they can always call their FRC, even if they're in an inactive status.

We want to make sure that our -- defining success, that the client gets appropriate health care benefits and services to which they are entitled. Our benefits and entitlement system, as you know, are kind of driven by what's wrong and kind of different phases. So, we want to make sure that we cover all of that. And then we want to make sure everybody knows about the resources available in the National Resource Directory, which we use quite extensively.

MR. REHBEIN: Karen, that third bullet, the inactive. Can you put a number of that, how many of those

you have?

DR. GUICE: It's around 160, I believe. What we found is that individuals -- and what we say, initially the program had said that we're there for a lifetime.

Practically speaking, you're there for as long as they need you. And some people, that may be a lifetime, and some people that may be a few months. So, very practically and pragmatic, we say we're there for as long as they need us.

When we make someone inactive, it's because we can't reach them anymore, and we have a whole protocol where we go through 90 days' worth of trying to reach the individual. If we can't do that, we follow up with a letter. We follow up with calling the last known case manager and making sure that they actually have them, and the individual is okay, and everything is moving along all right.

We have a lot of clients who say, I'm good to go. The family says you got me to this point, we've got it in hand. You've aligned us with all the resources. We've got our benefits in place. The house has been modified. We got the automobile grant. We'll be okay. As you can see, you know, because we also make sure that they're aligned with their Wounded Warrior Programs for continued follow-up

premiere services if it's warranted.

We also make sure that these individuals know they can call their FRC at any time. And I think one of the things that's gratifying for the FRCs is that the clients do. The former clients call them and ask them for advice, or, gee, can you help me with this one little problem. If the FRC needs to make them active again, it's simply moving the status indicator into active, and they're back fully enrolled.

All right. So, what kind of data do we gather? Well, right now we're working -- we have mostly process measures. We don't have a lot of true outcomes. We're trying to create those indicators and making sure that we count the right things to show that the program does add value and is effective.

Right now, the measures for the FRCs are -- include time stamp things, so they have to complete evaluations within 30 days of referral. They have to initiate the FIRP after enrollment. They have to contact the client at least 30 days. Many of them contact their clients much more frequently based on the need of the client. And then we have to follow up on the redirects within five days. So, if someone redirects to another

level of resource, the FRC's responsibility is to call that individual and say, was the problem solved? Did we get you where you needed to go?

We're planning on tracking the numbers of closed goals because we've just gone through this big redo of our data management system. It didn't quite align nicely with being able to do that smoothly. But now that we've got that all re-wickered in our data management system, we're going to be tracking the number of closed goals because we think that actually is an indication of adding value and, you know, showing that the program is working.

We're also a part of something called the Information Sharing Initiative. This is an initiative that was put together about two years ago looking at exchange of information among case management and care coordination systems. We have a lot of stovepipe systems, as everyone knows and is aware of. And because we have lot of programs involved in the care and management of any given patient, we wanted to make sure that we could see the information from other people's systems. We wanted to make sure that we knew exactly who the case managers were, that eventually we could get to the exchange of the care plans or the Federal Individualized Recovery Plan so that we could

actually see the information and manage it better as a team. And we're on track, by the way, to actually begin our first exchange of information in September of this year with that project.

All right. So, we measure whether the FRCs meet their performance requirements. We measure the number of goals, and we did our client satisfaction. So, those are things that we look to to measure the effectiveness of FRCs.

Sorry about the font size, but this is our educational program. FRCs are extraordinarily -- they're exposed to a lot of information on a very frequent system. The reason they're here today is because this happened to overlap with their quarterly training, so I made them come. I can do that. I'm the executive director.

So, this is it. We have -- they come already to the program with fundamental knowledge about clinical care either as nurses or social workers, and they have to meet requirements to maintain their state licensure. So, that's one level of their education.

The other thing is when we bring them in as new FRCs, most of the time we also pull from either someone with an extensive DoD background or a VA background so that

it actually makes that cross learning a little bit easier because you just have to sort of fill in the gaps for one department instead of two.

They attend a two-week orientation that's here in D.C. We bring all of the subject matter experts in their area to talk to them about the various program, and you can see some of that there.

They also shadow National Capital Region FRCs to kind of get a real sense about what the program is and what it does and how they operate on a daily basis.

They're required to attend quarterly training throughout the year. The quarterly training is based on what the FRCs say they need along with some management needs to provide different kinds of education. We've focused a lot on effective communication and running good meetings as a management strategy, as well the latest TBI treatment, or various ways of addressing PTSD, and service dogs.

Quarterly training covers case management. That was one question that the team asked. It covers the roles and responsibilities of the individuals involved with the care of our wounded, ill, and injured.

And then every week we have a virtual team

meeting. Every Tuesday for 90 minutes, we usually present some sort of new resource to the FRCs. It may be home for our troops. It may be AMVETS. It may be whatever we can find for them to, again, supplement their knowledge about the resources that are out there that they can turn and use for their clients, or they can push the information out to the people that they deal with as well. So, it's another nice way to disseminate information.

They're encouraged to sit for the case management certification. After a year of being an active FRC, the Case Management Society of America has recognized that FRCs can go ahead and sit for the exam. We think that's a bonus, and we encourage them to do that.

How do we promulgate best practices? Well, you know, right now, best practices what works well and can we replicate it? They do stay abreast of best practices in the various fields, and they figure out ways to incorporate them into what they do. They share those best practices through the weekly staff meeting as well as required supervisor calls every week.

For the FRCs, we've divided them up in sort of geographical areas, and they talk among themselves with the supervisor. And we review cases, talk about difficulties

they've been having, talk about what works well, share new resources. It's a really good way to practice -- to share those best practices and what works and what works well for what reason.

And we have already -- we've conducted one site visit to each FRC location where they were simply observed. We sent out observers, and the observers weren't actually allowed to speak to the FRCs. They were just there as flies on the wall. They were observed as -- what they were doing during the day, and we actually identified some best practices that way and pulled those back into the program.

How do we define success for family caregivers? Well, families are very important to us. We actually within our individualized recovery plan, we can set a goal for a caregiver or a member of a family just as easily as we can for the client, and we frequently will do that, particularly if it's scheduling respite care or making sure that they -- if they need a career -- they themselves need career counseling or want to take advantage of some of the educational opportunities, we can set those up within the FIRP just as easily as we can for the clients.

What kind of data to support family caregivers? I'm not going to repeat a lot of this. You can see this is

-- we did -- our satisfaction survey was not just for clients. We actually called caregivers as well, so we matched those -- sort of had matched pairs, if you will, of people giving input back to the program.

That concludes my briefing, and we are to happily answer your questions. And I would invite you all to engage with the FRCs because I talk about it, but they do it.

MR. CONSTANTINE: Karen, thank you. Quick question. It seems like the educational background that your folks have as well as their certifications and continual training is a lot different than what RCCs have. Do you know why that is?

DR. GUICE: FRCs are coordinators for clinical and non-clinical care. So, they see the big picture. RCCs are really that non-clinical care. And to me, in talking with RCCs and really looking at what they do, they're really providing non-clinical case management, whereas the FRCs really kind of seeing what all the case managers do, and then having that -- keeping everything on task, making sure that things are moving forward.

And really, with the observation of all of those investigative bodies, where we were having big trouble was

in transition. When you leave one set of case managers, as you well know, and one medical facility, you go to another set, sometimes the information transfers pretty well, and sometimes it transfers okay. And sometimes there are critical pieces of it missing.

So, what the FRC is doing -- and one thing that sets us apart as well is that one FRC will stay with the same client. Once they're engaged with that client, they stay with them regardless of where that client moves, transitions, or goes throughout the country. So many of the FRCs have clients everywhere else, a few in their backyard, but will actually be providing that care coordination, that function for clients across the country.

MR. CONSTANTINE: Great, thank you.

DR. TURNER: I have a question for the panel as well. It says, caregivers' satisfaction was 77 percent in the 2010 survey. What do the other 23 percent say? And are there any lessons to be learned from that?

DR. GUICE: Absolutely, and that was -- one of it was you can -- we provided you with the full survey in the back, and you can see the questions that we asked. I think some wanted -- were not sure that they had seen the FIRP and wanted to make sure they had access to that. Of the

people who knew that they had a FIRP, it was amazing how they thought it was very useful and very functional for them. So, we want to make sure that that is a little bit better.

I think it probably reflects the fact that the caregivers at the time the survey was done might not have had all the benefits and things that they needed in order to make a successful outcome for their service member. I think that's changing now, some different dynamics. So, it'll be interesting to see how that moves forward.

The FRCs are very much involved with identifying or letting the caregiver support coordinators at the VA medical centers, who are starting to do that intake, to prepare the turn on of the caregiver benefit. They're very involved with the caregiver support coordinators to make sure that they have the information they need from us in order to fully evaluate a potential client who would benefit from the -- or who can qualify for the caregiver support.

MASTER SERGEANT MACKENZIE: So, with that being said, in this FIRP, does it show -- seeing as your contact is, you know, once within 30 days, is there any kind of indication to the FRC that the caregiver has not logged

into the FIRP or has not done that that raises a flag that says, hey, maybe I need to get with the family caregiver and make an effort to get them in there?

DR. GUICE: They can't log on to our data management system because of -- that's why we're putting it into e-benefits. This is just a new thing. They just now put it in there. So, what we're going to do is we're going to get a group of our clients and caregivers. Once they get the surrogate protocol down for e-benefits to take a look at the FIRP and kind of go over it with us, and make sure it's meeting their needs within the context of e-benefits.

Right now they have to rely on either faxing, mailing, or having -- if they're co-located with the individual, walking the FIRP to an individual. I know Michelle just had a client to show up at training this morning to sign a FIRP, and Karen Olichweir was walking around Rosslyn the other day looking for her client to sign this FIRP. So, these people will do pretty much anything to get the client the FIRP.

MASTER SERGEANT MACKENIE: Now, the other thing, too, is as these service members move major facility to major facility, I noticed in your chart there's all these

people that you work with. Is there a requirement for the FRC to make contact with those people that have got hands on, their patient, and what is that requirement? Because I know I've been working with a patient for over six months, and I've never even spoken to the FRC for this particular patient, who's not co-located with that patient.

DR. GUICE: There is not a requirement to do that. The FRCs will work with all of the people there, but we don't have a standard, you must call each one of these people. I think if we did that, they'd be spending their time on the phone and not actually tracking what they need to for the client. But we can certainly think about doing that.

I think one of the important things is as the information sharing initiative goes forward, there'll be better visibility of who all is involved and who's touching the individual at any one point in time.

I think one of the frustrations we're starting to hear from some of our clients is, I got called from 20 people today. Could you just stop? In fact, somebody said that, just take me off your list.

So, you know, all of our programs have some sort of mandatory threshold of contact. And sometimes I think

we do it so that we can check a box. But if we saw that one person had already contacted that individual and everything was okay, unless there was a very specific reason, maybe we could rationalize that a little bit better, and we wouldn't be so blind to what everybody is doing. And I think that's going to be a value added to what we do.

MASTER SERGEANT MACKENZIE: And I think that's kind of the basic communication. I mean, don't get me wrong. I know who the FRCs are, and I know how to get a hold of them because the one that works with me works very well. However, I'm not familiar with the requirement. I'm getting ready to do a major move with this particular service member. I don't even know if the FRC is aware. And I suppose part of that responsibility falls on me. But once again, I've been with this patient for nearly six months and never heard from that person. So, you know --

DR. GUICE: That's what I was going to ask. I was going to ask what's the requirement at SOCOM to get in touch with the FRC as well.

MASTER SERGEANT MACKENZIE: Normally it's if we need them.

DR. GUICE: And my guess would be that would be

the same thing -- the answer that the FRCs would tell you. If there's a need for that communication, it would happen. If there's not, they're not going to disturb you unnecessarily. And we also know that we have an FRC down there who can run interference.

MR. DRACH: First of all, I'd like to congratulate you and thank you all for the work that you do because you probably have one of the most intense, frustrating jobs in the country. And then, I'm familiar with the program since its inception. I was involved a little bit in some of the early training with the first FRCs when I was at the Department of Labor.

But one of the things that struck me in the GAO report was, I forget the exact word they used, but frustration level. One of the FRCs who had a couple of clients who were terminal. And my question is, do you engage hospice care at any point?

MS. WELLS: Okay. Yes, we do. In fact, I'm located close to MD Anderson. I am currently assisting a father who has some overdue medical bills from Tricare where his son expired in January of this year.

And to answer your question about getting in contact with you, we have to get permission from that

client to engage other people.

MASTER SERGEANT MACKENZIE: So, maybe something we need to look at --

MS. WELLS: Yes.

MASTER SERGEANT MACKENZIE: -- and even from a liaison perspective, saying, hey, obviously they need clearance, which is something I didn't think about. So, that's a very good point. Thank you very much, Ms. Wells.

GENERAL STONE: When you look at these 727 active clients that you have and the 79 in evaluation, which I would assume are evaluation for entry to the program, and when I think about the more than 10,000 that we have in our Warrior Transition Unit in the Army, how much of the need do you think that are you meeting today? How much potential need is out there?

DR. GUICE: The simple answer is we don't know. We're a referral program. We're not a mandatory program. The referral to the program is voluntary, and for the individual who said, would you like to be enrolled, it's voluntary for them as well. So, we don't have a list that comes over. And if you remember that slide with the categories, there's no checkbox anywhere. So, to be quite frank about it, we have no way of knowing the total

population out there that might fit within the -- within this program.

GENERAL STONE: For those of you on the panel that are doing the line work, how would you fix that?

MS. WELLS: I'm just going to say that we do get referrals from outside organizations that will refer, do you have Johnny on your list, you know. We have -- okay. We have relationships with mothers of wounded service members who will usually refer other wounded service members to us.

MS. ARNOLD: And certainly we have stronger relations with the care management teams, the entire care teams. I'm positioned at San Diego, so there's a pretty open and robust referral process because we participate in all the multidisciplinary teams. So, I think we have -- I feel pretty wired there that we pick up most, that we should certainly rely on the wounded warrior programs as well.

MS. WELLS: We also did a look back. We looked back on cases. Recently we did a look back, and I can't remember the numbers, but we received referrals from the look backs of clients.

DR. PHILLIPS: To follow up a little bit more on

General Stone's question, and again, you all being in the trenches, can you identify the specific -- I mean, you're doing such a great job that there are times and areas that you could probably identify that are really bottlenecks for you and interfere with what you're doing. And if you had unlimited funding and whatever, a magic wand, could you perhaps even consider listing for us the areas that you would try to improve?

MS. LEE-SING: I think -- unlimited budget. Wow. How many things? How much time do we have?

I think one of the big things is the information sharing. I think we spend a lot of time harnessing information, you know. If there were some way just like finding out how many hands are touching a particular service member or a veteran. You know, we have very limited access to that. Generally, it's calling a case manager and saying, okay, who have you talked to so far? Who do you know that's already involved in this case? And then can you also send me the inpatient records because I see them. Even though I sent in an MTF, I can only see the ALTA records, not the ESENTRIS records. And so, certainly I think one of the biggest challenges is IT.

And then I think something that I would say for

all the FRCs is that I wish that we were multiplied times nine million because there are very few service members that we see seriously injured. For every referral we get, even if it's something small, there is something that we can do, and we do do it. And so, those are some of the things that, you know -- I think the biggest one would be our IT issues, and the second one would be the staffing, just being able to have the time and to know who's out there and to be able to touch everyone. Those are the two that would stick out for me.

MR. BUCHOLTZ: I'd agree with that. I'd also add to that that not for us individually as our recovery coordinators, but for our clients, for the service members, the veterans, and the families. If they had some sort of delegated authority in the form of their individualized recovery plan, that if it's a need that's identified, it's a need they're entitled to. Everybody that has an ability to affect change and to benefit that person, if they could -- everybody kind of collaborate to make that happen, I think that would be helpful, too.

MS. LEE-SING: And I think to feed off of that, which I'm saying is just the communication portion of it. If, you know, when we got into the systems to work with the

teams that we do, which, you know, we get excellent responses, and we work very hard to create interdisciplinary teams and to become a part of them. But I think if every time we walked into a meeting, or every time any case manager, any RCC walked into a meeting, that it was all the systems were harmonious, that we would be much more effective in what we do.

DR. TURNER: Okay. If we could do a little poll here for just a moment. Mr. Bucholtz, what's your case load right now?

MR. BUCHOLTZ: Forty-one.

DR. TURNER: Ms. Wells?

MS. WELLS: Thirty plus, one added since I've been on training.

DR. TURNER: Ms. Arnold?

MS. ARNOLD: Thirty-six and three in evaluation.

DR. TURNER: And Ms. Lee-Sing?

MS. LEE-SING: I have 27 and four in evaluation.

DR. TURNER: Thank you.

DR. GUICE: One of the things that we're working on to address proper case load, this is a function -- care coordination is a function that's never been done before. There is no recipe. There is no body of knowledge that

says this is particularly the way that we are doing it between these two organizations, between these departments. So, there was really nothing to point to. We sort of guessed at what we thought a reasonable caseload would be.

But you have to remember, too, these individuals' needs will change over time. And since the FRCs stay with them from -- as close as we can get from their entry into the medical treatment facility all the way through, the needs change over time, as they should change over the time as these people are effective. If the intensity of their needs isn't decreasing, then we're not doing our job right.

So, what we're developing is something we're calling a system intensity tool because it's really not about the -- you know, how many people you have, but it's about how intense the needs are for any one of our clients. And we have periods where, you know, there'll be some quiescence and being able to manage. I'm sure, Mac, you have the same thing. You see the same thing. So, being able to manage people one call, two calls a month works fine.

And then something happens. And then the sky is falling. And then somebody -- we're having financial difficulties, or the mother gets diagnosed with cancer, or,

you know, something major happens. And then intensity goes up.

But as this process works its way, you know, the intensity is to go down and go down over time.

And kind of counter intuitively, the intensity of the FRC isn't while they're in a hospital because everything is around the individual then. So, it's having the knowledge of that hospitalization and being able to be part of that planning as the individual leaves and makes that first transition that's really critically important for these individuals and for the FRCs who try to keep all the balls in the air, so to speak.

So, we're working on that. We've done a lot of work actually this week, made sure that we kind of moved the ball a little bit forward. We're getting, I think, pretty close to some trialing it and seeing if it works and gives us what we need in terms of a spread to then assign a total intensity point system to the FRCs instead of an arbitrary one to 30 or one to 20. So, they could have a number -- a maximum number of intensity points, so you manage it by how much their services are being consumed based on the intensity of the client's needs rather than an arbitrary number that we will never get right no matter how

hard we try.

GENERAL STONE: Karen, you've -- you're doing something no one's done before, but yet very quickly you've accumulated some moderately sophisticated data on your patient population served and your intensity of services.

One of the things we've struggled with in testimony from almost everybody else in this delivery system is the lack of data, the lack of understanding their patient population served, their lack of being able to quantify need.

How is it that you so quickly have gotten this right?

DR. GUICE: We're good.

GENERAL STONE: Okay. So I'm not asking this question to her any more, and she's a short timer anyway. So, I guess the question is, is this just the availability of the VA resources? Is this the availability of data systems that are more mature? How is it and how can we leverage this best practice into recommendations for the rest of the delivery system?

DR. GUICE: Well, I think part of it is just the awareness of one -- what data do you need to manage a program. It should be sufficient, but not too much. But

it should be able to capture the information that we know inquiring minds want to know, so when task forces come to visit or Congress wants to know something, or the Secretary wants to know something, we can quickly roll the information rather than having to do data calls.

But really, it's about making sure that we're doing the right thing, and what are the piece of information? And I'll tell you that one of the things that I think that really helped us was we basically said, what information would you, Michelle, need if Lisa couldn't -- if she was out of the picture and couldn't manage her client. What would you need to step into the role of FRC for a certain client? So, that guided a lot of this.

But it just was -- it was actually trying to think about what kind of data do we need, and why do we need that particular kind of piece or that piece of information or data?

The system intensity thing is just something -- again, it was puzzling through -- we don't do intensive care nursing, so it's not a one-to-one or one-to-two ratio for an intensive care. It's not -- the case management is usually a one-to-30 range. But, again, when it came to what we do, because what we do is different. It's not case

management; it's this coordination function. So, really thinking about it and trying to think outside of the box about how would you go about measuring that, and how would you start to think about it knowing -- of course, that means no literature review and thinking about it in really creative ways.

So, it's just -- we've been lucky that we've stumbled on some right recipes, I think.

MR. REHBEIN: You operate by referrals, which means that's a fairly informal system. A few minutes ago we were talking about the difficulties of promulgating care techniques throughout the medical community. How have you made your presence known throughout the community so that people know you're there, so that they will -- so that they know what you do so that they will refer potential clients to you?

DR. GUICE: Over the last two years of the program, we have conducted about 100 outreach activities every year. Now, mind you, we're a small program. We're pretty small. So, I think doing 100 outreach activities every year is pretty huge, and we've maintained that for two years. We're already on track to increase that by 25 percent this year in terms of the number of outreach

activities we do.

So, all the FRCs know that this is part of their job to go out and promote the program, particularly in their area, to tell people what they do and how they do it.

Our VTEs, when we have an outside entity come in and tell us about what they do, it gives us an opportunity to tell them what we do.

Quarterly training is another opportunity to promulgate what the program does because we invite people in to tell us about something, and we in turn tell them about us.

We're in the process of creating a web page within the VA's website. We have program brochures that we provide to prospective clients or to people upon request. We have a 1-800 number. About 30 percent of the calls are to refer an individual or to find out more about the program.

So, I think we're doing a pretty good job of outreach. And as Verna said, we did a look back last year where I took eight different databases, cleaned them, merged them on common data elements, and then wound up with about 40,000 individuals. These are all now veterans. And then we had to develop proxies that would kind of get us to

that severe complex, because the data systems don't have that, little check marks. So, we did that, and I think we wound up with about 350 individuals. The FRCs came to town. They made a bunch of phone calls, and we identified about 35 out of that group who needed further evaluation. But all said, we could only find about six that really need continued services. So, I don't think we need to do that again. I think we're very proactive in telling people about what we do.

But the biggest selling point for the program is effectiveness. If you're effective, people will figure out that you're effective. And I think one of the trends we're starting to see as a big source of referrals for the program is from our clients and the clients' families.

MR. REHBEIN: That was going to be my next question, if you've tracked who you're getting your referrals from, what part of the community.

DR. GUICE: We do. We do. About 38 percent come from a case management team. And then, you know, we haven't been. But the most common referral is from a case management team. And we have -- we've been at between -- it's from a wounded warrior program on RCC. So, we actually track that and keep the statistics so that we can

tell where our referrals are coming from.

MASTER SERGEANT MACKENZIE: This is for the workers, not the boss.

We've discovered in some of our site visits the lack of involvement between the personnel, you know, non-medical and so forth, to the caregivers as much as to the service member. You guys are in a unique environment where a lot of your clients, the only people you get to talk to are the caregivers. What I'm asking is, those clients that can speak for themselves, do you equally involve the caregivers in those cases as you do the ones where the service members can't speak? And is that a requirement or is that something you just on your own?

MS. ARNOLD: I'd say I don't think it's an absolute requirement. I think it just comes with the nature of the business. It's an automatic. I mean, I don't think we separate the service member, the veteran, and they come with their family. And they should be integrated in every step of every process that we do with them. Does that answer your question?

MASTER SERGEANT MACKENZIE: Do you find it should be a requirement, though?

MS. ARNOLD: I guess they feel that it happens,

so I wouldn't see it as a need. But perhaps, yeah.

MS. LEE-SING: Well, I can give a specific example of that where recently I received a new referral from an active duty service member who had had a pretty severe motor vehicle accident and a TBI and was in the hospital. And so I was speaking his spouse. There was a PCS issue. There were all kinds of things going on. And really working with the caregiver and the team and the command. And then he has done remarkably well and is doing -- has recovered by leaps and bounds, has been discharged from rehab.

And I called the other day and I spoke to him. He said, okay, right now, you talk to me. My wife is here, but I want to be the one that you're talking to all the time, and then I will, you know, talk with my family about what else is going on. But there's always the invitation and there's always the inclusion because the service member and the family come together.

MS. ARNOLD: In fact, to make it sort of fun, we even do like three-way phone conversations sometimes where I'll get the service member and the spouse on the phone and we'll have a three-way conversation, and that actually turns out to be a great thing.

MR. BUCHOLTZ: And even in the cases where the service member, the veteran is able to speak for themselves, the plan has changed, that people go into the service saying there is the potential that I'll get injured, but they don't actually expect it. So, the plan was the person maybe was going to have a full career. Because plans have changed, the caregiver sometimes needs to get involved, and maybe now the caregiver wants to go back to college. And so, it's kind of a partnership. It's kind of a three-way partnership between spouse or caregiver -- it could be a parent -- and the veteran, service member, and FRC trying to figure out the new plan, the new way forward.

DR. GUICE: I would be careful about making it a requirement, though, because as you know, these family are not all the same. And sometimes you have families that probably don't do what they really be doing for their service member or veteran. And so, you have to be a little careful. So, if you make it a requirement, you might be talking to the wrong people sometimes. That's as dicey as it can be with some of our clients.

And sometimes, you know, he really doesn't want you to talk to Mom. The reason he went into the service is

to get away from Mom. Or we have a situation where the mom and the dad take the TSGLI money and split.

So, I think you have to be careful about making it a requirement. I think what you do is you leave it up to those people to sort out who they need to talk to and how you pull those people in.

We do track caregivers. That's one of our points of contact. We have people who are -- the individual says this is my caregiver, or is this a declared caregiver. And we track that and make sure that we involve them in all of that. And of course for us, because we do have people who are incompetent by virtue of their injuries, we have to include the fiduciary as well, or the guardian, who may not be the spouse or the caregiver as well. I mean, it may be a third party.

These are complex situations, and you have to kind of balance out the needs of information distribution and getting the right information to the right person at the right time.

DR. TURNER: A little bit of an odd question perhaps. I know you all work very hard. I'm sure this doesn't apply to any one at the table. But what quality controls are you under, and what happens to a bad person?

Like, have there ever been a bad one of you guys that had to get weeded out? You all have such an important job. I guess the question is, what kind of quality measures are on you, and what kind of assurances does the system place to make sure that you guys are all really good like all of you are?

MS. ARNOLD: I'd be happy to -- I was just going to say, there's the performance measures, the weekly supervision calls. But what I wanted to actually add to Dr. Guice earlier is that one thing that I think is unique about the FRC that impressed me from -- I was hired in June of '08 -- was the quality of people that were hired. Almost every FRC has been a senior -- either military senior officer or extensive leadership responsibilities within the VA system. So, I think the quality of people that were hired has made that a non-issue, in my opinion.

MR. BUCHOLTZ: I'd also like to say that this is the first time I saw Dr. Guice's slide with the four people holding the thing. But that's kind of how we do quality assurance is that it's a team effort. We have great supervisors. We have Dr. Guice trailblazing. And we all keep each other honest, too. And we're all kind of hard on ourselves. So, I think that all those things together, we

try to correct deficiencies and make sure that we do as effective job as possible.

DR. PHILLIPS: I have just one question, back to referrals. I know they're voluntary, and there are probably many reasons why you are referred cases. Are there any areas that you can identify that you were referred more than others, like people get frustrated and they can't deal with it any longer, or they know they can take it to a higher level of authority and you can move it along? I'm just trying to get a sense of that.

MS. WELLS: It seems like I get a lot of referrals lately for 24/7 care in the home when they're transitioning through recovery, rehab, and they're integrating into the community. These are young guys and there are no resources out there for custodial care. Tricare will tell you, we don't provide custodial care. So, I have to go to the directors, leadership, or the bigger leadership for request for 24/7 care.

I think right now a lot of referrals are coming in to me for that.

MS. ARNOLD: I think that, you know, there's ebbs and flows I think with those referrals. And there's the obvious ones and then there's the group that were maybe

perhaps chugging along okay and then started meeting one obstacle, and then maybe another obstacle. And then the family gets overwhelmed. They get fatigued. And then they're to the point of not being able to function. And then they need help. And so, sometimes that's when we'll enter the system as well.

DR. PHILLIPS: Would it be correct to say that you're kind of putting out fires then?

MS. ARNOLD: Absolutely.

DR. GUICE: And it's better not to. It's better to have it all coordinated ahead of time. And just from -- I mean, these individuals, they know what they're referred, but looking at it from a program perspective across all 22 of them, it really varies. I mean, I think we have -- and I did this statistic because I thought somebody would ask me last Friday. The average number of days between the injury or illness diagnosis and referral to the program is 145. But 35 percent of those are within the first 10 days, and the rest are outside of that 10-day window.

People stay on the program an average of about -- well, it depends. The inactives who have been on the program about a year, and those that are still active obviously are going to be little bit longer. They're in

the program for an average of -- well, we're 400 days now.

So, I think they come into the program at various points. I think the referrals from the clients are probably in that category of my friend who was so frustrated. It's all falling apart and we don't know what to do, but you solved these problems for me, so can you take a look at what's going on.

I think the FRCs who are in the military treatment facilities are the ones who get referred early on and brought into the process early on. At National Naval, they attend the trauma rounds, and I think that's a frequent source of, Doris, do you have this case? You got eyes on him. You're going to take care of him. Make sure that you're involved with this particular care.

So, it's various changes all the time. But in terms of really providing this care coordination function across all our systems, the earlier the FRCs get involved, the better I think is going to be the outcome. And certainly the families tell us that. they say, get them there as early as you can because we really value having that function as an adjunct to everything else that's going on.

MS. CROCKETT-JONES: Here, I've got a question

for you. Who does the evaluation to get into the program? How long does that process usually take? And how many people don't make the cut?

MS. ARNOLD: Well, we have a requirement of when we get the referral to assess them within 30 days. Usually I think it's probably quicker than that, probably within a week. If there aren't any extenuating circumstances, that we can reach everyone, and they're in one place, and they're not having a bunch of surgeries or whatever. So, about probably a week.

And we do the assessments individually and then we discuss them with our leadership. And usually actually in a group, so almost like a multidisciplinary FRC discussion to see if everybody agrees, you know, with the needs.

How many redirects we have? I think you might need to answer that one.

DR. GUICE: Again, I did the statistics because I thought somebody would want to know last week. So, fresh off the calculator, of all of those who were referred, and that includes those that are referred for assist, 68 percent are made active. But that includes the assist number, and the assists are going to be a little bit of a

different category.

I think the number of redirects is about 125 or so. But we frequently get people referred to the program. We had one referred -- can you help me get a well dug in my backyard? No, but we know somebody who can. So, we referred him to the right -- but that would've been an assist.

So, you know, there are people that get referred. Sometimes Vietnam veterans will be referred. That's not in our mandate. But our obligation is to get them to the right level of service. That's why we call them redirects. So, you know, if you don't meet the requirements of this program for whatever reason, we make sure we get you to the right level of resource, and then we check to make sure you got what you needed. If that didn't work, then certainly the FRCs have the capability of moving them back. They also have the capability of an assist, which is supposed to be a short, limited, quick, solve the problem. If it get into more than that, they can move them into active status as well. So, we try to make it very fluid based on the needs of the client and the family.

Oh, I'm them moderator, too. I think that if that answers all the questions, we will excuse you all.

Thank you very much. And I'd like to just point out the rest of the FRCs are sitting there in the back and certainly would be happy to talk to you guys after the session.

MS. DAILEY: Okay, ladies and gentlemen, thank you very much. We have one more briefing following this. So, I'm going to give my -- taskforce, please take a five-minute stretch, come back, and we'll have our last briefing of the day.

DR. GUICE: Okay. We need to go ahead and finish up with our last presentation of the day. We're going to be hearing from Dr. Charles Sneiderman on the topic of clinical decision support for civilian primary health care management of PTSD. The presentation is behind Tab G.

Dr. Sneiderman has completed a career in medical informatics with the National Library of Medicine, National Institutes of Health. His work has included research and development on telemedicine, distance learning, and medical language, and imaging processing.

Since leaving Federal service, he's developed a computerized clinical decision system to assist civilian primary health care practices in the recognition and

management of PTSD with support from the National Library of Medicine's Disaster Information Management Research Center.

Take it away, sir.

DR. SNEIDERMAN: Okay. I realize that you're welcome beyond compassion fatigue at this point, and I'm between you and getting back to your families. So, just, you know, try to go to your happy place, and like a family doc, I'll try to make this as painless as possible.

[Laughter.]

DR. SNEIDERMAN: As you've heard, I am a civilian family physician, and even more civilian at this time last year. As far as the alphabet soup here, EMR stands for electronic medical record. CDS is clinical decision support. PTS is post-traumatic stress. I will try to put some meat into this alphabet soup for you over the next few minutes. I'll also tell you why I'm passionate about putting these ingredients together.

My only other disclosure besides what I have on the slide here is that I know the more proper term is EHR for electronic record, but every time I try to type that on my computer, the spell check turns it into a lower case "her."

[Laughter.]

DR. SNEIDERMAN: So, if any of have figured out how to beat that, let me know.

Okay. Let's see here. Okay, again, more alphabet. PCP is primary care practitioner. NIH has no primary care, so they let me loosen the community a few hours a week.

I've worked in many settings. The one thing that was consistent, I was always behind schedule. During the Gulf War, I did some urgent careships at National Naval Medical Center where most of the military staff was deployed under Comfort.

My first patient my first day was an older veteran with constipation as the chief complaint under this form handed to me by the clinic assistant. While asking him the usual questions about constipation, I was struck that this guy couldn't give a you know what in more ways than one. I asked and he admitted that the war coverage on TV had stirred up some memories that were so troubling that he was considering suicide. The staff was rather surprised when I requested an emergency psychiatric consultation as the treatment for constipation.

Now, if he had not been my first patient, I might

not have taken the time to ask the extra questions. The realities are, as in the slide, we have less than 10 minutes to spend with each patient for each visit. Recommended screening for behavioral illness, for example, depression, alcohol abuse, occurs in less than two percent of visits in national surveys. And one-third of completed suicides have seen a primary care physician in the preceding month, many in the week before the act.

When President Bush made the announcement in 2004 during his State of the Union Address that every American would have a lifetime electronic health record in 10 years, I was as amazed as I was two weeks ago when President Obama made his Sunday night announcement. Similarly, there have been a lot of people working below the radar on this one for many years. Our war isn't over yet either. We're already seeing the results of our surge, hoping that the tax dollars spent will benefit the nation in the long run.

Let me digress for a minute. You heard about my career and know that I've had a very privileged life. I've had that privilege life because while I was in college, two of my high school classmates, Bobby Gardner and Doug Billard, died in Vietnam. Many others that I grew up with come back without obvious wounds, but are unable to be

productive or content. As you can see, I haven't gotten over this, and I don't want to get over this. For their families, every day is Memorial Day.

Fortunately, a lot of folks do recover. I was at a banquet last night with a guy who had lost both arms above the elbow, both legs above the knee. I asked him if he needed help to cut up his steak. He said, no, I'm good thanks, big smile. I've skied with a guy who had a bilateral BK amputation. He gets off the chair by tossing his snowboard down and doing a flip and a handstand to get it started. I mean, that's what you call resilience.

Unfortunately, we know that not everyone has handled their impairments all that well. I do believe that the military and the VA have done a fantastic job of reviewing the science and getting the message out to your own PCPs. But civilian providers need to be prepared for recovering warriors and their families. I don't know what proportion of visits of active duty folks are to civilian providers. I certainly know that many family members, of course, get their care in the civilian sector. And I suspect that any figure that you have may be an under estimate when it comes to behavioral health issues because some folks would rather pay cash and not have it counted by

Tricare.

As has happened repeatedly in the past, lessons learned from military medicine have led to improved health care for the nation. I believe that the information I have on this slide is accurate. I've gleaned it from press releases and websites open to the public, so please correct if I'm -- these assertions are no longer correct. But I'm fairly sure that the RESPECT-MIL program, which is being deployed -- is being deployed independently of the AHLTA electronic health record, VA's NCPTSD 101, are distributed with clinical practice guidelines by the website, but independent of the VISTA EHR. Tricare and the National Center of Excellence for Psychological Health and Traumatic Brain Injury offer PTSD guidelines and training to civilian providers, but again, of it's independent of the electronic health record.

The most successful clinical decision support systems have worked because the medical informatics -- and by medical informatics, I mean the science of utilizing health information technology, HIT, to do better health care. Simply documenting clinical care on a computer rather than a paper chart will save paper, but not necessarily save lives or money.

The four steps I've listed here can be done with most any ELR system, some perhaps a little more easily than others. That is to -- and we'll just go through these quickly on the slides.

This one is cut from the tool that I have provided to NOM. It's a human readable version of the machinery of the form. Admittedly, my pasting here wasn't as good as it could be. But what this is about is the 20 medical findings that have been associated in the literature with post-traumatic stress disorder. The corresponding international classification of disease, nine clinical modification codes. And uniquely, the NOM's unified medical language system concept unique identifier, a lot of these things like a life threatening event are not going to be represented by a traditional ICD code in the problem list. And in fact, may not even be presented in those terms, but because of the design of the Unified Medical Language System, we can find the synonyms. It may take natural language processing of the text from progress notes on past and recurrent visits.

This is going to add sensitivity to detection, so progressive screening of patients and alerting clinicians only if the threshold criteria on that is a strategy

consistent with the current clinical practice guideline, which, by the way, is based on the VA DoD clinical practice guideline. As obviously you've unfortunately had the most experience with, the detection of treatment of post-traumatic stress.

Now, PMID is the pub med identifier of the link to the evidence in the medline database. Clinicians want to see the evidence. They want to see it in a very succinct form, but they certainly want to know how the system works because they're the ones who basically take the ultimate responsibility.

Okay. How can we help them? These four steps, searching the electronic health record for risk factors -- either I'm having a déjà vu or I'm at the wrong one here. Okay. Here we go. The last time that you need at this time of the day is for me to go backwards.

Okay. Again, this is from the VA DoD clinical practice guideline latest version. This is the primary care PTSD screen. If two or more of these answers are positive, the recommendation is to administer the 17 item primary care checklist.

All of this can be done without taking the clinician's time. It can be done either online or prior to

the patient actually being in the exam room.

I apologize for the text here. Fortunately I think in your handouts, it's actually readable and it demonstrates that current best evidence from the scientific literature can be presented at the point of care when there is no obvious path of action. This medline citation with abstract summarizes the Society of Sleep Medicine's evidence review on the treatment of nightmares and PTSD.

EMR linked clinical decision support is -- this one is based on an already tested practice guideline. However, the medical informatics to do this is as yet untested. And the reason that I'm presenting this to you today is in the hopes that some of you might have access to a clinical venue for us to do this.

As a scientist, it's quite helpful to have a population in which the prevalence of the disorder that we're looking for is high enough, that the events are going to be frequent enough that it could be quickly tested. So, that's why despite the fact that this ultimately designed for the civilian primary care physician, that if there is an opportunity to test it in a military or VA setting, that would, I think, be helpful to both parties.

MR. DRACH: Doctor --

DR. SNEIDERMAN: Yes?

MR. DRACH: As we all know, PTSD is not unique to veterans of this generation or previous generations. Civilians also are subject to traumatic events and living with PTSD subsequent to that.

I just read something the other day that was a little disturbing to me that was put out -- I forget who put it out. But it was directed toward non-military, non-VA clinicians who are possibly going to treat veterans and service members for PTSD.

If I were a private clinician, the only thing that I would've liked about that document was the fact that I don't understand the military culture. The rest of it I thought was an insult to a clinical psychologist or someone that's going to be treating somebody with PTSD.

Do you have any thoughts on the civilian non-military, non-VA clinician as to what he or she may actually need in terms of training?

DR. SNEIDERMAN: Well, you're absolutely right that our knowledge of military culture is --

MR. DRACH: Yeah, important.

DR. SNEIDERMAN: -- is generally lacking. And I think that's one of the points made in the -- at least at

the DCOE's website. That's sort of the first thing that they recommend for civilians.

Now, as far as mental health professionals doing treatment, I think the sad fact is that because of the stigma, a lot of folks seek their care from primary care, and also the waiting times and the logistics of referral are such that primary care practitioners have to do more than most are comfortable with. And I say let's try to get -- I mean, I want to do my job as well as I can. And any assistance that I could get in that would be appreciated, at least by me anyway.

DR. GUICE: Any other questions? Thank you very much for your presentation.

DR. SNEIDERMAN: Thank you for --

DR. GUICE: We appreciate you being here.

DR. SNEIDERMAN: -- allowing me to do so.

DR. GUICE: All right. That concludes today, and we'll see you back here at 8:00 in the morning. Denise?

MS. DAILEY: Members of the public, the gates will open tomorrow morning at 9:00. We have some administrative information that we'll be going over at 8:00. So, (inaudible) and I do have a homework assignment for you. So, Tab H is the chapter one of the taskforce.

It is the first thing we're going to open up tomorrow. And I need everyone to have read chapter one by tomorrow morning. And take your pen, pull it out of this tab. Take your pen tonight and go, I like this, I don't like this, I want to go here, I don't want to go there. So, everyone has a homework assignment because we're going to spend 10 minutes in administrative time tomorrow, and we're going to nail this down. And I need feedback coming from you on what feels good, what sounds good, what doesn't.

DR. PHILLIPS: Excuse me. Is this the same as the electronic copy that you circulated?

MS. DAILEY: Correct.

DR. PHILLIPS: Okay. So, we have to take the paper --

MS. DAILEY: So, if you've got it at home, good. If you don't or you can't find it immediately, pull it out of the tab, take it with you. I do need your feedback on this for the first part of our exercise tomorrow.

Thank you very much, ladies and gentlemen. Very well done. Very well done. It's a long day.