

Department of Defense Task Force on the
Care, Management, and Transition of Recovering Wounded, Ill, and
Injured Members of the Armed Forces (the Task Force)

L'Enfant Plaza Hotel

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8:00 a.m.

MS. DAILEY: Ladies and gentlemen, we're going to start an administrative hour here, please. Ladies and gentlemen, good morning. So we have an important hour here, ladies and gentlemen, in which I'd really like to give you all a visual. And you know, as I said to Dr. Guice, take the stick to the beehive and get your feedback on a number of products that we're going to put out with you in collaboration with your input for the upcoming report. And this is a really important hour and hopefully we can come to terms, come to an agreement, on who's doing what. So we really need to kind of get to the end of this tab. It's all important. And I got a hard stop at nine for public forum. So let's -- the first thing I want to do is, up on the screen is, is indeed the sample you selected for the format of your upcoming report. And in it is Chapter 1. So it's not -- it says sample, but it's a draft. It is the first draft. And what I want to do is, you know, I'm really looking for your responses. So if you've got that draft front of you, and you took it home last night -- I did it and frankly I know that I did it between the L'Enfant Plaza stop and the Eisenhower stop, and I went through and I said yes on this paragraph, no on this paragraph, do you want this paragraph. And that's -- that's kind of the editing process that we're going to go through in mostly in evening meetings. Mostly in our one hour, Tuesday and Wednesday, 7 to 8, 8 to 9 meetings. So. And also in those 7 to 8, 8 to 9 meetings, we're going to pull your, pull a product out of your head, pull thoughts out of your head; or, if you've got a product you want to give us, we're going to incorporate that. And then, towards middle of June, we really have to start thinking about recommendations because we need to come to the table in July with a draft set of recommendations. So let me just ask you to go to page 1 on the preface, the preface page. All right. So it worked a minute ago. So here's my little blinker here. See this paragraph here? I went through this, this paragraph right here, and I asked myself, do the members want that paragraph in their preface?

MASTER SERGEANT MACKENZIE: Yes.

DR. TURNER: Yes.

DR. GUICE: But to me I thought it would better just to say the task force members are here, and then list everybody's name on a follow page or whatever, just so that everybody can -- it's more inclusive of all the names and where you come from and what you represent and bring to the table for the task force. I thought it was a little odd that it wasn't sort of right there in the front.

DR. DAILEY: Okay. See now that's the types of things we need to come to agreement on.

MASTER SERGEANT MACKENZIE: Although I agree with that, but I agree maybe in the fact of who the two co-chairs are. If we're going to refer everybody back to the appendix, you know, we list the overall experience, which is very powerful words and refer everybody back to find specific details on their background, do we really need to list the co-chairs names, or anybody's names for that matter? Because we're trying to -- I think when we talked in the last business meeting, we were looking at let's keep all the information in front as short, concise and powerful as possible because we want them to get to the meat.

DR. GUICE: The only thing that I think is traditionally part of all of these reports is way up front there's the members, and then we all sign the report and have that up in the front rather than the appendix, the bios, and all of that. So to me, we need one sheet behind this where we've all signed it and said, yes, this is what our report -- it's a consensus document, this is what we believe. And I think that's way up front where everybody can see it is a good place for that. But I would rather have one page that has everybody's name and our signatures on it.

MS. DAILEY: Yes. That's part of the -- I'll factor that in. That'll be there.

MR. DRACH: Should the signature page be part of the transmittal letter?

DR. GUICE: It's traditionally part of the report.

MS. DAILEY: Yes. Yes.

MR. REHBEIN: Is it going to get awkward in the writing now that we are changing one of the co-chairs?

MS. DAILEY: Yes.

MR. REHBEIN: Is that a good enough reason to drop that part from the, from that paragraph?

DR. PHILLIPS: Well, in addition, folks have been rotating on and off. So maybe somehow express the fact that --

MS DAILEY: Yes. We will take care of that. We'll have a term of service, correct.

MR. REHBEIN: Yeah, they don't -- the reason I ask that question is because when you read that sort of thing where a co-chair changed in the middle of the process like this, the question always comes up, Oh, who got fired.

MR. CONSTANTINE: If we're going to keep -- the second to last sentence talks about a membership. Where it says some individuals with personal experience, you know, I assume that's the three of us who were injured over there. That's an odd way to say it because everyone here has personal experience with programs and services. If we're trying to say three recovering warriors, then we should say that.

MS. DAILEY: Say again, Justin.

MR. CONSTANTINE: I'm talking about the sentence, the second to last one in that paragraph, it talks about the membership with RWTF includes some individuals with personal experience. Now, maybe that's the reason we were on the task force and it has to be written that way. But if not, I think it should simply say we are recovering warriors who have gone -- you know, something about that because it doesn't say that. And we all here have personal experience with their programs and services.

GENERAL GREEN: I agree. I guess from my -- I don't know why those two sentences about the two co-chair persons are in there now. I think the easier way to deal with this would be to just in the listing of members to have it at the end. And then basically, when she was replaced as the VA representative because of a new position, it basically lists the new VA representative. So it's easy to handle in the back of the report. And I don't see any reason to even -- I mean, you're saying paragraphs, but I'd take out the two sentences. So the DoD co-chair person is and the non-DoD chair person is, I'd just take out those two sentences. And then I agree with you, Justin, you know, that we should talk to the experience of the folks, not so much to who was a chair.

MS DAILEY: Okay.

GENERAL GREEN: On broad terms.

GENERAL STONE: We all remember Dole-Shalala. So this will be the Guice Green Report, or the Green Guice report, as you decide to work your way through that. It also is a blatant attempt for us to pass responsibility to the chairs for anything that may be negative.

GENERAL GREEN: That comes later in the report. The negative part.

DR. GUICE: As long as we get t-shirts with targets on them we'll be fine.

MS. DAILEY: Good.

MASTER SERGEANT MACKENZIE: I would further clarify that as Purple Heart recipients. I know that's something that the Secretary of Defense, you know, that as he lists, you know, his whole deal was the wounded warriors, I think that that would probably be a good clarification. Not necessarily as recovering warriors but as, you know.

MS. DAILEY: Okay. So we want to pull out the references to the chairs. We want to define to a greater level the combat experience of the service, of the members serving on the task force.

GENERAL GREEN: My recommendation is that you just substitute for the two sentences on the co-chairs and put in something saying that we had “x” number of wounded warrior and a family member of a wounded warrior and you know, kind of go that way. I mean, I'd keep it fairly simple. I don't think we need to go through the experience of everyone here because they'll recognize that from the bios at the end. But I think putting something up front that says we were focused on having people who had experience in the process is a very important piece of this.

MS. DAILEY: Okay. Okay. All right. So I picked that paragraph. If we go to the next page --

DR. PHILLIPS: Before we go to page --

MS. DAILEY: Good. Good.

DR. PHILLIPS: Before we go to page 2, I just had -- these are small issues, but this is a five-year task force, but we're only being convened for four years. I don't know whether we have to say that or not so that people understand that we've kind of tightened up our schedules.

MS. DAILEY: Okay. Got it.

DR. PHILLIPS: And then in the very first sentence, it says Congress directed the establishment. And I'm wondering, do we need to say and funding?

MS. DAILEY: They did not fund us so that would not be appropriate.

DR. PHILLIPS: Okay. Okay. Perfect. That's all I had to say.

MS. DAILEY: Good. Anyone else.

MR. CONSTANTINE: Yeah. Denise, not from one paragraph in particular, but this section up until we start going, it seems like it's kind of purple and the font seems kind of small. So is that --

MS. DAILEY: Yeah. Suzanne, that's the font and that's the color it's going to be?

DR. LEDERER: The color is the function of the printing. But yes, the font will be that size unless we request otherwise.

MS. DAILEY: Ladies and gentlemen, you picked those sample sizes. That's what you picked. You picked a font, you picked a style, you picked a margin, you picked a heading at the top. And we need to get this on the table now because I can't do this in July. Mr. Constantine: I think it should be the same size as the rest of the report, which is probably 12. There's no point in making it harder to read. If we picked 10, I didn't mean to do that.

DR. LEDERER: Does the preface look smaller than the rest or are you asking for all of Chapter 1 to be increased in size?

MR. CONSTANTINE: Well, all of Chapter 1 looks smaller than the rest of the report. Maybe I'm wrong. But --

DR. LEDERER: Oh, yes. The rest is not the report. I understand what you're saying now. We can certainly increase the size if you'd like.

GENERAL GREEN: The trick is going to be that we want to generate a relatively short report. We don't want to go smaller fonts but we also don't want to generate more pages by going larger fonts. And so this isn't bad. We're hoping for a report that, you know, that the substance of the report is, you know, I'm hoping somewhere under 50 pages. I'd love for it to be around 20 or 30 pages, if we can get it there. There's a lot of attachment and a lot of references materials, et cetera. But I think that, you know, I would stick with what it is. As long as the rest of it matches, I don't think that we should have different fonts in different chapters and that kind of stuff.

MR. DRACH: Okay. I think we also have to be cognizant of, I believe there's an ADA requirement as it relates to the font size. So we need to keep that in mind.

DR. JAGGER: We can make it available in large print, in addition to -- I believe this is 12 point. So we can make it 18 point.

MS. DAILEY: Okay. Okay. Next page. Let's go to page 3, which would be introduction, background.

GENERAL STONE: Yeah. I really struggled with the opening paragraph here. The characterization of the battlefield, the characterization of many experienced severe physical trauma that earlier, you know, in previous times. I mean there's a lot of wordsmithing that goes into that first paragraph, that the idea that combat veterans often survive. I mean, I think just the whole style of this paragraph troubles me, and I think needs to be reworked.

LT. COLONEL KEANE: Along the same lines, opening up with operations in Iraq and Afghanistan, we've learned that most of our wounded, ill, and injured aren't combat. So I don't know, should that be the focus?

MS. DAILEY: Well, we learned yesterday that 30 percent of them are.

LT. COLONEL KEANE: Okay. I would say that's not a majority, right?

MS. DAILEY: No.

LT. COLONEL KEANE: So 70 percent are car accidents, cancer, other accidents.

MS. DAILEY: Okay. Is this a philosophical position of the Task Force? Do you want to gear it towards the 30 percent or the 70 percent? Or do you want us to equally represent both? This can be a position on any one of the members on how the tone goes and where is it at.

DR. TURNER: It could just simply say military operations.

MS. DAILEY: You've got a position guys. You need to take it.

DR. PHILLIPS: I just, you know, I just wonder. Again, this is a man of philosophy. But we are hearing more and more that a lot of these folks have never been down

range, and if we want to perhaps make an impact on the philosophy related to recruitment, I think we need to emphasize that.

MS. DAILEY: Okay. Is that a position you want to take on recruitment? Because what I heard yesterday was 87 percent of the army warrior transition unit people had deployed. So a statement of the nature, a lot of these people have never been down range, is not going to be substantiated.

DR. GUICE: Let me let everybody know, when Dole-Shalala came out people read into it what they wanted to. And so some of the recommendations were interpreted as only applying for combat. So I think you need to scope this very precisely because whatever the recommendations are, depending on who the readership is, if there's a presumption that it's just for combat then they'll say, well, this is just for combat. And so if you want to make sure that the system works for everybody who comes in contact with it, I think we have to think very carefully of it. Because there were several things in Dole-Shalala that were meant to be for the broader good and were interpreted very narrowly, depending on the stance that whoever wanted to take by reading the report.

MR. DRACH: And that's why we changed our name. And also, I hate to be a nitpicker, but in that last sentence in that first paragraph, the prevalence of blast injuries associated with invisible wounds such as TBI and PTSD. PTSD is not actually caused as a result of the blast injury, so we need to tweak that a little bit, I think. It is certainly one of the hidden or the invisible wounds, but it's not directly caused by a blast injury.

GENERAL GREEN: Can I suggest a little different tact? I think we're looking at the ill and injured, and obviously the numbers do exceed the casualties, the wounded warriors. But I don't think there'd be a focus on this if it wasn't for the operations in Iraq and Afghanistan. And so I think that we can basically change the sentence so that it uses operations in Iraq and Afghanistan have brought new focus to, okay, recovering military members. And so

that way you're basically saying that this has brought new focus to looking at the recovery and the benefit structure that's there for the family members and for military who are injured while on the job. And so, I think that that would be a way to do it. The only other thing I would tell you is, and this is just me as a military guy, I really hate the language when you put in all the have created and all that. I mean, I'd much rather this was an active voice report. So, I mean, military operations in Afghanistan and Iraq created a generation of wounded, ill, and injured service members that have brought new focus on recovery of military members and benefit, you know. I think that that's the way to go. But make it an active statement, not this past tense kind of-- I don't remember what it's called.

DR. GUICE: Passive voice.

GENERAL GREEN: Passive voice. I'm not really ready to sign a report in passive voice.

MR. CONSTANTINE: And also, the second paragraph does talk about what we're talking about right now, that only 10 percent of service members are combat injured, and Congress is concerned with the care of all warriors. So although it's not in the first paragraph, it is addressed in the second half of the second paragraph.

MS. DAILEY: Yes. The whole context has got to be captured. It can't all be in the first page. So we do go down. And a number of times, repeated twice, is changed our name to wounded, ill, and injured. And in the bottom paragraph we say again, it is again the policy to include all wounded, ill, and injured. It's included twice in this page.

MR. CONSTANTINE: I definitely agree with General Stone that in the first paragraph about how they'll often survive. I mean, you can word it to say it many survive who may have been killed in previous conflict or something like that. But 5,000 haven't survived, so it's not a good thing to say there.

DR. PHILLIPS: I would almost suggest that if you look at the third paragraph, perhaps something like that should be the first paragraph. And perhaps we should either minimize or eliminate the first paragraph. I don't know. Let's see what the group thinks. I mean, it gives us a brighter introduction. It doesn't specify particular conflicts.

GENERAL STONE: You know, I think in that third paragraph, too, our leaders, if not our citizens. I'm not sure exactly what that means. Certainly all Americans have stayed connected to us and continue to have an extraordinary outpouring of support for us through many of our organizations. And American citizens expect us to do this right. And so I would be much more direct with that. And rather than us trying to wordsmith what I think is a really broken section, I'd send this back to the drawing boards and ask this to be written in active voice and really reworked in a broader sense.

MR. REHBEIN: The one thing that caught my eye in particular was Secretary Gates' quote, because when he specifically talks about the best possible care for those wounded in combat, that tends to go in a different direction than where this Task Force has chosen to go. So I think maybe if we can -- a quote from the Secretary is good, but I think maybe if there is something more appropriate out there in some of his remarks about all of the wounded, ill, and injured, all of the recovering.

DR. PHILLIPS: I know we've gone to recovering rather than wounded warrior, but we seem to interchange that those terms throughout the first few pages. And I'm just wondering if we can tighten that up a little more.

DR. GUICE: I would, I echo Rich's comments. I think that what we need to do is make sure that the broad topics that we want addressed and the tone and the direction we want is important. I think that -- I agree with Rich. This needs to go back for a considerable re-work, but then I think everyone has to edit it and send it back and make sure that we catch all the little glitches, because it's really hard once you're writing these to, you know, pay attention to

everything. But I hope that we kind of keep this discussion at a high level. We only have an hour and we have a lot of material to go through, and if we do paragraph by paragraph, we're going to probably get to page 2. So let's try to make sure that we get the broad specs done and that the team has a clear direction from us about what we want included and how we want to kind of scope this and frame it, but then let them work on the actual words and get it back to us with the guidance that we give them today.

MS. DAILEY: And there are some big blocks here that I want to get to. So good feedback, thank you very much. The page 3 rolling over into page 4, your Maslov hierarchy, that pyramid, I need, I think we need to -- do you want this in here?

LT. COLONEL KEANE: I would suggest if we have it in here, we have it at the end.

MS. DAILEY: Okay. Do I have another suggestion? Not that I'm counting yours out, I just want to get a feel for the Task Force's, you know, give me a gut reaction here.

GENERAL STONE: I think this is an annex. I'm not sure we need to teach people about this hierarchy process. That really is a diversion. I think the fact that we prioritized and established a hierarchy is great. You put it in there as an annex of, you know, what your supporting documents were and that there's some supporting literature that had you get it there. I'm not even sure I need it there. It doesn't do much for me.

DR. GUICE: It doesn't do anything for me. I'd reference it as a reference and not spend a whole page going over Maslov.

MS. DAILEY: Okay. It's not Maslov. These bullets are your --

DR. GUICE: I know, but I'm losing it in the --.

MS. DAILEY: Okay. Out it goes. Next page. Correct. Correct. Next, page 5.

DR. LEDERER: Denise, may I ask?

MS. DAILEY: Yes?

DR. LEDERER: Do the members want to keep a listing mandated topics in this chapter or just free standing?

GENERAL HORST: Take Exhibit 1 and move it into, refer to it in the --

MS. DAILEY: Okay. Better question is, in this introductory chapter, do you want a list of the topics that we're covering?

MS. CROCKETT-JONES: I actually think that a list of the topics would be a good way to show, to prepare for the organization and the way that we're looking at it. I think that's good. I just don't think this big pyramid of, yeah.

MS. DAILEY: Okay. Anyone want to fight for the pyramid? Sir?

GENERAL GREEN: I mean, I'm not fighting for the pyramid, but a lot of this is really in the way it's presented. So, I mean, the Exhibit 1 is really the hierarchy of topics considered. So the problem is you don't want to say hierarchy of needs. I mean, you do get into the whole Maslov thing. And so the question is, how do you present this in a way that everybody understands? Because the organization's report I'm assuming, then, is going to end up in these four different categories.

MS. DAILEY: That is correct, sir.

GENERAL STONE: So by showing the hierarchy of, you know, topics considered, all you're really showing is the, you know, why we spent time on it. So I don't have a problem with the triangle. I think sometimes people see the model and it helps them to understand why we're organizing the way we are. But I don't think it's a hierarchy of needs. I think that's inappropriate. It's a hierarchy of topics considered. And so, you know, we can look at the, what the graphics should be later. I mean, because it may just, you don't necessarily need the pyramid. It may be that it takes away from all the words that should be actually in a way, you know. So the pyramid may not be the way to do it but we need some kind of graphic that

shows how this comes together at the right time to take care of a patient. I mean, that's the other piece that somewhere on this we need a patient centered, because this is about how do we get services to the individual.

MS. DAILEY: Patient centered. How are we getting services to the individual? Good.

GENERAL GREEN: My suggestion. I don't know what the graphic would look like, but some way or another we need to have a family kind of there in the center of the patient. One way or another we've got to this together.

MS. DAILEY: Okay. Good guidance.

MASTER SERGEANT MACKENZIE: I know it's kind of, I mean, I was thinking the same thing, where it's let's not get into whatever foundation we used to come up with this idea. This was, we as a Task Force took all these things, we came up with a way to put it together that actually meets the needs of the wounded, ill, and injured.

MS. DAILEY: Okay.

MASTER SERGEANT MACKENZIE: Stabilize it real quick. Because we go right into the body of the report that understand what is optimizing. I don't want somebody to read it and go, what does optimizing ability mean? So we at least have to have that, why we came up with what we came up with. I mean, what we came up with. Why and background. All that kind of stuff and how it's -- I agree.

MS. DAILEY: Okay. Next page. Page 5. And we're almost finished, ladies and gentlemen. But these are big chunks I need you to get your head around if we can. We've only got two more pages. You're doing good. Anything? Exhibit 2, the listing of your site visits and activities. And I will change that up there. There we go. This block here, this is a block about your list of activities. In, out? In, out? Yes, no?

MASTER SERGEANT MACKENZIE: One of the things, if we do keep it, one of the things that I saw was on the focus groups, it should be recovering warriors assigned to recovering warrior units, or line units. And then caregivers.

MS. DAILEY: Okay. Caregivers. If we leave this in here -- I'll tell you, this isn't, wasn't my favorite piece.

GENERAL GREEN: Yes. I was going to say, I think here Exhibit 2 is one of the backup documents. I don't see it as part of the report. That's my two cents. I mean, it's not bad to tell how we did it, but I think it's one of the things that they can refer to if they're wondering because it's not really a graphic.

DR. GUICE: I agree. I think it goes in the backup and it goes, you know, we just say, if you want to see the details of it. But you know, this is, it's fine back there. But again, I think what we're all looking for is something short, to the point. The recommendations, get those as early as we can, and the actual documents so that people can just cut to the chase because that's what they're going to do anyway.

MS. DAILEY: Okay. And so that includes the bulletized activity levels right below it? Yes, no, do you want those left in there or out?

DR. TURNER: I think that's backup.

GENERAL GREEN: Yes. I think it's all backup. I think in the reports you can simply say that we held multiple public sessions and then visited several sites and for details see Exhibit 2. I mean that's --

MS. DAILEY: Okay. Okay. We're good. Got it.

MR. CONSTANTINE: I do have one question about the list set up. The first one, four business meetings equaling 158. I mean, how'd they get that number? It sounds crazy.

MS. DAILEY: Yes. The first bullet there, four business meetings totaling 158 Task Force person days.

MR. CONSTANTINE: I know it's details but...

DR. LEDERER: Would you like us to explain?

MS. DAILEY: No, no. We're good. We're just trying to, trying to capture your workload, how much you've contributed. But we'll pull it all out into annex. Okay. Next page.

GENERAL GREEN: Is person, day, something that anybody relates to? I mean, I'm kind of like, normally you would just say the number of hours if you wanted to include something. But I'm not sure.

MS. DAILEY: It's a manpower way encapsulating the number of days worked.

GENERAL GREEN: Yes, I would hope the reports not about how many hours or how many days we worked. I mean that's, that would be counterproductive.

DR. TURNER: Again, I think that's why this is just in the backup, and I think all of us want to get to what we found and what our recommendations are as quickly and as most efficiently as possible.

MR. CONSTANTINE: Even if it's in the annex, it should mean something. I agree, it should move to the back, but it shouldn't just, you know here we spent 32,000 hours on this, because nobody cares about that.

MS. DAILEY: Yes, Congress is going to care, ladies and gentlemen. Let me tell you, when other task forces put out their reports, they've got a lot of information in there about how much time they put into this so Congress couldn't tell them, what were you doing the whole year?

MR. REHBEIN: If it goes into annex, it can be more detailed. Putting it up here, it needed to be shrunk into a very concise summary. If it goes into an annex, it can more detailed and the details, the numbers can be there.

MS. DAILEY: Yes. Yes. It's gone. Page 6. We got it. We got it.

LT. COLONEL KEANE: Ma'am, if Congress is concerned with how many hours and we decide that this is important, then we probably need to capture the conference calls that we have and are going to have.

MS. DAILEY: Okay.

DR. GUICE: I think Congress wants to know that we did the work. If you put the number of hours down there, somebody is going to say it's too few, somebody is going to say it's too many, and some are going to look at the amount of money and do a calculation. You know, if Congress wants to know, put it in the testimony as an answer to a question. They can answer that, you can have the answer ready. I think in a report it looks weird and somebody is always going to find something wrong with it.

MS. DAILEY: Okay. Got it. All right. The last page where we're talking about assessing effectiveness. We're going to be seeing this model a couple of times as we gather and synthesize data.

MR. REHBEIN: Is the focus group section also going into that annex? We kind of slipped right by that.

MS. DAILEY: Okay. So we're moving the focus group data somewhere else also. Okay. Page 6.

DR. LEDERER: Ms. Dailey, if I could interrupt. We did not anticipate providing any separate focus group results in the report at all, actually --

MS. DAILEY: Just that paragraph.

DR. LEDERER: -- just that they would be integrated into the Chapter 2 along with the other results.

MS. DAILEY: Correct. Correct. All right. Last page, assessing effectiveness. Our model for assessing effectiveness.

DR. GUICE: I guess my question is, why is it here? What does it -- again, I think this is something you can put in the back. I don't think people are going to be interested in trying to figure out what a logic model is and it may just confuse and dilute our, what we really want, which is go ahead and tell them what we thought.

DR. TURNER: I think dilute is a very good word. It dilutes.

MS. DAILEY: All right. Anything else?

DR. TURNER: I think we should write this for very short attention spans.

DR. GUICE: We're going to tweet it.

MS. DAILEY: Okay. So Chapter 1 re-write. We will get it back to you. Steven, I need that second page that I had asked you to screen. All right. So we'll get that back out to you very quickly. Ladies and gentlemen, this is a, this is a drill we have to have pretty much done by the 15th of July. We'll have one full report gathered and given to you as a first draft on the 15th. So now let me just ask, let me just focus your eyeballs up here. This is the last sheet of paper in Tab H. This is the very last sheet of paper in Tab H. It says page 47 at the bottom. So do you see page 47? Visual. This is, right now, what your Chapter 2, the guts of your reports, would look like.

[Pause, Task Force reviews.]

DR. GUICE: And you want us just to look in this in terms of, do we want the format to look this way? So recommendation and then a paragraph of explanation.

MS. DAILEY: Yes, ladies and gentlemen. Again, it's going to be very difficult to be formatting after the 25th of July. So there are other styles. We, the research staff

and I, thought this is what you told us to do. I've done reports where all these recommendations are in a separate chapter. We were under the impression you guided us to integrating them into the second chapter.

MR. REHBEIN: My eye is drawn to the paragraphs rather than the recommendations. And so if we can design a font or an emphasis that draws your eye first to the recommendations, I think that might be preferable, as far as I'm concerned. Because that's -- immediately as I look at this page I start to read the paragraphs. I slide by the recommendations, they're inset, they seem to be smaller, they just don't seem to be as important as the text.

GENERAL GREEN: Yes, I would say as well that one, the problem with this format -- well, I actually think the format is fine with a couple of minor tweaks. One is, if we end up with a recommendation 5.3.3.2, we're dead meat. Okay? So I'm hoping we don't have any of that. And so when you think about, there's going to be solid numbers. And so really you would expect that the recommendation would be in a little bit larger font, would be at the left, and that the paragraph that supports it would be indented below. And so I would say kind of we need to think of how we're going to do this. Some way or another, maybe it's just a larger font and making it to the left. But something has to change.

MR. DRACH: My preference would be to state the issue first followed by the recommendation, rather than the recommendation followed by the issue.

DR. GUICE: I think it's easier to go with recommendation first so that people go, oh, that's your recommendation. Now, why did they do it? Rather than why and then the recommendation. I think it -- to me, I like to read the recommendation first and then try to understand their thinking to it.

MR. DRACH: I'm not going to fall on my sword over it, but the Congressional Commission on Transitioning Service Members stated the issue first followed by the recommendation. It's --

MS. DAILEY: I mean I picked this one because when we were up talking to the Hill, Dr. Guice and General Green and myself, this is from the Mental Health Report and they raved about the Mental Health Report. Now, I don't know if they raved about its style but...

MR. CONSTANTINE: What was Dole-Shalala, Karen?

DR. GUICE: Dole-Shalala, the body of the report, was really small. We only had six recommendations. If I remember right, the recommendation came first but it was in a different font, certainly a different size than the explanation. But the whole punch that that report had was that the basic report was -- I don't remember Denise, 10 pages? 20 pages? I mean, we had Dole-Shalala said there will be six recommendations and there will be 20 pages. I don't care how much you put in that backup report stuff but we're going for splash. And that's what makes it memorable, is because it's short, readable, understandable, and quick.

GENERAL STONE: Yes. I think that's exactly -- I think in the opening chapter it's very effective to say there follows 14 recommendations and additional comments as follows if they just don't fit into a recommendation but something we saw that's beyond the purview of the committee. I think there's a section that says, you know, we ran into this, it's something you may want to tackle. But I think you just focus this down. And I think the strength of Dole-Shalala is its brevity. And I think that we have to continually drive this down. I'm respectful of where Denise is, where you need to justify certain things and annexes, but you need to keep this really focused and into a few areas. We'll have time in subsequent years, but if we don't get their attention in year one, you have to wonder, you know, where we're going to be in year two, three, four, and five.

MS. CROCKETT-JONES: And as far as the style goes, this box, if that box is isn't something important, it's just distracting. This little, on this page, this little inset box which seems to be commentary on the commentary, I don't know about anybody else, but unless that box is some sort of synopsis of the whole page, I think that people are going to think it might

be, and their eyes are drawn to it and it has dominance. And I hope we don't do much if any of that.

MS. DAILEY: Yes. And guys, you all picked a style that included boxes. Now, I can -- I mean, that was part of the deal when I gave you two styles.

DR. LEDERER: Those boxes are an option. We don't have to use them at all.

MR. CONSTANTINE: If we could just have it the same way throughout, as we just discussed, like a tweet, I would recommend we just follow that the whole way through, without the stuff that Suzanne is talking about.

DR. GUICE: I think the boxes can be useful. You have to be careful about what you put in them, they have to be short, they have to be supplementary to what is in there. And to me, it's where you place them on the page, too. I also find this one, my eye immediately goes to, oh, I've got to read the box first before I read anything else. So I think if we want to use them, I think it's a placement and then a punch piece, not another paragraph.

MS. DAILEY: Okay.

MR. REHBEIN: Yes. Something of very high importance because that's what's going to happen. You open, you turn to that page, you see the box and that's the thing you read first.

MS. DAILEY: Okay. We'll try it.

GENERAL GREEN: The other thing in the boxes is that it's a great place to take quotations or without attributing, remember because of the privacy. But we can say, you know, a wounded warrior, Belvoir Wounded Warrior. Or we can say, you know, that's the place to put the kind of things that prove our point. So...

MS. DAILEY: Go back. Go back. No, wait, wait, wait. No, I'm sorry. You were right.

MASTER SERGEANT MACKENZIE: I was going to say, that's exactly what I was thinking. Unless it's like the most important point.

MS. DAILEY: Okay.

MASTER SERGEANT MACKENZIE: If it's important enough to say --

MS. DAILEY: Got it. Got it. Ladies and gentlemen, thank you very much. Good. I'm going to very quickly, because we've got 20 minutes, I need Jessica, Dr. Jagger, to talk quickly about these products in your chapter and in Chapter H.

DR. JAGGER: Okay. So you can see it on screen very quickly. This is just based on the logic model that we sort of agreed to upon in the beginning for assessing effectiveness. Remember, because we're dealing with some younger programs and some programs that don't have outcome measures, we're trying to look at effectiveness from a more broad perspective, so we use the logic model in order to be able to do that.

MS. DAILEY: Now, it says "sample," but ladies and gentlemen these are actual documents that we're going to be giving you to help you get your head around these programs. And they're organized in a logic model format.

DR. JAGGER: So this is the place where we go from stacks of information, stacks of testimony, whatever it is, to results that we can integrate into something that goes into the report. And you'll see, some of them are longer than others. This one with DCOE is focused on the Center for Excellence for Psychological Health and Traumatic Brain Injuries. So we don't have obviously the content from the other Centers of Excellence yesterday. That will be integrated later into a follow on to this piece. But what you can see is we start with a legislative mandate. That comes straight from our establishing legislation. That's what the issue was that we were tasked to look at in relation to DCOE, PH, and TBI. And then you'll see the purpose. The purposes are assembled from usually mission statements or something in the headquarters level briefing that we're given. And then under that you will see, we're on page 2, is the

maturity, and there's a little timeline there that gives you some sort of background as to how long the program or service has been around, and some milestones in the lifecycle of that program or service. On page 3 you'll see the information sources that were used. This list, for the DCOE, consists of the briefing that we heard on January 7th, a follow-up memo that was issued by Captain Hammer, who is the new director, and then the GAO report that came out relatively recently on DCOE, PH, and TBI.

MR. CONSTANTINE: Jessica, is this in the annex or is this in part of our report?

DR. JAGGER: It's not part of the report and it won't be in the annex, unless you feel for some reason that you want it in there. It's the step between the piles of paper and the report. So it's not meant to be a public document or part of the report. So then starting on page 4 you'll see we start with resources. And you remember from back in January we gave a list of research questions and we've tweaked those research questions and then we've asked them in different ways to different audiences. And so you'll see that under resources we have one resource question that was asked. And you'll see that we have data from the briefing on January 7th. And we have data from Captain Hammer's memorandum. And we have data from the GAO report that answers that question. All sort of bulletized there for you. And that's basically the format. It repeats through activities, outputs, and outcomes.

MS. DAILEY: There's activities -- so what is this? Activities? What is this organization doing? What activities have we seen? And some of these will be extensive. You can see a couple pages of activities from DCOE.

DR. JAGGER: You will see sometimes questions repeat, like that 1.6 was in your resources. It's also in your activities because the question is about internal and external factors preventing them from better fulfilling their mission. And some of those factors are resources and some of those factors are activities. So the question is repeated for you so that you

can see the resource factors versus the activities factors. And there'll be a little sentence that says, you know, the answers under here are responding to activity issues that were identified as barriers to fulfilling their mission.

GENERAL GREEN: So help us all understand. I mean, so this is comprehensive and it's not going to be part of the report. And so this is almost like notes that'll be available to us as we write? Is that how it's going to be used?

DR. JAGGER: Yes, sir. It's based on the request of the committee at the last meeting. We're taking it and doing as much writing with it as you want but it's so that you have information all along the process so that you are seeing more of where we're gathering information from so that you're seeing the information yourselves as much as you want to within your groups, and then we put together the draft report for you and you do with it as you wish.

GENERAL GREEN: Clearly I'm taking too many notes. I mean, I'm impressed.

GENERAL STONE: I find this a very helpful format in order for us to formulate concepts. And when I cross-reference this to some of my notes, it's sort of interesting you're starting with Defense Center of Excellence, which you know has gotten my blood pressure up over the years. I find this very effective to just sort of see what one of my classmates has written down. Okay. It's sort of like getting somebody else's notes from a lecture. And so I think as we work our way through an issue, rather than try to wordsmith it, I think there may be some clarification of what the note or what the bullet means. But from my standpoint, I think it'll help inform me in my thought process. Thank you.

DR. JAGGER: Good. Thank you.

GENERAL STONE: Where were you when I did war college?

MS. DAILEY: Can I get everybody to stand up here? Thank you. These all formatted and bulleted and gathered and cross-leveled, Karen Pulliam and Diane and Allen have

done a lot of this work. [Applause] And a couple more people behind the scenes, so... And ladies and gentlemen, these products are not finished. They do not include at this point site level data, and they do not at this point include the focus group data. And so you will get these, you'll get these in another iteration with this meeting, site information, and focus group folded in.

MR. REHBEIN: What we have isn't subject to revision, it's just simply subject to addition.

MS. DAILEY: Correct. Correct, because it is not a recommendation document, it's a compilation of everything we've heard in one place. It's a lot of material and that's why General Green organized you all into four groups. I know you'll have interests in groups outside of your group, but when you get overwhelmed, which you may very well, you only have to deal with those four topics and those effectiveness documents that deal with your group. Ultimately, that's what I can ask of you, is that you get your head around that information. All right. Now, for the hard part. We need to go through this document. It's page 2, which is when you're going to see all these tools. Steven, page 2. Thank you. No, no. Different file, please. And it should look like -- there it is, page 2. Page 2. All right. There it is. I see Dr. Stone has it. Yeah. Should be up front, should be up front. Because as I said, these -- yes, yes, not the other two page 2's. You all are doing really good following along. This is very complex trying to get you all through this so I'm very, very appreciative of your tracking with me here. Suzanne, let's try and walk everyone through this. You in fact left me a lot of time. Actually, truly, 10 minutes will be good on this. I need you to get your heads around this. This is when you're going to get these products.

DR. LEDERER: All right. Between the conclusion of this meeting and the end of June, over the next several weeks we will continue to furnish you with these preliminary results, effectiveness results documents that Jess just introduced. So you have five of them now, and they are incomplete. We will send you the complete effectiveness results documents for

those five, as well as the documents for the remaining topics between now and the end of June. And we'll try to come up with a schedule for that so you can know when to expect these. During June, you will be these meetings, these conference calls that Ms. Dailey will be coordinating, so that you in your groups can be determining what your findings are and your impressions and your recommendations are. Some of you, our understanding is that some of you will choose to write and some of you are less inclined to write. And we hope that you will pass along your writing to us so that we can incorporate it into the draft report. We will be submitting a draft report to you on July 15th that will contain a revised Chapter 1, which you gave feedback on earlier this morning. It will contain Chapter 2, which will be these results but no recommendations. The recommendations will have to come from you folks. And it will be an outline of Chapter 3. Chapter 3 is the plan for next year. And as General Stone mentioned at the previous meeting, you really can't know what that plan should be until you have your results. So we will mock up some recommendation, an outline of that chapter, but it will be very sparse and it will await your input, which you will hopefully provide at the end July meeting, July 26 to 28. That's the point at which you will, as a group, review Chapter 2, provide substantive feedback on Chapter 2, and also provide substantive guidance for Chapter 3. If you go down to row number four of this chart, you're looking at where it says July 7th, members provide consolidated edits to Chapter 1, you gave us some general feedback this morning. Denise, what is the plan for --

MS. DAILEY: I need you all to take that back pretty much immediately and turn around another Chapter 1 by the end of the month. Let's incorporate their changes now and let's get another draft out to them on Chapter 1.

DR. LEDERER: Okay. So that July 7th date, we don't know really what that means.

MS. DAILEY: Correct. Correct. We can pull that one out altogether.

MR. CONSTANTINE: So you'll just send us electronic copies and we individually will make any comments we think.

MS. DAILEY: Correct. Correct. Now, what we did this morning on Chapter 1, we got to find a way to do it between now and pretty much the 15th of July for the rest of the work that you're doing. So we have got to, you've got to get -- these meetings have to clarify what the researchers are going to craft out of your head, and if you are going to give me a written product, I need it because on the 15th of July I need to have a first draft. And I will give you five working days to wicker it, but on the 27th of July, I need a product that I can pretty close take to the printers. With, in that -- so that meeting on the 26th, 27th, 28th of July, is the final tweak on any editing. We can't do what we did now. And hard work on voting on your recommendations. And we'll build some draft recommendations in the last week of June and first week or so of July. So editing, bringing your recommendations to the table in draft form all has to be accomplished.

DR. LEDERER: When the meeting is over on the 28th of July, we will take all of your input and integrate it into yet another version of the report, and we will provide it once again to you for a final review around August 10th. And at that point, unfortunately, your opportunity to provide input will be, further input, will be very, very limited, and it'll really be mostly crossing the t's and dotting the i's in terms of the type of feedback that we will be able, that we will have time to incorporate from you. And then the final product is due to Denise and to the printer on the 19th of August.

GENERAL GREEN: I have -- we're talking up here, we have a couple of concerns.

MS. DAILEY: Good. Good.

GENERAL GREEN: You're saying that basically on July 26th through the 28th is when we have to basically do all the last part of the report, if I'm hearing you right.

MS. DAILEY: Correct. The most important thing to come out of the 26, 27, 28, is you have to vote on your recommendations. If you cannot come out of the 26th, 27th, 28th without a vote on recommendations --

GENERAL GREEN: The problem is that without knowing the recommendations, I'm not sure how you write the report. And so you almost need to back it up a little bit to make certain that you can write the report in a way that supports the recommendations. So we're just wondering whether we shouldn't have a meeting on the top finding recommendations a little earlier so that when we see it we now see the text as it supports the recommendations. I mean, I understand what you're saying about the last time to change them may be the 26th. But if you're waiting until the 26th to vote on the recommendations, then you don't know if the report is going to be written in a way that supports the recommendations. So we're kind of thinking we need to move the formulating vote on top findings and recommendations to an earlier date.

MS. DAILEY: Good. Okay.

GENERAL GREEN: One other thing before we go on. Just we're up here kind of calculating. There's four groups. I was saying that we should have the groups focus on their top five recommendations. And then Karen pointed out, there's almost 17 different topics that we have to address. And so we're looking at it and saying, okay, no more than two recommendations per topic area, looking at this pyramid. Granted, the graphic will change. But that gives us a maximum of about 34. And so now I say that knowing there's going to be some things that are important enough that we need to either go higher, and then some things when we actually talk they'll be consolidated. But for each of the groups, as you think about what you're going to recommend, to keep this somewhat manageable, be thinking about kind of where are we? If I have, in my group I have five or six different things, then if I have to do two per each of those areas, well that would be six would be you can come back with 12. And so you

see what we're trying to do, give you a little bit of guidance. And if you come back with 15 because you just couldn't eliminate something, that's fine. And then we'll look and see where the overlap is. But that's why I think we need to have these recommendation meetings earlier, so that we can kind of get to the point where we're all in agreement with what our major recommendations are. And then the report, as it's written, is written to support those recommendations.

MS. DAILEY: Okay. If I'm getting information out of you at these evening meetings, then I can write the report to your recommendations. Because that's what's on the top of your head, is what you want to make a recommendation on. So if you're going through this information that we're giving you, you're getting your heads around it, out of that is going to say, well, I want to talk about training for case management. You know, I saw in here, I heard out there in the field that more training is needed. We will pull together in your section a discussion of what training is ongoing and what needs to be conducted. So if I'm getting out of you in these focus, in these evening events that we're doing, what is at the top of your head, the text that they write will be about your recommendations. So what you're talking to me about in these meetings is what your recommendations are going to be, where your head is so that I can write to it.

MASTER SERGEANT MACKENZIE: That's exactly -- the one thing I'd like to do though is each one of us has attended different focus groups, each one of us has collected a bunch of information. On that initial cut, I'd like to vote that we come up with the recommendations that we see fit as a group, and we vote as a task force during our 26 meeting as to how many of those recommendations -- you know, with the idea that we hierarchy the recommendations as we see fit as a group. But if we've got ten recommendations on a group, that's okay because when we sit down as a task force we say, no, the top three is what we're going with. Or the top two is what we're going with. I don't want to limit the level of information we're passing around before we make our final vote.

GENERAL GREEN: Yes. I don't disagree, I just still am wondering if we don't need to do that. Some of this has to be done at these, some of it is preliminary. I just -- if we wait till the very last meeting to come up with our final recommendations, we're going to have troubles with this.

MASTER SERGEANT MACKENZIE: I think what I was getting at, sir, is that the recommendations are all there. We just vote which one of those recommendations are actually going to go in the report.

GENERAL GREEN: Okay. And I don't disagree. The other thing I don't want to have happen is as we give out some general guidance on what we're trying to find, I don't want you to turn them into (papum?) In other words, don't combine three or four into a single recommendation and nobody would understand. We need to be clear in terms of what we're looking for. So if it takes more recommendations to be clear, I think what you're pointing out is exactly what we should be doing. But to give you a little bit of guidance, we don't want each subgroup to come back -- you know, you don't have to come back with a hundred. Okay? So you understand.

DR. GUICE: I also think that it's important to know that you don't have to come back with a recommendation if a section doesn't warrant it. You can say, we investigated it but at this point in time we do not have sufficient information to make a rational recommendation about which way to go. We will continue to do it. So don't feel compelled to come back with recommendations if you just don't have enough evidence to make a decision about is it effective or not.

MS. DAILEY: Okay. Now, we're going to pull this information out in the evening events. We're going to write to your input to us from those evening events. We are synthesizing information now. If you feel you have to have more research, more information, I need to know it now because I don't have any more time to gather data. So as you're getting

these products in, you're gating your effectiveness documents, you've got the focus group top you've -- got the focus groups for the family members, which we haven't had a chance to talk about and which we won't have a chance to talk about. If you absolutely have to have more data, I have to know now because I cannot -- we are going to be -- I don't have any more time to gather data.

DR. GUICE I think we go with what we have. I don't -- I really, given this timeline, I don't -- we don't have the time and we don't probably have the energy either to do more of this. I think there's sufficient information to make some very solid recommendations. But again, I mean, I don't think that we have to make a recommendation for everything if we don't have sufficient evidence then we just say we don't. I mean, I know you're compelled to answer the (male?) to each 17, but if it's just that we don't have enough and we're continuing to --

MS. DAILEY: Okay.

DR. GUICE: -- identify information, we'll do that.

MS. DAILEY: I got it. I'm good with you.

GENERAL GREEN: And we have the opportunity to say we're going to defer 1-17 to next year. Or two or five or ten of the 17 to next year. So, I mean, we can also leverage the fact that we're a multi-year function.

DR. PHILLIPS: I agree. I was going to say that. We don't want to overwhelm whoever is going to be the audience with a whole host of recommendations that are not possible to achieve. I think we need to also decide which ones are achievable at this point in time.

MS. DAILEY: Correct. You've got it. All right, ladies and gentlemen --

GENERAL STONE: Can I just make one comment please before we go?

MS. DAILEY: Yes, sir. Hit it.

GENERAL STONE: I think we nudged up against that yesterday. I think that final presentation from the civilian provider system and some of the commentary from a number of task force members yesterday, really nudged up the need for us to recognize how much of this care has been given out of the civilian system, and for us to spend some time next year working through the civilian delivery networks. And I think that it just struck me on my way home how much time we need to spend really thinking about how we capture that civilian delivery network. I think your comments yesterday were so well placed of, you know, how do we gather in this for this geographically dispersed force? And I don't think we've gotten it yet this year. I don't think we've gotten it.

MS. DAILEY: Okay. No, you're great, sir. I appreciate it. Again, success at the July meeting is your voted-on recommendations. You come out of that meeting without voted-on recommendations, we will not make our suspense.

DR. LEDERER: Denise, may I just add that and I know time is short that you all, although you didn't have the opportunity to attend each and every focus group of all of those 18 sessions, you have access to the comprehensive results from all 18 sessions in those focus group products that Denise disseminated to you on Tuesday, Monday or Tuesday. So you -- your input does not need to be limited to those sessions that you attended.

MS. DAILEY: Good. I just want to ratchet up the level one more time. You need to read through that hundred pages of focus groups. And you need to read through these documents that are the effectiveness documents. These are your source documents. You've got to have your head around them. Okay. That's it. Sir? You're the man. Thank you all. Thank you all.

GENERAL HORST: Denise, I have a copy of the annex(?) Of yesterday's hearings on VA DoD collaboration if members of interest will make a copy of it. This has executive summary, salient points by members of Congress.

MS. DAILEY: Good. We have public forum now. I've got four to five presentations, two minutes. You get one minute to ask questions, if you want. But I've got the public waiting out there, I'm opening the doors, it will be cool in here the rest of the day. Please, five minutes, come back, let's listen to our public. Thank you. Well done everybody. Very well done.

(Whereupon there was a recess from 9:06 a.m. to 9:12 a.m.)

MS. DAILEY: We're going to introduce the public forum now. And Dr. Guice, you're on for that. I have some text here that I'll be reading. And just to remind our public forum panel that you will have 2 minutes per presentation and then Task Force will be given an opportunity to ask you questions. And then we'll move on to the next one. And we appreciate your time, I know it's 2 minutes, you've probably come a long way, but Task Force is on very tight schedule right now. We're going to begin this morning with our public forum presentations. Ladies and gentlemen, it's at Tab N. So for my members, it's at Tab N. Our speakers are Ms. Julia Ray of Disabled Sports USA, Ms. Angela McConnell of QiRei Integrated Healthcare and Consulting & Services, and Dr. Marianne Cloeren of Managed Care Advisors. Thank you. And Ms. Julia Ray, would you please begin.

MS. RAY: Good morning. My name is Julia Ray. I work for Disabled Sports USA, and I'm here this morning to speak about adaptive sports equipment needs for those who have chosen to continue in service after injury. Presently, veterans with disabilities are reimbursed for specialized adaptive sports equipment and adaptive sports technology through The Department of Veterans Affairs once they've been discharged from service as disabled veterans. There are a growing number of service personnel with severe wounds that are choosing to stay in service, and some are even returning to the battlefield. According to the Army's AW2 Program, they estimate that approximately 200 individuals who may have been considered unfit for duty in the past and would have been discharged as disabled veterans are

now continuing to serve in the military. These service members still have a need for the same adaptive sports equipment and assistive technologies as disabled veterans. However, there is no government funded program that will provide this. DSUSA is suggesting that regulations be modified to allow active duty service members who would have otherwise qualified for reimbursement for adaptive sports equipment purchases be allowed to do so under the present VA sports equipment program. Using this equipment to maintain an active healthy lifestyle through sports will not only benefit the wounded warrior but will also benefit the military through increased fitness and performance and endurance of its service members with severe wounds. I do have examples of the types of adaptive sports equipment we're talking about. We're talking about a relatively small number, and really there is an existing program that could take care of this problem. There are some individuals currently still serving who do need sitskis or hand cycles or similar adaptive equipment to maintain an active lifestyle. So thank you for your attention this morning.

LT. COLONEL KEANE: Ma'am, have you coordinated with Chris Nowak at the VA?

MS. RAY: I just met Chris last month. He's new within the VA, but yes, I've discussed all this with Kendra Betts as well.

MS. DAILEY: Thank you.

MS. RAY: Thank you.

MS. MCCONNELL: Good morning. I'm Angela McConnell. I'm with QiRei Integrated Healthcare, and I'm a wounded warrior volunteer mentor. I'm a veteran of 22 years, combined service time. And the following strategy is in direct support of the recovering individuals' whole health, mind, body and spirit, which is in my mind the absolute priority and will dictate their ability for clear thinking to consume, understand, and act upon the many decisions they must face while in the WTUs. This strategy's intent and focus is for increasing

personal independence and self-management while lessening the need for multiple medications and lessening the abuse of other abuse substances, escape behaviors, and addictive activities. There are evidence-based complimentary programs being used throughout the military, like mind-body skills training, yoga, different types of meditation, that have proven beneficial in regulating the autonomic nervous system and reducing symptoms of anxiety, hyperarousal, insomnia, while increasing feelings of calm, grounded, and focus and control. I'd like to encourage the use of these complimentary therapies in initial and standard approaches to care, to make them available daily in the WTUs, not only because they're relatively inexpensive and easy to establish but because they're effective. Service members are taught about their body and minds, they're educated and become aware of how and why they react, and they begin to gain greater control over their bodies and reactions. They're taught coping strategies and develop the tools that can be used today and taken home with them so they can use them for continued self-care and management. These programs should be easily accessible to the WTUs, offered on a daily basis, and prescribed and monitored as well. So we're offering non-pharmacological options and therapies that are learned and self-administered as needed. These programs are easy to track and measured, and would be perfect to use in conjunction with the new T2 mood trackers that are currently out. Total force fitness is the new paradigm. So let's offer those programs that will support this movement and, more importantly, have an immediate and direct positive impact on the health and well-being of our recovering, wounded, injured and ill. Thank you.

GENERAL STONE: Each -- excuse me. Each of the warrior transition units that we visited and talked to have been working to actively integrate alternative therapies and have been reported metrics on the reduction of psychopharmaceuticals, as well as pain medication usage. Can you comment on your experience with those efforts? And are you asking

us to go further and recommend to go further than is currently done or do you feel that the current alternative methods are not appropriate?

MS. MCCONNELL: I think what I'm familiar with, as far as what's being offered at the WTUs, it's being offered at the hospitals, and they're not as easily accessible. Am I correct in saying this?

GENERAL STONE: I can't comment.

MS. MCCONNELL: Okay. That's my understanding. So yes, I think to go further would be to make them easier accessible. To prescribe them, not just have them available, but to prescribe them. I know acupuncture is being prescribed and other things, but to prescribe the mindfulness-based training and the mind, body, skills, so that people are required to go and learn these things and learn how to take care of themselves without the need for increased medications or medication at all sometimes. So yes, it is my position to kind of up this movement because it is inexpensive and it is effective, and we're teaching these guys skills that they can take with them and keep with them as well. Thank you.

DR. PHILLIPS: Is this extended -- are these programs extended to family members and caregivers as well?

MS. MCCONNELL: The only program I understand is one that's put forth by the DHCC in conjunction with their Track II PTSD program. And I just heard this by the way yesterday, it's for spouses that come in and do a one-week program. I'm not sure what all that entails, but I believe that's part of it. And the family should be included because the caregivers, the stress that goes on with the caregivers and what they have to go through, and the children, it's all, you know, compiled upon themselves and it would be helpful to have the families involved, as we know.

GENERAL GREEN: Thank you very much.

MS. MCCONNELL: Thank you.

MS. CLOEREN: Good morning. I'm Marianne Cloeren. I'm an occupational medicine physician. Thank you for the opportunity to provide you with some information about PGAP, a behavioral intervention that reduces disability risk-related factors. The progressive goal attainment program is a short-term structured intervention that can be delivered in person or telephonically. Managed Care Advisors is the only company in the US right now offering telephonic PGAP at this time, and we use experienced workers comp nurse case managers. It can be delivered in weekly one-hour session for a maximum of ten weeks. We've all seen the difference that resilience and a positive attitude can make in the recovery of a person with catastrophic injuries. There are many examples of this among wounded warriors who've recovered from debilitating, devastating injuries and returned to active duty or successful careers. But we've also seen service members who are anxious or fearful or depressed, and who sink into the role of a disabled person, never recovering to their full potential, despite excellent medical and psychological care. PGAP was developed to help people with the behavioral risk factors that contribute to unnecessary residual disability. These risk factors are disability beliefs, pain catastrophization, depression, fear, and perceived injustice. But PGAP is not cognitive behavioral therapy. Rather than trying to persuade people with these risk factors that their beliefs and attitudes are part of the problem, PGAP works by showing them in incremental ways that they're not as disabled as they think. PGAP provides a person recovering from a disabling injury or illness with the tools to set and achieve small goals directed towards increasing activities and life role involvement. These successes build on each other from one week to the next, demonstrating ability and capacity rather than disability. PGAP reinforces recovery and promotes reintegration. PGAP was designed to complement existing clinical services for the treatment of debilitating or painful physical and mental health conditions. Its effectiveness has been proven in several research trials, and its use for Canadian veterans is increasing. PGAP offers a new tool for the Wounded Warrior Programs, one that's standardized, cost effective, and

can be delivered telephonically to increase convenience and geographic reach. We'd be delighted to answer any questions you may have.

GENERAL GREEN: Okay. Thank you very much.

DR. GUICE: Okay. I believe you all are excused then. Thank you very much for coming and telling us about your positions. We're going to move to our employment panel, so we would like to go ahead and change set. For the members, it's Tab I, if you want to go ahead and turn to that and we'll get ready to go. Okay, if everyone is set we'll go ahead and begin. Under Tab I you'll find the briefings, and for the people at the table this is a specific panel that was brought together because we expressed interest in kind of delving into employment issues for service members. So we're looking forward to hearing the presentations. We've all heard that unemployment rates for veterans are high. We're trying to better understand what's driving that particular dynamic, and then trying to figure out if there are cogent ways to step into the right place for the employment for our service members who then leave. Mr. Skip Rogers, Executive Director and Co-Founder of Able Forces, it's a veteran owned, not for profit, providing professional career oriented and employment exclusively to wounded warrior and disabled veterans. Mr. Michael Conklin, who is there, yes, Sentinels of Freedom Scholarship Foundation. Jolene Jefferies, Vice President of Strategic Initiatives for DirectEmployers Association. And Ms. Adams, Branch Chief of Employment, Education, and Internships with the Army Warrior Transition Command. So which -- you're up at the podium. Excellent. Thank you.

MR. ROGERS: Thank you, ma'am. Good morning and thank you for having Able Forces part of this task force. My name is Skip Rogers, I am Executive Director and Co-Founder of Able Forces. Able Forces is a veteran owned, 501(c)(3), Ability One affiliate, and we are referred to in the community as a community rehabilitation program. Our mission is to provide high-cognitive, career-oriented employment and community-based job

preparation training exclusively for wounded warrior and disabled veterans. That distinction there of wounded warriors and disabled veterans encompasses all of our warriors, going back to kind of my time, even and before during the Vietnam conflict. So we encompass our warriors having physical disabilities, post-traumatic stress syndrome, and at this time minor to moderate TBI. And we hope, God willing, that will change soon to get into more moderate to advanced TBI for some of our programs, as well as employment opportunities. What we believe we have done or are doing is establishing what can be a national model for employing wounded warriors and disabled veterans. Able Forces, we believe, has established this model, validated it, and we believe what we are doing can be done nationally by other 501(c)(3)s in communities all over the United States, and that's the focus on my presentation.

Background and really the foundation of how our model will work: About 35 years ago, a national set-aside program was established, then called JWOD, currently called Ability One. Ability One, historically, has been a program that last year was funded at 2 billion dollars in federal contracts, employed 43,000 employees under 600 community rehabilitation programs like Able Forces. It is defined as a program in FAR, Federal Acquisition Regulation, 8.7. Historically, these employees have been developmentally disabled and executing under contracts such as housekeeping, janitorial, landscaping. When my partner and I -- and some background also, my partner and I have spent well over 35 years in the federal market, primarily in DoD areas, supporting DoD contracts. We know about Hub Zone set asides, 8A service disabled. Never knew about Ability One. The legislation defines it as severely disabled. Not developmentally disabled, not low cognitive, but for 35 years, historically, that program has only been used for low cognitive. We believe, in looking at the definition in the Federal Acquisition Regulation, that it opened up a world. If we could establish federal contracts just like the Tier 1 companies of the world do, the Booz's, the General Dynamics, professional service contracts using the Ability One program to hire specifically wounded warriors and disabled veterans. So

we started down this course a couple years ago, we established Able Forces a year and a half ago, and our focus to make this work -- and it's rather challenging, as all of us in this room know. I've heard many comments. How do you access wounded warriors? How do you find wounded warriors for employment? I can find onesy twosies, but I don't know how to get to numbers of them. We have, over the last year and a half, established some fairly close relationships with most of the organizations on the federal and community or state level that touch wounded warriors and disabled veterans. They include the VA and the variety of organizations or departments within VA that touch our warriors, including VRNE, the social workers, the OE/OIF advocates, and so forth. We have relationships at the local level, and more broadly with the warrior transition units, AW2, wounded warrior regiments. We also have relationships on state levels with the employment commissions within the states that most of them now have a very focused veterans organization. And then, in addition to that of course, our work with VA on a national level, Department of Labor Vets. And what this has required is a lot of effort and focus on the part of the Able Forces. But what we have found is we now have a way to identify our warriors in any community in the United States.

Using the Ability One program, our contacts in industry and our relationships with those organizations that touch our warriors, Able Forces has been able to execute. And before you you will see the current contracts that we are executing exclusively for wounded warriors. I would like to highlight one because we are very proud of this. United States Army PEO Simulation Command in Orlando, we have established what we believe is the first national contract exclusively focused on wounded warriors as subject matter experts in positions such as urban operations, tactics, Bradley tank operations, pre-deployment training. We currently have two wounded warriors there, we have seven more slots to fill. This, we believe, is a pilot program that we are showcasing as a way that the United States military and DoD can structure contracts exclusively in high cognitive areas for wounded warriors. I won't

go into the details. We are not marketing, ladies and gentlemen, we are being contacted by the Tier 1's of the world to add Able Forces and our warriors to their existing contracts. We are at the Missile Defense Agency, we have been contacted by NR on teams of General Dynamics, Booz Allen, SAIC, and they're coming to us.

So quite basically, Able Forces, or any 501(c) under the Ability One program, having established relationships with those organizations that touch our warriors and then those relationships more broadly on the national community, meaning the VA's of the world and so forth, the state organizations, we believe that what we have been able to create can be replicated across the United States, and we honestly believe that this is one of the answers to employing thousands, if not tens of thousands. One of the solutions is for -- and DoD , and God bless DoD because they have taken the lead in this -- one of the things that is needed for every federal contract, in addition to specifying small business requirements such as Hub Zone service disabled, 8A, and so forth, the language to have Ability One represented in a small business category is critical. DoD has taken the lead, where you see our work at Missile Defense Agency, for example. Special Operations Command in Tampa. Because the language of Ability One is in there, they are identifying, trying to identify, companies that exclusively provide wounded warriors. Right now we're the only one. But we don't need to be the only one. Our work is to have this replicated.

This has been a very, very exciting time, ladies and gentlemen. We have spent, my partner and I, the last year and a half putting this model together. It has only been in the last 30 days that the traction -- we're making traction, we are beginning to execute contracts, and we are very, very excited about sharing this model nationally. I very much thank you for having us here.

MASTER SERGEANT MACKENZIE: Let me ask you a couple questions, sir.

MR. ROGERS: Yes, sir.

MASTER SERGEANT MACKENZIE: First of all, are you providing any education to these wounded warriors or are you just simply getting them a job?

MR. ROGERS: Great question. One of the contracts I have is at Ft. Belvoir Mark Center. Those are going to be apprenticeship jobs. So those positions will couple a full-time position with training, apprenticeship training, under a journeyman. The contracts we're executing at Missile Defense Agency, which are secret-level analysts, require no training. Their training, their experience in the military, is what we're using as their experience for that job. PEO STRI, same thing. We have subject matter experts there, two of them currently, that have backgrounds in simulation training that have pre-requisite knowledge, and they can come right in the door.

MASTER SERGEANT MACKENZIE: So along that thread, these contracts or these jobs, is there -- are you providing any guarantee to the wounded warriors as to how long this is going to be? Do you have a minimum required length of employment before you push forth a wounded warrior to take this position?

MR. ROGERS: Great question.

MASTER SERGEANT MACKENZIE: And are you collecting data on your success rates versus unsuccessful rates based on contracts, individuals, those kinds of things?

MR. ROGERS: First part I think was length. As many or most of you may know, government contracts will generally be executed as a base year in multiple years following. We have a government contract, so we have one year base and multiple years if that contract continues to be executed. I do want to make a comment about how Able Forces is using both our warriors and these contracts. It is our hope that Able Forces is used as an entry point into careers. We want to get these guys in there, get them working. These are solid mission-focused guys. Our hope is that the Booz Allen's of the world, or the PEO STRIs of the

world, will say, six months down the line, I love John Doe. Do you mind me taking him from you? I'd like to make him part of my staff. Take him, and we backfill. So that's how that part of it works. I'm sorry, the second question you had?

MS. DAILEY: Let's -- I got four more people up there. Can we hold that?

MASTER SERGEANT MACKENZIE: Okay.

MS. DAILEY: And we'll come back around to it.

GENERAL GREEN: Thank you very much.

MS. DAILEY: We're going to hit you with a lot of information, guys, and question is good, so... But we've got to get through all four of these guys who are going to stimulate those questions, so let's maybe one question and then we'll see where it goes.

MR. CONKLIN: Great, thank you all. I'm Mike Conklin, Chairman of Sentinels of Freedom Scholarship Foundation. It's a pleasure, it's an honor to be here. The old saying was, I don't know you, but I love you for what you're doing. I honestly mean that. I know this is a tough business, and you guys spent a lot of time at it. As a father of three sons in the Army and one of them who was wounded, I want you to know how deeply I appreciate that.

Well, there it is, there's our logo. Great. There's our mission statement. Great. This is what we do. Target our population, 60 percent hire permanent, service connected. Mentoring, transportation, everything that you could imagine. Very personal program. Four-year term. We set a team of mentors around each individual, a financial advisor, an attorney, a doctor, career planner. Everything that that individual needs is a network by the time they get home. So we start working in the hospitals talking to them. They apply online. Interesting part about this is we are very small; 66 people in our program, we've only had two failures. The end goal of this is financial stability, education, and a long-term job, something that has a career opportunity. So in all of this, the warrior, his personal responsibility, is 99

percent of this program. There just is no free lunch even for a wounded warrior. I don't know how to tell you guys this, Corporate America wants to hire these guys, but they want them to come to them qualified. So we can talk about all the sorts of different programs, but unless that warrior is on the path to qualifying for that job, he's not going to stay there long. I'll tell you from another aspect as an employer, I don't like people coming and telling me I have to hire people; I want people to come and tell me why I should hire those people, why they're qualified, and what they're going to bring to my corporation. What's the value? I understand the rest of it, I understand my responsibility. But I want somebody to walk in the door and say, I'm excited about this young man, let me tell you about him. That's where we work. One on one. That's why it's so intensive. In your package, I don't know if we've got the story out there on Navy Ryan Sikes. We've got 100 people around that young man. A whole Rotary Club has adopted him. He's got private doctors, we've got tutors, we've got people to come to my office and help him walk every day. Duplicate that a thousand times. Can it be done? That's the question. We're doing it, not very fast. So as a model, this is an intensive model. We look at the severe; we focus on the severe. The guys that we think, like Ryan, was headed to a VA rest home if we hadn't gotten involved. That's where he was going. He's too smart. We could see it in his face; I could see it in his face.

How do we measure success? Great question. We're looking for community embrace. Long-term community embrace. And that means re-integration and helping with that. We look to corporations to invest. We don't call this a charity. We want them to invest sua sponte, few Rangers know what that means, of their own volition, because they feel not that this is a diversity program or affirmative action, because it adds value to their corporation. Education is the key to employment. I'm going to go back to education every time somebody opens their mouth and talks about employment. Bring me a qualified guy. We've got very robust systems in place for education. The GI Bill, scholarships, you name it. I mean, it's out there.

Self-sufficiency. We talked yesterday, I heard a little bit of talk about, geez, there's so much information. So much information out there for these guys, it's so confusing. Let me tell you, if somebody can get front of a computer and they have cognition, if they have basic cognitive skills, I can bet any one of these guys, if they say I can't find it or I need help, I can bet them \$10, and I'll lose every time, if they can find me a naked picture of Britney Spears in under 2 minutes. And they will do it. They will find what they are looking for, if they'll take the time. Or they will ask somebody else to do it for them.

Now, what kind of an individual am I looking for? I'm looking for a hunter, somebody who comes to me and says help me, I've found this information, now I need to decipher it. That's the kind of guy I'm looking for. A couple of our guys. This is Ryan Majors, he's up in Baltimore. We're working with him, we're trying real hard. This is a tough one. These are the guys we take on, the tough guys. Started school, now he's having an issue, had another operation. Out of school for a while, we're trying to get him back in. This is what represents a community team. This is a kid named Ian Newland out in Colorado, blown up with a hand grenade, beat to hell. He told me, he said Mike, I joined the Army to escape poverty. I wanted to be a Ranger Sergeant Major. And that ended. That was taken away from him. This is a whole community of people that came together in Colorado that are still with him, four years out. Graduating from college, he's got a great job, wants to help wounded warriors out there. He's got a future. This is a team out in Danville, California. In that team you'll see Ruben Jones up at the top there, General Jones, who is the head of the -- well, he was the Army Adjutant General at the time. There's three wounded warriors in that group, a couple of mayors. That's one team for a kid at the top on the left, Joey Bocik, a couple of retired generals in there. That's what a community team looks like. That's the embrace I'm looking for. When somebody says we want to set up a team, I ask them what they bring to the table. This isn't just Hi, thank you for your service and see you later. This is one of our kids working for a police department. Leg

ripped off on the Kitty Hawk. All right? Service connected. Still serving in GWAD. There's Ryan Sikes, with the Daughters of the American Revolution. Took him down there and he's doing great. Could hardly talk when I met him. Doing great. One of our blind guys, Travis Fugate, straight-A student after two years. We found him in a little town in Western Virginia, Western Kentucky, lost. No hope. Well, there's nothing there. So anyway. Joey Bocik at work and some of the guys we're working with right now. Pictures tell a million words. This is a young man, I call him the Russian, he's Romanian. State Department asked us to help him, we sent him out to Palo Alto, embraced him for six months. He is back working for the Romanian army. There's the end game right there. That's what I want. First day on the job. This is a kid named Ian Tran, lost an eye, was at Walter Reed for a long time. Came to me and said, I'm just mad as hell, I've got to get out of here. I said, if you work on your anger for the next six months, I think we can work with you. We're not an employment agency. Great. Sorry if I rambled on there a little bit.

GENERAL GREEN: Not at all. Mr. Conklin, how do you identify folks that you work with?

MR. CONKLIN: Very simple. We have website where they can go. A lot of it is word of mouth. Over the last five, six years, we've made a very good relationship with DoD and the VA. We act as partners. We don't go in and beat you guys over the head and tell you what to do. We ask for professional courtesy. And people call us and say Mike, I've got a guy I want you to see, could you come up to Walter Reed? I'm up here for three days. That's exactly what I'm doing. Lee Miller back here works with a group of West Point mentors, he calls me and says Mike, there's a new guy, I think he's sharp. This program isn't for everybody. One size doesn't fit. It's too long in term, it's too expensive. It can range from 20,000 to 60,000 to us over four years. We raise all the money privately. We don't ask the government for a

dime. Never have and never will. That's our doctrine. Thank you. I got hours I could talk. Really appreciate the opportunity.

GENERAL GREEN: Thank you very much,

MS. JEFFERIES: Good morning, everyone. My name is Jolene Jefferies, and I'm with DirectEmployers Association, and I'm very honored to be here and thank you for having me on the panel. I just wanted to mention very quickly, I've been in the private sector for about 25 years, been in human resources the majority of that time. Worked for, my most recent position was at Union Pacific Railroad, and I was the Director of Employment and ran the hiring operation there system wide. I was there from 1998 to 2008, and in '99 we rolled out an online application process which now, today, is very common among companies. Got lots of phone calls back then about the process because that was such a new trend. We were early in that process, and were able to implement that even for the very lowest level positions in the company we actually had people applying online. The reason companies are doing that is for efficiency purposes. And so while I was there, I ended up joining DirectEmployers Association, or the Railroad did, for the services that the Association provides for companies. And now I work for the Association. So I've been with DirectEmployers since the end of 2008, and I develop partnerships primarily in the government relations area but working with community and education partners as well. So I want to just tell you a little bit about who we are. I'll talk about our partnership strategy and our key military partnerships, how we engage employers, how you can engage employers, and just understanding employers because we're not all alike. So we're a non-profit, we're a 501(c)(6) trade association, and we're an HR consortium of leading global employers formed to improve labor market efficiency through the sharing of best practices research in the development of technology. We have just over 550 member companies, most of whom represent the Fortune 500 corporations. 21 board members come from the member companies, our Executive Director is Bill Warren, and he is known as the father of Internet

recruiting. He actually started the very first job board on the Internet in the late 90s, and TMP Worldwide came and bought that out and then they changed the name to Monster. And so Bill was the first CEO of Monster. And shortly after that in 2001 started the association as a nonprofit because he didn't like what was going on in the industry with job boards and the way they like to gouge employers with charging very high prices and not getting a return on that investment. So the association was originated from that. The mission is to provide a cost-effective national employment system that improves labor market efficiency and reflects our nation's diverse work force. We've grown tremendously and we continue to grow. This is our partnership strategy. The employers are at the center of partnering in order to seek jobs, in order to attract job seekers to their job openings at their companies. And what we do, we help facilitate those partnerships for and on behalf of our member companies. And one example I can share that I'm working on right now is with the Marine's Wounded Warrior Regiment. That's how I met Dave Rehbein, who asked me to be on the panel today. We're very close to partnering with the regiment. We're working on providing our job feed to their job banks, and so that will expose job opportunities to many more of the Marine's wounded warriors. And so, when we do that, those partnerships are extended out to our members and that way they don't have to source and find, you know, all these contacts and who do you call. Because it's not easy. When you're running a big hiring operation for a large corporation to find all of these resources out there. And there's some 8,000 websites that serve veterans. And so for employers it's extremely challenging to try to sort through all of that and to try to determine which sources are going to be the best sources depending on the industry you're in and the occupations that you have. So what we do is, we reach out both to government partners, education partners, and community partners. We've done very well in working with the states. We have a great partnership with the National Association of State Workforce Agencies. It's an exclusive partnership. We feed our jobs into all of the state job banks, they feed us their jobs. So it's a labor exchange. And so we work

closely with the DVOPs and the LVERs and the State Workforce Agency administrators. We have a lot of relationships in that area, federal, military. We have quite a few relationships, I'll review some of those with you. We also seek partnerships in the community with economic developers like chambers of commerce; community organizations like the Urban Leagues, and so forth; labor unions; as well as the education partners. We have a great partnership with the National Association of Colleges and Employers. We're starting to work with the Student Veterans of America, for example. We have a partnership with the American Association of Community Colleges. And so our partnerships are wide and vast, and it does really save our employer members a lot of time of just sifting through that and who's good to partnership with.

And what we do is, when we partner with these groups, and in fact we just met with the American Legion. Dave and several people from the Legion were in Indianapolis the first week of May, and they came over to our headquarters office there and met with us. So we're looking forward to, you know, identifying the partner opportunities with the Legion. And through that, what we'll do is allow them to have access to our members. We want to invite them to come in and educate our members through webinars, provide information about your programs and resources to our members, we'll share that. Employers really need a lot of education about this, again, because there's so much information out there. And help us lead employers to the right resources on a national, regional, and local level, and provide your contact information to us so that employers don't need to sift through that and try to figure out who to call.

So this is our partnership with the National Association of State Workforce Agencies. This is our most significant partnership. We literally are married to them. And we have the Job Central National Labor Exchange that we operate together, with both associations. It's a joint alliance. And there's some extraordinary opportunities that have resulted because of this partnership. It's really opened up the lines of communication between employers and the

state workforce administrators. There are six employers on an operations committee that runs the National Labor Exchange, and there are six state agencies on that committee. And so it's really, like I said, opened a lot of good dialogue. We have 48 contracts signed in 48 states. Michigan is not participating at the moment. And we're in process with Puerto Rico. Otherwise, we have all of the other states are partnered with the National Labor Exchange. 41 of those states send their jobs to us so we can distribute those to the National Labor Exchange. 41 states take the download so that our employers do not have to manually post jobs in all these job banks. If you think about it, if you're a federal government contractor, through affirmative action you're required to post these jobs through the state agencies. And I just remember when America's job bank went down in 2007 and I was at the Railroad, I panicked because I thought, oh, my gosh, we're going to have to manually post jobs in 23 state job banks because we operated in 23 states. But you want to go beyond that because recruiting requires that. And so I would have had to have a resource sitting there and posting jobs, and I couldn't have done that, you know. Joining the association saved much more because it happens literally in your sleep at night. Every 24 hours we update those feeds, we come to a corporate website, scrape their jobs, and feed them out to over 3,000 websites across the Internet. So this saves the employer an extraordinary amount of time. And we have 35 states displaying jobs in the Armed Forces Employer Partnership database. We've been supporting that program since October of 2008, so I work closely with those folks.

This is the job delivery for the states. All the states in red get e-mail, fax, or mail delivery plus the state file transfer of all the job openings. Those in gray just get e-mail, fax, or mail. They aren't set up yet to take a file feed so we're working on that because, again, employers don't want to have to manually post or set up separate feeds of their own.

And so above and beyond the state side over to the right is the National Labor Exchange, what I just described. And those jobs reach all the DVOPs and LVERs through

that relationship with NASWA. Over on the left side we have the commercial syndication, and that goes to over a thousand additional websites. One is the Armed Forces Employer Partnership. I mentioned the Marines. We're working with them to syndicate jobs to their websites. We have a wide variety that represents all the different protected classes: females, minorities, veterans. And so this helps employers be in compliance with the affirmative action regulations, if they're a federal government contractor. And with our military partnerships, the websites we syndicate to that are specifically to attract veterans include not only the National Labor Exchange and the Armed Forces Employer Partnership, but we also work with Higher Patriots, Military Spouse Corporate Career Network, the National Marine Corps Business Network, Recruit Military, Save Our Veterans, Veterans Enterprise, and we also feed our jobs to vetsuccess.gov. And we recently rolled out the .jobs universe. This is a top-level domain, much like .gov, .edu. It's a protected domain. Employers are very excited about this. Employers created it. We're getting a lot of pushback from the job board industry. In fact, they've created a coalition against us because they're threatened by what this might represent to their business model. And we just announced in April the military .job network. And this is all automatic and it's a platform that is operated by DirectEmployers Association. And jobs can be searched if you go up to a browser, because we've done research and we know that today job seekers go to Google or a browser to seek jobs, and they're not going directly to job boards all that much anymore. And so through search engine optimization, we've created the platform so that this makes it really easy for employers. And any employer can post on this for free. And we vet the jobs, we vet the employers so that the job seeker knows that these jobs are real, they're not going to get pop-up ads for a credit card or prescription drugs or other things that they might get on some of these other commercial web sites. We did a press release, or a press conference, rather, in D.C. here on April 6th to announce the .jobs network for the military. So we also have, we have the MOS. So if you go to a browser you can type in our MOS.jobs whatever your MOS is

and it will render back results that match that. And we use ONET coding in order to be able to do that. We also have the .jobs military family feature, which includes the bases. So you can type in ftknox. jobs, and jobs around that community will pop up for that job seeker. And that helps to support the military family in a relocation.

And by the way, all of this takes that job seeker directly back to the corporate website to apply online through their own process. And there's very good reasons why employers want that. We call that direct navigation. And when you're a federal contractor, you're required to keep lots and lots of data on your job seekers and your applicants, and so you have to get them back to your website and it's very cumbersome to go to a bunch of other websites, search resume data bases, because they still need to ultimately come back to your website and complete an application in order to really be considered an applicant. Employers don't like to deal with resumes, and it's very tedious to go to a database and sit there and search and search and search. And you only do that when you're in dire straits or if you have some really tough positions to fill.

And so in terms of engaging employers, what we do, we have a variety of products, and these again, these products again are requested by the employers, a lot of this helps them track their job seeker activity, including the veteran job seekers that are coming to their websites. We use a product called Direct Traffic that, with all those websites that we work with, we can tell in our corporations where these job seekers are coming from through the tracking methodologies on the Internet.

MS. DAILEY: And Jolene.

MS. JEFFERIES: Yes?

MS. DAILEY: I see you have a lot of slides here, which I'm very appreciate of. Can we get down to Employer Differences and Challenges, and then I'd like you to wrap up and then we'll go on to our next briefer, please.

MS. JEFFERIES: Sure. I'll skip through these.

MS. DAILEY: Employer Differences and Challenges. I think that is --

MS. JEFFERIES: Yes. And so this is here because, in my dealings with a lot of different organizations, you kind of get a feeling that programs are one size fits all. And different corporations work differently in their hiring process. Large corporations have things much more automated. The smaller companies tend to use more of the manual processes. And so it's really important when you're working with employers and you're approaching them to really understand who they are, their business model, their size, the industry they're in, and so forth, the occupations that they have. Are they unionized? Profit? Nonprofit? That really makes a difference in how you should approach an employer.

Recently our Recruitment Regulatory Compliance Committee did a survey in February, and there were ten key points that came out of that. We wanted to understand some of barriers in hiring veterans. And so ten points came out of that survey. Most of the employers believe that VEVRAA regulations are effective. The OFCCP just came out with a new notice of public rulemaking on April 26th. That's really going to require a lot more data gathering on behalf of employers. And so we're looking at that right now and preparing a comment letter to those regulations.

Number 2 there, employees utilize a just in time hiring process. Essentially, that means when they post a job opening, they need someone ready to go, skilled up, trained up, and ready to hit the ground running. Employers can't take on all of the burden for educating. And the contracts are shortening. A gal from Lockheed Martin gave a good example that some of their contracts were five, six years long; now they're lowered down to around 18 months. So it even emphasizes more that when people start, we need them trained up right now. And so that presents a challenge to employers when it comes to disabled veterans. So we need to see them when they're ready to start working.

Number 3, of course you hear this everywhere with the translation of credentials. Number 4 is the accreditations and certifications. We have some of our professional service organizations accounting firms, for example, if you don't have a CPA you cannot work there. And so some of these certifications are needed, again, right at the point of hire. Even truck drivers with CDL licenses and so forth. Number 5 --

MS. DAILEY: We've actually got the rest of them in the presentation.

MS. JEFFERIES: Okay.

MS. DAILEY: Any questions? We're going to have some time at the end for questions also, so.

MS. JEFFERIES: Sure.

MS. DAILEY: Can I bring our next briefer up?

MS. ADAMS: Good morning. My name is Nancy Adams. I manage the branch in the WTCG1 on career and education readiness for the WTs and all of our WTUs and CBWTUs. Just a little bit about myself, my professional and academic background that I bring to the Army Warrior Transition Command is that of a vocational rehabilitation counselor. Been working at WCT for about a year, and today I'm here to answer several different questions that you all posed to us and asked to have addressed.

The first question you asked was, how are wounded warriors identified? I understand that back in late February, our command briefed this same group quite extensively for about a day. This is a slide taken from that brief on how the active component, reserve component soldiers are identified to be assigned or attached to a warrior transition unit. They need to have at least typically extensive medical needs that would go longer than six months; reserve component soldiers would be attached to a WTU if they need medical treatment prior to demobilization. Now, as far as AW2 soldiers, they are a component of soldiers within our

WTUs that are tagged as either VSI, very seriously injured, or seriously injured soldiers. They're identified through either a physical disability case processing system, some kind of a feeder report that comes to identify them. They also come to us through leadership referrals and AW2 advocate referrals. In CONUS and outside of CONUS, typically through the MTFs, the warrior transition units, the VA Medical Centers, and there's also a mechanism for them to be identified through a hotline referral.

The career and education readiness of a wounded warrior in our unit is a collaborative effort, and I will tell you that the primary mission we have as they first come to us is to try to return them to the force. And so as part of that teaming process, a WT is typically going to work with three different entities in the warrior transition unit: a military career counselor, occupational therapist, and a position we have down in the units now called a transition coordinator. We have designed a process, which is our career and education readiness model, where a wounded warrior is assessed by a career counselor and an occupational therapist to determine whether or not they're ready for career-readiness services. This is a little roadmap that we use, fairly high level, that explains the process. In our warrior transition units, every wounded warrior that is medically eligible is required to have what we call an EEI plan. They have a comprehensive transition plan that they identify for themselves. One of the subcomponents of that transition plan is their career or education plan for themselves. And as a part of that comprehensive transition plan, whether they are returning to the force or separating from the military, they're required to participate in employment preparation, education, and internships. So whatever it is that they're doing down in the unit, and some of the backup slides that go with my brief today will show you who's participating in various kinds of activities in the unit, they are working on some facet of improving their situation related to employment, education, and their personal career goal for themselves.

You'll see down there in the bottom left corner, where you reach a point, is the WT fit-for-duty? If they are, they return to duty either in their own MOS or in a separate MOS that they have been working on with the career counselor, if they're not able to return for various reasons to their normal MOS. If they're not fit for duty, they are processed and sent to ACAP and also provided access to the VR&E counselor to start the vocational rehabilitation process, if they're eligible for those services. And they will continue with their EEI plan until the point where they separate.

I wanted to focus this morning on two slides in my brief. That would be best practices and the challenges that we're having. We have initiated a civilian position down in our warrior transition units called a transition coordinator, which I've referred to in a previous slide. This person is responsible for working with the OT, the squad leader, and the nurse case manager, to ensure that the wounded warriors are moving their way through their EEI plan, that they're identifying the proper educational opportunities to go to school, and to do internships while they're still in the unit. That person is there to monitor and to help that process along, and to integrate the soldier and activities they're trying to do with the staff and the Soldier and Family Assistance Centers. That would include Army education counselors; the ACAP counselors; DOL, if they're working with DOL; and the VA VR&E counselors; and the SVACs.

GENERAL STONE: Ms. Adams, if I could interrupt you for a minute. Do you have success metrics on any of the warrior transition battalions and the number of people placed in employment in transition?

MS. ADAMS: We have not defined success metrics yet. That was -- I have a slide, and I guess I can flip around here. We have not defined the metrics yet to measure success as it relates to our programs that we're doing with the soldiers in the units right now. What we're in the process of doing at the moment is trying to define the denominator to put into that equation to define a solid metric. And what that means is that we're having to define what a

medically ready and eligible wounded warrior is in order to participate in education, employment, and internship opportunities. So in just the past couple of weeks as we go to work, our balance scorecard in the War Transition Command as part of the Surgeon General's scorecard, I've had to work with our nurse case managers, our licensed clinical social workers, the OT's, the doctors, and other staff to try to come up with a definition of what medically eligible to participate in EEI means. So we're moving towards getting an answer on that. We're not there yet.

GENERAL STONE: So tell me about your defining population that you believe that you serve. How many have transitioned in the last 12 months?

MS. ADAMS: Okay. Just a moment. I'll --

GENERAL STONE: It would be okay if you don't know the answer to that to give that to us later.

MS. ADAMS: I have some statistics for you. I thought you might answer that. Right now we've got about 9,924 WTs assigned to 38 separate WTUs all over the -- well, primarily in CONUS but also in Europe and the Pacific Rim. About 4700 of those folks are active duty. 3200 are National Guard, 2000 are Army Reserve folks. Of that, the AW2 population, which is the more severely injured, is at about 8400 veterans and active duty soldiers. Right now, 7100 of those AW2 folks are veterans and about a thousand of them are still on active duty. We have 175 COED and COAR soldiers, which have returned to duty as well. The AW2 population, the very seriously injured and seriously injured, is growing at approximately a rate of 179 soldiers a month. Total numbers to date of wounded warriors passing through our command from June of 2007 until March of this year was 36,000 soldiers.

MASTER SERGEANT MACKENZIE: If I could interrupt you for a second.

MS. ADAMS: Yes.

MASTER SERGEANT MACKENZIE: As we found in a lot of our site visits, you know, you base your connection to these people through the comprehensive transition plan.

MS. ADAMS: Yes, sir.

MASTER SERGEANT MACKENZIE: Yet we find that there's no effective use of the -- there's no standard model across the command that people are actually using this stuff or that it's even an effective tool. We find people's lack of access and many other things that we saw out there, so how is it we're saying -- how is it you're saying you're being successful with this EEI when the base route of this EEI, being the comprehensive transition plan, isn't even being used effectively?

MS. ADAMS: Well, I will tell you that the guidance for the comprehensive transition plan has just recently gone out in March of this year. So the units, as we're going out to inspect them to do staff assistance visits and OIP inspections, are being looked at for compliance. We have an automation platform, it's called the automated CTP right now. All of the multidisciplinary staff to include the OTs, squad leaders, and others are supposed to be tracking the progress of the soldier, and the soldier is tracking their own progress in that automated CTP. I will tell you that when our folks go out and inspect, inputting information into automated CTP is spotty. I will agree with you there. It's not perfect there. We're in the process of migrating to a different platform that's going to be easier to use. I believe that...of IT solution is coming out at the end of this calendar year. It's called AWCTS. But the automation is only part of it, certainly. The process of what you need to do with a wounded warrior related to career planning is much more integral to actually having a transition coordinator or an EEI point of contact down in the unit working with that soldier and knowing where to steer them, depending on what their level of disability is and whether or not they're returning to the force or not. I will tell you that the transition coordinator is the operational arm of my office out in the field. The

units were advised to hire those positions as civilians last spring, in spring of 2010, during our annual conference. There still are only 11 civilian transition coordinators hired as of this week down in the units.

GENERAL STONE: So, Ms. Adams, you have 11 people who are actively working. How many jobs have you actually created or matched wounded warriors to jobs?

MS. ADAMS: I'm not sure I understand your question, sir.

GENERAL STONE: Well, the key to transition is to provide a smooth transition from active duty through the recovery of medical disease processes and wounded processes to effective employment and to find a way for people to transition their lives when they're significantly wounded.

MS. ADAMS: Right.

GENERAL STONE: Do you have any metrics that show that we've actually gotten employment for anybody?

MS. ADAMS: If you go to the backup slides -- and what is being tracked is being tracked in the AW2 program. There's a slide and I will flip to it here. In the first quarter of this year, I can show you that folks that indicated to their AW2 advocate, and again, this is the AW2 subpopulation, 18 percent of them were either impaired employment, self-employment, or identify that they were doing some type of unpaid volunteer work experience, with our AW2 considers being employed. I don't, but perhaps they're working towards gainful paid employment. I think what's more telling is the statistics over in the first column. The advocates work with the AW2 veteran to identify what bucket or column they put themselves in. 43 percent of the folks that report back in are not involved in career planning, and it's for a variety of different reasons that are listed there. The one that bothers me the most is the bottom one that I tagged as "red," that they may be discouraged that they're not making progress in their plans.

DR. GUICE: What does that actually mean, discouraged, not making progress? Do we have any idea of what that means?

MS. ADAMS: I do not know. We're a separate set of staff in our AW2 program within our command, a separate career cell, and those are the definitions that they tell the advocates to use in collecting these particular statistics. 20 percent of the AW2s that are veterans at this point are involved in education and training. I think it's important to know that because another statistic that I find rather telling is that when I looked at this population, when I first got to the WTC, 80 to 85 percent of the folks that we're separating had as a terminal academic credential either a high school diploma or a GED. So this thing that you've heard this morning, that people need training or education in order to be able to move out from where they are, really is a critical piece in the conversation. Their military skills don't always translate into something in the civilian workforce, and they do recognize the need that they need to be more involved in education and training in order to get work.

DR. GUICE: My take home from the panel is that it's a readiness problem. They're not ready to go to work because they're still in recovery or they've got a lack of education and training. So there's a mismatch. They're just not ready yet.

MS. ADAMS: Yes.

DR. GUICE: And I think that's what that first thing is showing. So what would be solutions to that particular problem? And this is for all of the panelists.

MR. CONKLIN: Can I just say --

MS. DAILEY: I need you on the microphone, please.

MR. CONKLIN: Do I have one?

MS. DAILEY: Staff, please?

MR. CONKLIN: Could we all talk about the timeline? Whatever point the event happens where an individual is injured, we're looking at an average of two years before

they are out of the medical system. Now, take that individual, and if he or she is a high school graduate, they've got minimum of six months by the time they get home to reintegrate, rent a house, move in with their parents, whatever, get signed up for GI Bill, six months minimum. I know this from personal experience. Now, we're looking at two years undergrad, or four years undergrad, and possibly two years postgrad, postgraduate school. Let's just say we're talking about six and a half years to get them to the point where they are considered entry-level hire for a corporation. Why? Because they're not going to be on a loading dock throwing boxes. The severe guys, any of our guys that are rated at 60 percent or even 30 percent higher, they aren't going to be doing that kind of work, most of them. So how do we beef up their skills so that they're competitive? They've got to get education.

MS. DAILEY: Ms. Adams, let me let you rejoin the panel. I think this is going to be the substantive part of our discussion.

MS. ADAMS: All right.

MR. CONKLIN: So that timeline -- just being, managing our expectations is critical. From what I see, from the end of the funnel, which is you guys up here making all the decisions and doctrines and policy, and us back on the ground, a very narrow part of that funnel back home, where everything lands. We all have to manage our expectations.

MR. REHBEIN: One of the questions I have, and this is for the whole panel -- I'm sorry, I interrupted.

MS. ADAMS: I just wanted to address a couple of things here, in terms of challenges. Everything that people are saying here is absolutely accurate. One of the things that I'm most concerned about is early integration of VRNE services while the soldiers are in the units. I don't think it's happening soon enough. Unfortunately, the career and education readiness process is overlaid on top of the medical process. So we don't always have control over timelines. But getting a soldier or a service member engaged early in the process in some

type of internship or education to get them thinking in that regard is important, and if they need the assistance for the more severely injured, to get them vocationally assessed to see what may be appropriate as a career goal because sometimes one's own expectations of what they want to do or can do, they may not be ready for it and may not be vocationally appropriate.

DR. GUICE: From your experience, when are they ready to have that? I mean, we all talk about getting voc rehab early and early, but what your data is showing is that there's a definite timeline of readiness, these people, when their mind is ready, when their body is ready, when the whole thing is ready to engage in that. I think we run the risk of putting voc rehab up so early. And we've seen it with the GI Bill too, the post 9/11 GI Bill. People start in an educational program and then they quit.

MS. ADAMS: Yes.

DR. GUICE: Because they're not ready. So how do we define readiness and when do we apply the solutions to get the outcome that we want, which is everybody employed?

MR. ROGERS: Ma'am, my experience, and I'm dealing directly with the lawyers across the nation, and we've got some wonderful pre-discharged, pre-separation programs at a variety of locations, and consistently I hear, I want to go home. Right? You've got a TAP program, they're going to prepare me my resume, I'm going to learn -- I don't want that. I want to go home. So it's my experience that is now -- my focus is to work directly, in terms of prepared warriors, with VA, with OEF/OIF, with the social workers, with VRNE. And our warriors, once they get out, there's a period where I need to come back to civilian life. It's kind of this getting back to a reality. And that can be anywhere from months to sometimes longer. The key I'm finding is their advocates working with us and a potential job are critical. Once they get to the point where they feel they're ready, emotionally, physically ready, they may not be. All right? Now, I'm mission focused, I want to get a job. But they may not be ready at that time for that job. So it's our experience to work with the advocates, the social workers, the

clinicians that are saying, yes, I think John, I've been working with him, I think John's ready for that job. I don't think there's an answer, in terms of when people are ready. I don't think it's before they're discharged. And I'm not even sure that the time and effort of really good meaning people is being put to the best use, ahead of discharge and separation.

MS. JEFFERIES: And if I can add to that, what complicates this for employers when they do get our doorstep is that in the pre-employment stage, we cannot ask, one, if they're disabled; but you can ask, do you require any special accommodations to perform the essential functions of this job? Well, they don't know enough about all these jobs to be able to adequately answer that. And so you're at an impasse, in terms of your dialogue and what you can discover about them so that you can really help them and help get them in the right job. So that's extremely frustrating for employers and it just stops any communication. And so it would be nice if we could figure out a way to have a safe haven to be allowed to have that conversation without fear of lawsuits. And you can ask once they take post offer through the medical process, you might realize through that process that they can't do this job. And so now you're faced with, well, now what do we do with this candidate and how do we rectify this situation? And it creates a lot of problems to do that after the job offer is made.

DR. GUICE: DOL has a program called Ticket to Work, and Ron, you probably know much more about this than I do. But isn't that kind of that period where you can do the safe tryouts, make sure that the employment matches correctly?

MR. DRACH: Well, Ticket to Work is a social security program, and it's designed for those in SSI and SSDI, primarily SSDI, and it gives the recipient a ticket to take to a vendor, be it an employer, a trainer, whomever, that that individual can get the training that he or she needs with the goal of getting off of social security. Certainly veterans that are on social security disability are eligible under the Ticket to Work. I don't think the Ticket to Work has been that successful for lots of reasons, which I don't have time to get into. But, you know, one

of the things that I particularly like is Operation Warfighter, because it gives them, you know, a lot of the training and the experience that they need, and even though Warfighter was never intended to be a placement program, it's morphed into that because it gives the employer the federal sector employer, you know, unpaid work experience, which gives them an opportunity, like a trial work period, so that they can move into that. But, you know, let me thank you for that. I'm a little confused and concerned. I've been doing employment stuff for a long, long, long time. Ms. Jefferies mentioned there's 8,000 websites out there. Okay? Ms. Adams indicates, I think in her sixth dot point, duplication of services creates confusion among wounded warriors and providers. Okay. We have 8,000 sites out there. Why did you all feel the need to start a new program? What problem did you identify that nobody else is addressing?

MR. CONKLIN: I can answer that. I'll answer it from my standpoint, I don't know about everybody else. I didn't start this to start a program. How's that? I started it to say, to help one individual who came to my community. Just one. And I gathered our businessmen up and I said, if this happens, and it will, we need to be prepared. We are not. And so I did happen. A kid came home seriously broken and bent. We got him a job, we got him a roof over his head, we got him a car, we furnished an apartment, we got him into school. He was a success. And somebody said, geez, couldn't we do that again? Maybe invite a kid to our community that's from a rural area, somebody we don't even know? And we did it again. It just hasn't stopped. That's how it started for us. It didn't start as, we didn't come, I didn't come from the charitable background world of social services. This was all business, professional people in one community who just said, we're going to make this work. And the results were good. So that's how we got it going.

MR. ROGERS: The 8,000 -- I'm sorry, sir.

MR. REHBEIN: That's all right. I want to jump in and change the subject at some point. But go ahead.

MR. ROGERS: Thank you, sir. The 8,000 sites are overwhelming, and I would agree with you. We don't find assistance through those sites. Our assistance is very specifically focused on those organizations, primarily federal, some state, that touch the warrior. Not where a warrior puts his resume in a database; we're not an organization that take resumes and distribute them. But we operate directly with the advocates. We don't have to adhere to ADA restrictions. I can talk very intimately with our warriors about their disability because we're under a federal program that is specifically focused on dealing with the disabled. So our relationship is much, much different.

MR. REHBEIN: I'm involved in the education process with young people out at the university, and that process is threefold. Does the young person have the ability to absorb this education? Does the young person have the passion to stay with the career track? But thirdly, does the job market exist? And it's that third one, it's the barrier between those first two and that third one, that really causes the problem. And I'm wondering from each of you that are involved in the education, and Jolene that's involved in the employment, how we cross that barrier for those folks, because frankly I see an awful lot of young people come to the university with a passion to become a history major, and they get to the degree and then they start to look for a career. How do we prevent that from happening? How do we make sure that that job is out there for them?

MS. ADAMS: I'll have to tell you, I'm a history major. No kidding. UVA.

MR. REHBEIN: I know several, I know several history majors.

MS. ADAMS: We all find something to do in life. You raise a good point. I am a big, big fan of anybody who's looking for a job. And I even tell this to my two college students at home, to do some labor market research before they decide on something they want to do. So I believe in wounded soldiers doing their own career planning. And as a part of that, looking at the labor market to see where the jobs are before they embark on the training program

or on an education program. So I'm with you 100 percent. That's part of the vocational rehabilitation process.

MR. REHBEIN: But how do they look at the job market? Are they provided with the tools by your program to do that look at the job market?

MS. ADAMS: I'm ready to move out in that mode right now. In my own personal background, I worked in the worker's comp system in the State of California several years ago, and in order for a client to change occupations, which is what we're talking about soldiers doing here, and to know how much money they're going to earn in their next or follow-on career, you have to educate yourself to what is out there before you move towards that new goal. And in the worker's comp system, when I was working out there, the clients were required to do their own labor market research in a particular career field before an insurance company would pay for them to go to school to get retrained into a new occupation. That's the model that I want to use in the warrior transition units. I can't say that it's being done right now, but I think it's a piece of what the soldiers need to do. The other piece of this is, I also believe when your self-image is changing because of something that's happened to you, such as an injury or a wound, you don't know where your abilities are and how much you can do. And one of the philosophies I've always lived in life is to allow a disabled student, when I was working with disabled college students and wounded soldiers, to pick a personal goal, to pick a career path that seems to viably make sense, and allow them to either try to succeed or fail. Because sometimes it's through the failure that you learn where you're able to maneuver and where your employment world is. So it's an evolutionary process. The healing process is a long and arduous one for different types of disabilities, so you can't make any blanket statements about when is somebody ready to engage in work. I will tell you, the process that we have in our units right now has graduated, in terms of doing some volunteering and work. Operation Warfighter was mentioned a few minutes ago. A lot of times soldiers aren't ready to go off post or out of the

WTU to work with a federal agency outside the gate. So we start them and help them working on post. We call that on-post work, on-post volunteering. A lot of our soldiers are there.

GENERAL GREEN: If I can ask just one more clarification along the same lines. So for Ms. Jefferies, clearly you're linked to a lot of different employers in terms of how they post jobs and things. So is there any aggregation of that data to show, say by educational level? So with a high school diploma, where are the jobs in your world, et cetera?

MS. JEFFERIES: Employers struggle with labor market information when it comes to veterans. We've been talking about this in a number of circles because it would really help us in developing our sourcing strategies and plans if we could go to a website or wherever, BLS or wherever that's at, to be able to query it to say I'm looking for mechanics. Where are the in the case mechanics that are coming out of the military, where is home for them? We don't need the names and all of that. We just need to generally know where to target on the map so that we can go to those communities and do an all-out recruiting push. But we can't even get simple data like that that tells us that information. In our data, we can get information that shows -- like, if I'm still sitting in a corporation, I can tell where I'm getting my traffic from, my applicant traffic, which websites are driving the most traffic to my website. But once they hit the corporate site and they're applying online, then we at the association, we lose track at that point, because now they're into a new database. But we do hear from employers, and I know this from personal experience, that especially with the younger veterans coming out and those who have been in the infantry, they have fewer skills to sell. And again, they don't have education. Many of today's occupations, if you're a mechanic, a plumber, truck driver, whatever, you need some education. And so then we resort to, okay, let's do more of an exact match and find the MOSs of the people coming back and do that. But we don't have a tool that leads us to where they are so that we can find the qualified veterans. Not just any veteran, but the qualified veterans.

GENERAL GREEN: But without trying to perform the linkage(?) I'm wondering if you could help with the market research, in terms of where jobs are. So as people pick education --

MS. JEFFERIES: Oh, absolutely. We have all that. We have the demanded of information, because we post -- we have all the demand information for the majority of the occupations and job openings out there. But when it comes to the supply side, we don't know where to find them because we don't have that data.

GENERAL GREEN: And do you have any data on the number of veterans that may be applying? Or success rates, in terms of web- based applications?

MS. JEFFERIES: Again, that's hard because, you know, corporations, once they land on that corporate website then the tracking is done by that individual organization. So we don't have an easy process to pull that up and aggregate it at a higher level.

MR. CONKLIN: Can I make a point, sir? I think the other part of this, too, is the employers themselves. California has a very interesting model coming out right now, been beta tested for about a year, tracking not wounded but all veterans, tracking 35,000 of them, and doing point-to-point communications with corporations that are interested. For instance, Pacific Gas and Electric asked me to help them on this. I took them out to the State Director of the VA. They're tracking because these guys -- 75 percent of them, not wounded, normal veterans, are asking for employment first, before education. Why? They had a job. They want another one. They've got a family to feed. Our wounded guys face the same thing but actually have a little bit more resources. But that point-to-point link, where PG&E says, look, I'm going to hire people in a region, Sacramento Valley, and I need line climbers, they now can go directly to the State of California VA and query them, and they will send it out to their individuals. Okay, HIPAA, right? They can't give the information to PG&E, but they can go through the portal. And they're doing that. That's a model that can evolve, actually even for wounded.

MASTER SERGEANT MACKENZIE: One of the things I'd like to bring up and something that you touched on, Ms. Adams, was you said there's an overlapping timeline problem with medical and education. At the ground level, what I hear quite often is, I want to take a class or two. I want to knock out some basic requirements. I can't attend any college classes because I can't get my paperwork signed because I have to come up with some kind of degree program. I don't want to decide on a degree yet; I'm still going to physical therapy and occupational therapy. But I've got some time at night, I want to get some stuff knocked out. Is your program breaking down that barrier so that these guys can start knocking stuff out one at a time without trying to make them make a decision while they're on a narcotics roller coaster and attending therapy all the time?

MS. ADAMS: I haven't gone down into the units specifically and heard that piece of it. I used to be an ACES guidance counselor, and I helped to build the GoArmyEd portal. As with a lot of automation, I can tell you that there are some restrictions on that particular entity, in terms of setting up a degree plan in order to get tuition assistance to go to school. Any soldier that would come to me right now, a wounded warrior, saying I want to take some classes, I would totally stand aside and let them take what they want. My advice to them would be to start out as a general studies major. That gives them a lot of flexibility in the classes that they can ask for from that GoArmyEd portal using tuition assistance.

MASTER SERGEANT MACKENZIE: But within the WTC, they're not getting to you because the advice that they're getting at their squad leader level is that they have to come up with an education plan, and your office is an education plan. This guy just wants to take some classes, number one. And number two, we're not talking about a regular army soldier here. We're talking about a wounded warrior that's in medical care.

MS. ADAMS: Right.

MASTER SERGEANT MACKENZIE: Why can't the command authorize that difference so that this guy can still get tuition assistance to take classes?

MS. ADAMS: The commander can. The commander can. I will tell you that the ACES guidance counselors belong to INCOM. They don't belong to MEDCOM. And one of the challenges that I listed up there are some of the interfaces that we're having between INCOME and MEDCOM to make the service delivery and the movement of the WT back and forth from the WTU into the SVAC to get the related services that he needs smooth, working relationship. It's not there yet, and it needs to be.

MS. DAILEY: And ladies and gentlemen, we are well --

GENERAL GREEN: I was going to say, I want to cut this off. I'm afraid we're about 30 minutes over. You folks have been extraordinarily helpful. We think that the work that you're doing to take care of some of the most seriously wounded and get them jobs, and then the work that's going on to try and help all of our veterans find jobs, deserves our applause. So thank you very much, and we appreciate your time.

Q. Thank you. Ladies and gentlemen, 10 minutes, and we have the Cognitive Rehabilitative Therapy panel in 10 minutes, please. Thank you.

(Whereupon there was a recess from 10:45 a.m. to 10:55 a.m.)

MS. DAILEY: Okay. Do I have all my members reassembled? That would be great. I know I lost one, and I'm looking for another one, two. So yes. So I'm really just looking for two.

DR. GUICE: All right. We'll go ahead and begin. Our next series of briefings are Tab J. Congress has shown some interest in cognitive rehabilitation therapies as strategy for addressing TBI. They consistently hear from constituents and stakeholders that this is a value added for individuals with TBI and should be available more widely. In an effort to kind of, for us to really understand the issues and the topic, we've asked you all to come and

present today so that we can have something cogent to say back to Congress about this particular topic. So we would like to begin with Dr. Michael --

DR. VANDERPLOEG: Actually, Rod Vanderploeg is going to start.

DR. GREEN: Okay. Wonderful. Okay. Well, why don't we just go ahead and if each one of you will introduce yourselves as you come to the microphone, that would be great. Then we'll go ahead and get started. Thank you.

DR. VANDERPLOEG: Okay. Well thank you for having me. I'm Rod Vanderploeg, I'm an neuropsychologist at the Tampa VA and have been with the VA since '84, at the Tampa VA since '87. Not loud enough? We're not on. But I'm not here really representing the VA, and I'm also not here representing the Veterans Brain Injury Center, which I've been part of since 1992. And what I see my purpose today is really to sort of give you an overview of cognitive rehabilitation, particularly as the research literature suggests its importance and its potency. So I'm going to try to answer the first two questions the panel posed to, you folks posed to our panel, which is so far, what is cognitive rehabilitation and what is the effectiveness of it all? I'll answer part of that, and the other two gentleman will probably address part of the effectiveness in their clinical programs.

So cognitive rehabilitation is typically one component of a much more comprehensive brain injury rehabilitation program. And cognitive rehab focuses on treating both specific cognitive deficit impairments or problems, but more importantly, it really focuses on trying to remediate the effects of those cognitive problems on everyday functioning. So this slide basically simply shows that if you have a comprehensive brain injury program, cognitive rehab is one component of it, but there's certainly other components of most traumatic brain injury problems -- I mean, programs. So what is the toolbox? What does it consist of? On the top of this page here, the left column really represents tools, if you will. So cognitive rehab activities consist of paper and pencil tasks, computer assisted retraining programs,

communication skills training, memory aids. And then approaches that those tasks are used in the process include both direct instruction with feedback on how a person is doing, modeling of different kinds of things, guided practice as you work your way through different activities, distributed practice so that it generalizes better, and aerialist learning is often used with more severely brain injured individuals because it helps enhance the sort of habit way of responding and improving functional performance. But all of these really are tools, and cognitive rehabilitation is really how you use the tools. It's not the tools in and of themselves, which I think is a common misconception in the lay public and in the press. These type of interventions can be carried out, those in one-on-one settings or in groups or a combination of both. There have been a number of meta-analytic reviews of the literature looking at the effectiveness of cognitive rehabilitation, and I've listed the three that are most commonly cited, and the most recent one was really published I believe this year. What's the date on that? Yes, 2011. Now, what I'm going to try to do in the next few slides is summarize what the findings of these reviews of the literature show. So this is a summary slide, and then I'll go into just a little bit of detail of this.

Direct treatment. Well, direct treatment is really trying to rehabilitate the underlying impairment. So what the literature supports is the direct treatment of attention deficits is effective, that indirect treatment -- and what's indirect treatment? Well, it's more strategy training, it's more coping, it's more compensation -- that indirect treatment of attention and memory problems is supported by the literature. That both direct and indirect treatment of executive functions and communication problems is supported by the literature. That family and patient education is particularly important for mild TBI. In fact, the literature really supports psychoeducation and stress management as really the only effective intervention for mild TBI, and I'll get into that in a bit. The literature also supports the use of external aids,, particularly for memory and functional day-to-day activities and environmental modifications. Again, more so

with moderate to severe traumatic brain injury, but it can also play a role with mild traumatic brain injury.

So a little bit more detail. What is some of the direct treatment of attention?

Well, what's referred to as a process specific approach, so you can break down attention into the ability to simply focus on something, to divide your attention between two different activities that you need to engage in at the same time and move your attention back and forth effectively between them, and to sustain attention across time. So those are sort of different subcomponents of attention, and there are paper and pencil tasks and computerized tasks that help develop and redevelop those kind of skills through repetitive kind of practice.

So there's a direct training of those subcomponent skills and typically those are used in conjunction with what's referred to as metacognitive training, where essentially you're teaching strategies and approaches and ways to engage in those tasks more effectively, and practicing not only the task but much more importantly of the strategies for being effective on those tasks.

So the direct training involves repeated stimulation of attentional processes, with the goal again of strengthening the underlying neural process. Exercises are typically arranged hierarchically from easier to more complex, according to various theoretical models, and sufficient repetition and practice is essentially to ensure the generalization of those games that are made in therapy to real-life function.

The indirect treatment, or the metacognitive attention training, again, is teaching behaviors that facilitate information processing, such as enhanced self-monitoring, self-instruction, pacing yourself, checking for errors, doing those kinds of things, which often individuals, all of us, don't do well, but particularly if you have cognitive deficits in attention, you don't necessarily do well with checking for errors and checking your work and working on one task at a time, all of which are important to enhance cognitive abilities. The last bullet here

really is crucial, however, because often when people are referred to an individual practitioner in the private setting, what happens is they're given a list of activities and they're basically told, go do these things and then come back and we'll work on things. Well, providing a list of strategies does not constitute cognitive rehabilitation. It's really the practice of those strategies and getting feedback on what's working and not working and modifying those strategies which really constitute the core of cognitive rehabilitation.

Treatment of memory. What the literature suggests is that strategy training for mild memory impairment should be a practice standard. Well, a crucial point here, which is mild memory impairment. For moderate to severe memory impairment, the literature really doesn't support that anything enhances memory performance. What does help people function better, in terms of moderate to severe memory difficulties, is compensation strategies, like organizers, smartphones, personal digital assistants, environmental modifications, and those kinds of things. But strategy training is effective for individuals with mild memory problems, and those strategy trainings include things like rehearsal and practice and self-questioning and trying to make it more meaningful and more organized. Various kinds of mnemonic strategies. And what these strategies do is they provide an alternative way of learning. But again, those strategies must be adapted to the individual who has a difficulty and to their functional life goals because some strategies may work very well for a remembering a shopping list but not work well for taking notes in a lecture and remembering and comprehending a lecture in a classroom. So the strategies and the approaches must be individualized, goal directed, practiced repeatedly, and monitored with a good cognitive rehabilitation therapist and adjusted for maximum effectiveness.

Memory compensation aids are very effective and are frequently used in rehabilitation programs. They are used, essentially, to help complete functional activities. So, I mean, I, in my pocket, have essentially a daily calendar, which I often forget what I'm supposed

to be doing. So I look at my calendar. That is a memory aid. Other people have that built into there is smart telephones or into paper and pencil schedules and activities. Those are memory aids, and they are effective for compensation for underlying memory difficulties and problems. But as you all know, they're also effective for all of us in the room. So that's why they are effective: They are a tool that helps us accomplish a functional goal. But again, for an individual who has cognitive problems, they need to be individualized to that person and to the task that that person needs to accomplish.

Executive function training. Executive functions are the ability to think, to problem solve, to be aware of your performance and errors in your performance. It's sort of like the overall monitor of who and what I'm doing and how I'm performing. Well, the literature suggests that problem solving strategies with application to everyday functional situations are a practice standard and should be integrated into individuals who have executive problems as a cognitive rehabilitation technique. And these include things like self-regulation strategies, self-instructions, and self-monitoring. An example that I often give, in terms of a problem solving strategy, is long division. All of us who are older in the room learned long division in elementary school or middle school, and that is a problem solving strategy to divide numbers. So that is an example of what might be meant by a cognitive strategy to solve problems. Other things in terms of sort of lectures, trying to learn new information, is to outline it ahead of time, figure out what the main points are. In reports that I write, I often talk about bookends, where you basically say what you're going to say, then you say it, and then you basically summarize it again. You have two bookends on either end. That is the strategy that enhances learning and executive performance.

The same kind of strategies that are beneficial for attentional and memory problems are again the same kind of strategies that help with executive function problems. I'm going to skip through some of this. Now, social communication is really not an issue or problem

for individuals with mild traumatic brain injury. Or if it is, it really doesn't have to do with their mild traumatic brain injury. It probably has to do with social skills, training, and lack of functioning prior to sustaining the mild TBI. But social communication is a significant problem in individuals with moderate to severe traumatic brain injury. And what the deficits they show is, they tend to talk too fast or too slow; they tend to be tangential and ramble on; they tend not to appreciate the cues that their listening partner or communication partner is giving them, like speed up, slow down, get to the point, those kinds of things. Social skills training and communication training is an effective tool to help people improve their pragmatic communication skills. But again, they have to be repeated and practiced, and videotaping or mirrors are really an effective tool because people need to see sort of what they're doing wrong, and it's much easier to see it on a videotape than it is to realize you're doing it at this time. I'm going to skip over this in the interest of time, and we can come back to it if we have time at the end or in the questions, and get to mild traumatic brain injury, and mild TBI. There's one literature review in terms of what is effective treatment for mild TBI. There is a VA DoD evidence-based clinical practice guideline that was developed, and much of this area is really based on the literature for more moderate to severe traumatic brain injury. Because really, again, as I said earlier, the only clearly empirically supported treatment for mild TBI is early education, early support, and sort of compensation and adjustment of issues. So providing appropriate patient and family education about concussion and mild TBI, and the expected recovery.

What's crucial here is the message that is conveyed. And in the earlier presentation here this morning in terms of the panel on work, what message we as systems are providing to these individuals is crucial. One message could be, you are screwed up, you were impaired, you are brain damaged, and, therefore, you are going to be screwed up. Another message is, mild TBI and concussion is a recoverable condition and, in fact, the majority of individuals who sustain concussions or even multiple concussions -- think about your football

players who play every Saturday -- recover from their concussion and recover in a relatively brief period of time. Of course, there are some immediate symptoms, things like headaches and maybe some dizziness, some concentration and thinking problems for a period of time. If you expect those and realize those are a normal part of recovery, then they don't hit you in the face as boy, I'm really screwed up, I must be really brain damaged because I'm having these symptoms, because you realize because of the message that's conveyed here, that these are normal, they're expected, and things are going to get better.

The other treatments that are supported from mild TBI is to identify, particularly in the patient population we're talking about here, comorbid conditions, things like PTSD, depression, anxiety. And even if individuals don't meet full criteria for those different psychiatric diagnostic conditions, many of them have symptoms of anxiety, symptoms of PTSD, symptoms of depression, which are, in fact, quite treatable.

So the clinical practice guideline says provide the education, identify and treat comorbid conditions, treat the symptoms that may be but not necessarily may be related to TBI in a symptom-based manner, through both psychotherapeutic techniques, such as cognitive behavioral therapy, but also through symptom-based pharmacological treatments. So if you have sleep problems, identify the nature of the sleep problems and provide the appropriate intervention. If you have headaches, identify the nature of the headaches and provide the appropriate intervention. Also, essentially, return to physical activity as soon as possible, as long as it doesn't result in significant increase in the underlying symptoms, is recommended because that, again, gets people back to normal life and functioning as fast as possible.

So where does cognitive rehab come into play in terms of this clinical practice guideline for the mild TBI? Well, individuals who present with memory attention and/or executive function problems, which typically are the problems associated with traumatic brain injury and which did not respond to initial treatment, the education, the reassurance, the

sleep hygiene, the sleep management, the pain management, may be considered for referral for cognitive rehabilitation.

Two therapeutics who actually have some expertise in treating TBI, which typically are speech pathology individuals, some occupational therapists, psychologists and neuropsychologists, typically are the professions which end up treating patients with traumatic brain injury through cognitive rehab.

This was a consensus-based meeting that was pulled together by DCOE a couple of years ago and resulted in findings and resulted in some recommendations for the types of treatments that could be done, but it's not an evidence based. It's a consensus-based document. However, it is basically consistent with that evidence based that I've been reviewing up to this point in time.

But I want you to think about what it is that we're really talking about here. This is a meta-analytic study that essentially reviews the literature on cognitive problems in individuals with mild TBI, and looks at studies that assesses individuals within the first seven days, seven days to 30 days, 30 to 90 days, and greater than 90 days. And in these studies, most individuals do have some cognitive impairments within the first seven days and that continues but decreases in the next several weeks, but by 30 days post injury in groups that are prospectively studies, essentially the cognitive impairments have returned to baseline performance. This is true in the civilian literature. So car accidents, fender-benders, those kinds of accidents. In the sports literature, the same pattern follows here, except return to baseline is actually by the end of seven days.

Okay. The military also did an ANAM validation study in theater by Dr. Russell, and I'm going to present this, which you may or may not be familiar with. And basically the findings were that they evaluated people in the field who sustained concussions, and they had a symptom measure, they had the ANAM as a cognitive measure, and they followed them

immediately upon identification and over time. Well, most individuals who had initial performance difficulties on the ANAM returned to normal levels of performance within one week with no ongoing cognitive impairments. Most patients also had complete resolution of whatever those initial symptoms were, things again like headaches, dizziness, concentration problems. With headaches being the one that tended to resolve last, and the vast majority of battlefield concussions returned to duty in the field within 48 hours, or after 48 hours.

This is another study that was done by BAMC, which looked at ANAM performance following deployment for individuals who were not injured during their deployment, were injured but did not have a TBI, or were injured with a mild TBI, and following deployment, so they're assessed now weeks to months, potentially many months later, there was no difference in cognitive performance on the ANAM across these groups.

So what are we potentially faced with and what are we potentially treating? The military and the VA basically uses, commonly uses a neural behavioral symptom (?), which is a measure of I think 22 symptoms. These are the symptoms that are associated with post-concussive symptoms, but they are not unique to nor are they diagnostic of post-concussive symptoms. They overlap with many other diseases and conditions.

Well, this data was collected at Walter Reed in individuals who had mild TBI, and sleep problems was the number one complaint with 71 percent of individuals at Walter Reed who were there for other injuries but also had a mild TBI, reported moderate to severe sleep problems. Headaches is also high, and then you basically see what the symptoms are. So they're reporting significant symptoms.

In the VA, so now we're potentially seeing the same kind of individuals months, if not years, after they would have been at Walter Reed. What you would have noticed between the two slides is that the rate of symptom endorsement is actually larger, and that it's very high throughout all of these things. So when you have the slides I showed you earlier about

the resolution of cognitive difficulty and the resolution of symptoms in the field in the theater ANAM study that Dr. Russell did, what is this all about? Is this really due to mild TBI? Well, the literature that I reviewed earlier would suggest that this is probably not due to TBI; it's probably related to other kinds of things. But these clearly are symptoms and problems that these individuals are reporting. So, if we're going to do rehabilitation and treatment, what is it that we are treating? Are we really treating cognitive impairments? The other point that I should probably make here is that if you actually look at correlations between performance on measures of attention and self-reported attentional problems, or performance on memory measures and self-reported memory difficulties, the correlations are tiny and nonsignificant. I mean, we're talking about correlations of .1, .2. They're tiny and nonsignificant. So cognitive impairments is not the same thing as reporting cognitive difficulties.

So, what are we treating if we're going to treat this? Are we treating impairments? Probably not. Are we treating comorbid conditions? Perhaps. Are we treating previous conditions to individuals that had a previous let's say depressive disorder or substance abuse problem? Perhaps. Are we treating self-perceived efficacy? I can manage my life, I can manage my symptoms, I can manage my thing, my difficulties and problems. These individuals wouldn't be reporting these symptoms if they didn't feel like they could manage them. So maybe what we're simply doing is treating the sense of self-efficacy.

The post-deployment gunk is my term, and what I mean by that is, you have been deployed to a high-stress situation for months and you may have had multiple deployments. When you come back, I think in the individual's head the belief is everything is going to be fine. Well, it's not fine. There's huge readjustment issues returning stateside. Family situations have changed, all kinds of difficulties are going on which require some readjustment. And whether or not people meet diagnostic criteria for anything, there's a lot of post-deployment gunk. And I think our rehabilitation programs may be treating post-deployment gunk. There's also that

symptom attribution bias. So it's easier for many military personnel to say, I sustained a concussion, I had a blast injury, and I have TBI, than it is for them to say, I'm having difficulty coping, I have depression or I have PTSD. That is perceived incorrectly, in my opinion, as my fault, where a concussion or TBI is perceived as not my fault. So what you want to attribute the difficulties to is an issue here.

So what should be the target of mild TBI rehabilitation programs? Should it be cognitive abilities, which the literature would say should be fine? Should it be functional day-to-day abilities? Probably, because that's where the rubber hits the road, and part of that really is the experience symptoms, the I'm having day-to-day attention problems, I'm having day-to-day memory problems, and self-efficacy probably also needs to come into play here, in terms of an important treatment focus. So this is a civilian study with mild TBI and some mild-moderate, meaning their initial injury was a moderate TBI but currently they're having mild problems. And it would be in the chronic phase when people feel like they should have recovered from TBI but they're having ongoing symptom complaints. So the interventions were what I talked about. They had an attention process training, which is a process-specific computerized treatment for underlying attention problems. They used memory compensation skill training, which again is a practice guideline for memory problems that are at least in the mild range, and the strategies included work on one thing at a time, remove distractions, and use this five-step problem solving approach when you run into difficulties.

Organize things, and organizational abilities and problem solving skills were addressed throughout. Now, those cognitive rehabilitation interventions were accompanied by cognitive behavioral coping skills, emotional stress management, which again is part of that CPG practice recommendations. What were the results? Well, in these individuals there was improved emotional functioning, assessed by the SCL-90 in the areas of anxiety and depression, and there was improved performance on one of a number of cognitive or now psychological

measures, and that was a PASAT, which is actually a difficult complex attention working memory kind of task. So that combined treatment was effective in the chronic phase with these individuals.

But what was it treating and what was driving that improvement? Is it really cognitive impairment is improving? Is it treating the comorbid depression and anxiety, which this group has? Is it treating, again, self-perceived efficacy? What is it treating? Well, DVBIC, through DCOE, is doing a study at SAMC BAMC called the SCORE project, the Study of Cognitive Rehabilitation Effectiveness for mild TBI. And this study, when it's done, should help sort through some of those issues. So there's four arms in this study. The first arm is simply that psychoeducation. TBI is a recoverable condition. You have immediate symptoms and problems, they get better with time. That kind of thing. However, what's important to realize here is that intervention is in a civilian population. And a civilian population that's provided in the ER. Well, we're not talking about that here. We're talking about individuals who had their TBI months, if not years, earlier, and have had symptoms throughout. Whether those symptoms are due to that mild TBI or post-deployment or gunk or PTSD or depression is a matter of debate, but they have chronic ongoing symptoms. So you can't give the same kind of psychoeducational intervention. But what you can do is, you can say of course you're symptomatic, of course you're having problems, look at what you've been through, look at everything you've experienced, look at all the readjustment issues you're trying to manage. Of course you're having symptoms. How long did it take to get this way? You didn't get this way in a week or a month; you got this way over a deployment of many months or multiple deployments, so it's not going to go away quickly. It's not going to go away in a week or two. It's going to take some time. So the educational message has to be changed from what the literature supports in an ER setting, in the civilian setting.

But, that kind of psychoeducation is Arm 1, and it's going to be provided to all forums. Arm 2 is basically, here are some computer programs that we think will help you improve your cognitive functioning. Work on these cognitive programs over the course of this treatment study on your own, and let's see if they get better. Why is that one of the arms? Because that's often what happens in the private practice kind of setting, in the private setting. The third arm is what happens in good rehabilitation settings, which is therapist-directed individualized cognitive rehabilitation. And the fourth arm is duplicating that earlier study, which is both that individualized cognitive rehab, accompanied by stress management, cognitive behavioral therapy, those kinds of psychotherapy interventions.

The outcome measures are such that are similar to that other study but there's a number of co-variants or moderators which should help figure out what really is a driving improvement. Is it a locus of control? People go from everything is out of my control, learned helplessness to it is within my control and there are things that I can do to improve. Improving self-efficacy is a changing symptom attribution to this is TBI to this is just normal readjustment issues. And I see people looking at their watches, so I will stop here. And maybe it's best to wait for questions at the end of all three presentations, though I would be happy to answer questions if you have them.

GENERAL STONE: I wonder if you could discuss with us, because we've seen a fair amount in the civilian press as well as questions from Congress, about your ability to access these therapeutic tools due to the presence or absence of a payment mechanism through Tricare and the bundling or unbundling of those services as part of other rehabilitation strategies.

DR. VENDERPLOEG: Well, I can't answer that question because I work in the VA, and in the VA basically we will take all of these individuals, active duty or veterans and work with them within the polytrauma system of care, which has different components of care from polytrauma rehabilitation centers, to the moderate to severe, to outpatient programs and so

on. And that system is not at capacity, meaning we can continue to take new individuals, veterans, active duty, and work with them within that system. I can't really address the issue.

GENERAL STONE: Except that especially in our Reserve components, the geographic dispersion of those soldiers require access to a delivery network outside of the VA or the military treatment facilities.

DR. VANDERPLOEG: I agree and I really can't address that issue. I'm sorry.

GENERAL STONE: Thank you.

DR. PHILLIPS: When you mentioned the cognitive rehab has to be individualized, when you individualize the model, is it hit and miss or do you have some sort of template that you can enter that individual into?

DR. VANDERPLOEG: Well, the individualization comes from what are the functional goals, what is this person's life like, and what difficulties are they having in their life. And identifying what's standing in the way of them accomplishing those functional goals. Then as you develop sort of the strategies, you find that some people work well with mnemonic strategies. I am not one of those individuals. I do horrible with mnemonic strategies. I work well with organization, outlines, structure. So you have to individualize the approach to the functional problems and the functional goals and to the type of strategies that work better with individuals because of their unique differences. And that takes one-on-one intervention with a skilled therapist. That's why the literature doesn't support work on these computer programs and you'll get better. There's no study that shows that that is effective.

MS. CROCKETT-JONES: What kind of data is out there? It's mentioned that family education is a factor. What kind of data is out there showing the significance of family education?

DR. VANDERPLOEG: Patient and family education, and there have been studies by Wiley MiHenberg and Jeannie Ponsford. Jeannie Ponsford is in Australia. Wiley MiHenberg is in Florida, and others as well, that basically show that early education and conveying the appropriate message again, which is not that you are screwed up and that you are brain damaged and you're screwed for life. The message is, you sustained a concussion, concussions are recoverable, you will have some immediate symptoms, which should improve across time. And as I said, that's identical message will not work for our military population because they have had symptoms for months. So that message needs to be tweaked and modified and explained to give the same underlying message, which is, of course, you're going to have these symptoms, but they are recoverable. They are treatable. You can get better. I mean, what I like to think of is, there used to be a Pepsi commercial back when I was young called, You can do it, we can help. One calorie, dah, dah, dah, Diet Pepsi can help. Now Lowe's has the same thing, which has to do with home remodeling. You can do it, we can help. That is the message that has to be conveyed in this kind of psychoeducational intervention both to families and to patients.

COMMANDER COAKLEY: I have a question for you, if I can. Specifically, when you talk about the natural course of the OEF/OIF mild TBI, on that slide it says most concussions get better. And you cited that most concussion ANAM scores returned to normal after one week. Were those ANAMs actually conducted in people in theater?

DR. VANDERPLOEG: Yes.

COMMANDER COAKLEY: And the second thing is, you said the vast majority battlefield concussions returned to duty after 48 hours. My experience in combat, and most of my colleagues, is that a lot of the warriors want to get back into the fight as soon as possible and they'll basically tell you whatever you want to hear to get back in the fight. So is there any discrimination or is there any ways you could fair out those kinds of biases?

DR. VANDERPLOEG: Well, I didn't do that study; Dr. Russell and colleagues did. But you can fool symptom questionnaires; you can't necessarily fool performance-based measures, which is what the ANAM is. And the ANAM improved to normal within seven days. Now, could they basically still have headaches and say I don't have headaches? Yes.

COMMANDER COAKLEY: Thanks.

DR. GUICE: Thank you very much.

DR. VANDERPLOEG: You're welcome.

DR. PRAMUKA: So good morning. I'm Mike Pramuka. I'm a rehabilitation psychologist at Walter Reed Army Medical Center, and I am probably going to skip through some things here that may be redundant with what Mr. Vanderploeg presented. So briefly, I want to talk about the history of cognitive rehabilitation in military veterans. Rod addressed cognitive impairment issues. What I can bring here is to provide some overview and some information on the Walter Reed TBI service and the population we serve there, both overall and for the MTBI population at Walter Reed, with the idea of asking you or getting you to think that you'll have to get that information from other sites because we vary so dramatically -- and I'm not sure that services that are relevant at Walter Reed will be the same at other sites -- and a few opinions on outcome measurement. And I'm going to violate Rod's recommendation. Rather than bookending with what I'm going to tell you about and then going in detail, I'm actually going to present my summary right now because I probably won't get to the detail. So here are the takeaways that I want to leave you all with today. First, there is a very long history going back to World War I about providing cognitive rehabilitation for service members with traumatic brain injury after a war. Cognitive rehabilitation is neither novel nor experimental, and most of what we do in today's world in the civilian setting is really completely thanks to the military and VA infrastructure, which attempted to develop some strategies and

therapeutic services for injured service members. As Rod talked about, there's lots of reasons that people have problems thinking. It's multifactorial. And the brain injury, the traumatic brain injury, is maybe sometimes the least contributory for the reason to the cognitive impairment that people report or that is documented functionally. There is a huge diversity in the kind of populations that we serve and the services that we have available to us in different MTFs. I can describe here what Walter Reed has, but I know that it is highly discrepant from other MTFs, and so you've embarked on a very complicated question and the answer is going to be complicated as well. You'll need to find out, and I think that Dr. Handrigan is going to be able to provide some information on this, but to start to compare the huge variations in the kind of service members and injuries and needs people have at different MTFs. Probably in terms of Walter Reed, we have an MTBI, mild traumatic brain injury, population that in large part are a polytrauma population who have many reasons for changes in their cognition. And at least in our case, as Walter Reed, neither the complexity of the service members injuries nor the environment in which they recover really have a civilian parallel. And I will talk a little bit more about that. And maybe the biggest issue at Walter Reed when somebody has a diagnosis of TBI, that diagnosis provides access to relocation services from the TBI team for the whole person. We assess and interview and intervene with their core function, regardless of the etiology, and we many times know and even articulate to the patients and families that the primary reasons for their difficulty are not TBI. But if we don't provide those services, I'm not sure who else will? Who else is expert at function related to cognition and the strategies that support that? And so we basically own people when they've got a TBI diagnosis and bring them in and provide whatever rehabilitation services that we deem reasonable and that we can find a way to provide for individuals.

So to jump back then, really way back to Germany in World War I, when Kurt Goldstein started to meet people with aphasia, they developed some version of aphasia

language rehabilitation programs for veterans in World War I. And in the United States there was some emphasis on compensatory strategies, particularly vocational rehabilitation efforts, so that was really more directed ultimately for service members with amputations, as well as for TBI. After World War II, in Europe in particular, there was a lot of work in language disorders and developing speech disorder units for service members with brain injury. In Britain, we saw the idea come out of, as Rod mentioned, the idea that there's direct training for changes after brain injury as well as compensation or substitution changes. And there's often a disconnect between what people, what we see on tests, and how people actually function in real life. And although our tests have come a long way, they still can't always document how people are going to function in everyday life. There was an Israeli War of 1973, which ended up establishing a TBI cog rehab program with the help of Yehuda Ben Yishay from New York University. He then came and brought that program back to the United States, and that program still exists. It's one of the premier holistic traumatic brain injury programs here in the US. And many programs for TBI rehabilitation and cognitive rehabilitation are really based by the early work of Yehuda Ben Yishay and the NYU program. So we still use many of those same models and strategies.

In the Vietnam War, things worked a little differently. In the Vietnam War there was not an immediate response to service members returning who had traumatic brain injury. Instead, there was some literature, research literature that came out in the Vietnam head injury study which identified deficits, problems, as well as increasing the number of service members then becoming veterans, and their families complaining to Congress. In fact, there was not an orchestrated set of rehabilitation services to them, which ultimately resulted in the Defensive Veterans Head Injury Program, now called the Defensive Veterans Brain Injury Center, being developed and initially there were three military sites and four VA sites. It's now much more complex at this point. So even though there was not an immediate response there

was ultimately a very sophisticated response to the problems of service members with head injury, mostly penetrating head injury, after the Vietnam War.

I'm going to skip that for now. So at Walter Reed, our traumatic brain injury rehab services are primarily outpatient and that's primarily because people who come to us from Landstuhl who are medevac'd out are very sick. And secondly, because when they leave the inpatient setting, they typically go, they remain on campus in a Warrior Transition Unit, and so they're only a few hundred feet away. So we can bring them over daily for rehabilitation appointments. We have no waiting list. I know that's something that people have expressed concerns about. We have capacity to meet the needs of any service members that come to us for TBI rehabilitation. We begin everybody, regardless of level of head injury, with a series of five educational classes or sessions on the natural course of recovery of traumatic brain injury. We emphasize a lot of the information that Rod presented in literature on the rapid recovery that the majority of people experience after a concussion. We then talk about other symptoms: sleep, pain, physical, other physical symptoms, changes in family role and function, and bring in families as are available also. And so we start that education process with everybody very early on. We can currently refer people to our other allied behavioral health providers or other systems for ongoing issues with sleep, PTSD, other mental health issues, medication management.

We have a very large team of dedicated therapists from all rehabilitation disciplines. In addition to that, we have the, the Warrior Transition Brigade has an internship program. It's not specific to traumatic brain injury but it serves all of our members with traumatic brain injury and creates education and internship opportunities either onsite or in federal agencies in the local D.C. area for service members with TBI to start a return to work or in a therapeutic capacity return to gainful employment.

We also have a brain fitness center, which offers computer-based rehab services for which there is no clear efficacy in the literature; however, it's really with us as a research project but so many service members were interested in using it that we basically opened the doors to them. And I would just comment anecdotally at this point, what I hear people talking about most is an increase in confidence, an increase in awareness of what they're good at versus not good at, as opposed to changes in cognition, per se. But we do have research data being collected on that and we'll be able to respond to that in the future.

We use an interdisciplinary model. We serve all levels of TBI regardless of their comorbid conditions. So here was a cross-section, I just picked a day, I think it was early April this year when I heard I was going to come here. At that day in April, we were following 108 patients with some version of TBI in active rehabilitation at Walter Reed. And so you can see, maybe the first thing to point out is although 71, there's 108, do have a mild head injury, a total of 37 others had some other version of head injury. And so there is this idea that Walter Reed just sees the vast majority with MTBI; in fact, we were serving 37 individuals who had more moderate or severe or penetrating head injuries. A lot of people we see have an amputation. Most of the amputations are multiple amputations. Majority of people are in the Warrior Transition Unit, 62 of 108. Many of them had had been involved or are currently involved in cognitive rehabilitation. And 54 out of 108 were one year or more post-injury, and 32 were three years or more post-injury. In fact, we have many service members who stay around in the Warrior Transition Unit for several years and we continue to provide rehabilitation services as best we can manage, in terms of meth their needs, which change over time. So this is very different than most other MTFs, I think. It's certainly different than a civilian rehabilitation TBI program, in terms of characteristics of the population.

I want to switch now and talk briefly about service members with mild traumatic brain injury at Walter Reed and make a few comments on when people come to Walter

Reed and are in a Warrior Transition Unit, their activities really preclude their returning to everyday function and, therefore, they don't get those natural re-enforcers. If I have a head injury tonight, a concussion, within a few days I'm going to get myself to a grocery store, I'm going to try and get myself to work, I'm going to get myself dressed, I'm going to try and resume. And for the most part, I will at some level, I'll succeed and be reinforced by those at least partial successes. Our service members going into the WTU are there to go to appointments. They don't have to get their own meals, they don't have to get themselves any further than a few hundred feet away. They really -- they are not returned to duty in any sense of the word. And so they're in a very different recovery context than a civilian with a concussion would be. And so one perspective we have in our cognitive rehabilitation services is that we're look to establish an environment that will allow us to convey ongoing success to confirm someone's abilities when they may not be having an opportunity to see it and what they have to do during their day-to-day function in the WTU.

The other issue is that many of those individuals with MTBI end up entering the medical board process to be boarded out of the military, which has significant forensic and compensation issues that really muddies the waters in terms of symptom reporting.

GENERAL STONE: Before you go on off of that slide, would you go back? Certainly the model of the WTU is one that has been under substantial debate. Do you have a different model that would create different reinforcers to the recovery from these problems?

DR. PRAMUKA: Well, I don't have one that's implemented.

GENERAL STONE: I understand that. But do you have a suggestion as to a potential different model that would create different reinforcing mechanisms to allow enhanced recovery?

DR. PRAMUKA: Well, I think what we've all begun talking about, both in the Warrior Transition Units in general and at Walter Reed, we've started to implement, to bring

a more kind of pre-vocational, a vocational approach to it, where we return people to real-life demands as rapidly as possible so that they get legitimate feedback from peers and from the community about their level of function, which for the large part will probably reinforce their abilities, and on the other side will allow them to recognize when there are some changes, that they're going to have to grapple with. And some of those changes may just mean working more persistently in rehabilitation efforts. Others are more permanent changes which will require them to make some decisions and changes about their future direction. But I think in general, drawing them out more into the community, drawing them more back into real-life demands as a general theme is my overall suggestion.

GENERAL STONE: Thank you.

DR. PRAMUKA: So I have, up to now reported 98 individuals to the DCOE MTBI study, that Dr. Handrigan will talk about. So these are all service members diagnosed with mild traumatic injury. Of them, numerous of them have amputations --

GENERAL GREEN: Can I interrupt one more time?

DR. PRAMUKA: Yes.

GENERAL GREEN: So the question is, with no objective diagnostic criteria, if the reason for them being there is MTBI, if that is the reason, why are you keeping them there?

DR. PRAMUKA: Well, there is -- I mean, they are diagnosed with many other conditions.

GENERAL GREEN: Meaning that, are all the MTBI that are in the WTU basically also have associated physical injuries that are under rehabilitation, et cetera?

DR. PRAMUKA: Right. So for example, of the 98 I've reported on so far, 23 have chronic pain, 41 have PTSD, 36 have headache diagnosis, 53 have a diagnosed sleep disorder. And of the 98, 63 are greater than one-year post, and 24 are greater than three-year

posts. The majority of those are people in the WTU who are there undergoing a medical board process.

GENERAL GREEN: I guess I have a lot of people in the Air Force that are undergoing a medical board process that I don't take out of the unit. Is there a reason that you're separating them from things that you think might actually be helpful, in terms of day-to-day simulation and --

DR. PRAMUKA: Well, the majority of these people come to us, they're medevac'd out of (theatre?), so they come to us from Landstuhl with significant injuries. And so they've already left -- they're now already at Walter Reed. And so they usually have significant pain, surgical issues, a variety of things, and so they get placed in the WTU initially for medical care continuity. They then stay there as the medical board begins. So I guess the question is, could the Army transfer them? And the Army, they become assigned to the Walter Reed or another WTU, whereas Marines, for example, you know, do not detach from their original unit. And so there's differences between Army, Marines, Navy, Air Force, with how they handle service members going through the WTU, the MEB process.

GENERAL STONE: I think there is. And you hit upon an important point, and that is, is this the best place for these service members to heal? We heard in the previous presentation on employment and the challenges, a number of bullet points that suggested that an integration process may be a better model. Now, we recognize the fact that we got to this point from 2007, in which people were lost in the system. But have we provided such a structured environment that we are inhibiting recovery?

DR. PRAMUKA: Well, and I guess my purpose here today is to report on you is, given the circumstances that are as they are at Walter Reed, what we as a TBI team do is attempt to respond to the presence of these service members and the functional problems, which we observe, the WTU case managers observe, and then continue to engage --

GENERAL STONE: That's not an answer and the place we need to go as the Department of Defense. I understand that you're responding to the population's lot to you. But do you have no opinion on where this ought to go for the future?

DR. PRAMUKA: I mean, as a clinician I have an opinion. And as somebody with a voc rehab background, I'm interested, as I said before, in having them move more quickly into community settings or into return to duty opportunities. For the subset of our patients with polytrauma, they have so much significant surgical and medical intervention required that they really do need to be either in or right next to the hospital. And at Walter Reed, that's a lot of the what we see.

GENERAL STONE: So if this is the right place for them to be, how do we overcome the negative pieces that you have approached in your presentation and as we've seen in other presentations of this very structured environment that doesn't create the triggers towards recovery?

DR. PRAMUKA: Well, again, if we build a more natural recovery and people, and the reinforces come from the community instead of from an artificial structure from the WTU, then they're more likely to recover as civilians do because they're going to be getting information about real life issues as opposed to an artificially structures WTU environment.

GENERAL STONE: All right. When we were out in the West Coast in San Diego, we had some catastrophically injured Marines. All of them were living in the community, often they were living are roommates. They were dressing each day, they were getting themselves to appointments, and they were being aggressively case managed in a much different model than what the Army has chosen. Have you looked at that in the recovery or is there any venue that brings these different models together?

DR. PRAMUKA: I'm sorry, I actually don't know the answer to that.

GENERAL STONE: I understand. Unfortunately, there's not many people prepared and it's one of the things we're struggling with as we look at much different models and delivery and have recognized the real challenges of these models is that it creates negative reinforcement in certain areas that we saw both in the last presentation and in this presentation. But thank you very much for allowing me to have this --

DR. PRAMUKA: We often discuss this informally among ourselves, of course. But this is usually where it ends. So let me just make a few other points.

Dr. Phillips: Let me just -- is there a way for your community to get together and develop a consensus?

DR. PRAMUKA: I think that if the leadership calls upon me, of course I'll come. And as many people know, I have extensive opinions that I backup partly with research and partly with clinical observations. So I'm always, and everybody in our TBI service, is very willing to take a part of it and be a part of a planning process to revise things. But my leadership role is really at a very low level in terms of managing the clinical rehabilitation needs of the TBI team at Walter Reed.

DR. GUICE: My observation, from what you've said, is that you have one model with which you're dealing and that because you don't have the comparator, it is difficult for you to provide the answer that general Stone is looking for.

DR. PRAMUKA: Thank you. Yes.

MS. DAILEY: If I would have known that was the question, I might have been able to come to table with it.

GENERAL GREEN: But go to the next steps. So if I use Dr. Stones' example, so you're actually managing mild TBI and trying to present us with data regarding your population. Have you compared your population in terms of the skill sets that they have and

their ability to readapt, with another program, such as San Diego? And if not, where is that objectivity in your approach to what you're doing?

DR. PRAMUKA: We have not. I think that that is the, part of the initiative with the DCOE cog rehab pilot study, to compare us to gather data points, common data points across our sites and -- but part of the problem is what I'm trying to convey here is I don't think our population is the same as the San Diego population. It's very different from the Ft. Carson population, for example. And so I think what we develop at Walter Reed, or what we work for service members at Walter Reed will be different than that Balboa.

COMMAND SERGEANT MAJOR DEJONG: One thing that you both have said, with Dr. Vanderploeg and including yourself, is so far this model and education is not going into the civilian sector as of right now. And civilian vectors are treating TBI completely differently than what the military is doing right now, which again, takes out, as representing national guard bureau, takes out several thousand soldiers that are now basically in a civilian sector from being treated based off of their location and where they're at. And what are you guys doing to take these models and this education and, as a medical field together, combining what's best for to meet all branches of service that don't have the opportunity to be at Walter Reed or somewhere else?

DR. PRAMUKA: You know, I'm probably talking out of turn here, but I think a lot of the service members become veterans, become service connected veterans and can access VA and VA vocational rehabilitation services, which can purchase appropriate rehab community reentry services in their home community, which really is a much more holistic and appropriate model than getting them to an MTF a thousand miles away from where they actually know anybody. So I don't actually know that they are being poorly served. I think that in some ways, moving that direction and getting somebody to buy you services in the civilian setting where you live is actually ultimately a better model.

COMMAND SERGEANT MAJOR DEJONG: Well, I think some of what you guys are bringing up is a great point, but you're also bringing up research that the military is doing is not being conveyed into so much of the civilian sector, and with the VA being part of hopefully advertising that and hopefully getting that out there, I think part of what the panel is talking about is getting the best, is coming together as a Mental Health Organization and coming up with the best practice to then present and move forward with.

DR. PRAMUKA: Thanks. Just to comment, a lot of our service members with MTBI have many other conditions that are certainly the more likely reason for their cognitive problems. Out of our 98 people, 11 have ADHD, five are bipolar, two have Schizophrenia, two have major depressive disorder that hasn't been resolved for several years. And numerous, in fact last time it was six, had some other neurological disorders, like an AVM or stroke or brain tumor. In fact, we have even more than that right now. And these people have a legitimate diagnosis of MTBI, but another neurologic disorder that sometimes preceded and sometimes followed that MTBI. And that clearly is the real reason that we're providing rehabilitation services --

GENERAL GREEN: Can I ask, when you say a legitimate diagnosis of MTBI, since you can't give us objective diagnostic criteria, what does that mean?

DR. PRAMUKA: No, they met DoD criteria. There is fairly explicit DoD criteria for all levels of TBI that we use to diagnose MTBI across the different sites. So we acknowledge that they have had a concussion, but we also acknowledge their stroke is the reason -- I'm sorry, I guess I missed the point.

GENERAL GREEN: Well, I think that very validly we've got a clear understanding of a concussion. I mean, not that we understand everything about it but we know how to make that diagnosis. But the persistent symptoms are now being associated with MTBI. I don't know whether that's a new diagnosis or comorbid conditions associated with the original

concussion or something subsequent. And so it's interesting when you say a legitimate diagnosis of MTBI, I'm a little lost in terms of exactly what you mean by legitimate.

DR. PRAMUKA: Well, I probably misspoke there. I meant that they have two conditions. They have a severe neurologic condition like an AVM that ruptured, and they have a concurrent or sometimes previous or sometimes after the fact MTBI diagnosis.

GENERAL GREEN: Okay.

COMMANDER COAKLEY: I have a quick question for you. Just to be clear, you say 21 have other psychiatric disorders, you listed them there. Were they antecedent to their being brought into the program before you saw them? Were they being treated for them actively beforehand?

DR. PRAMUKA: Especially for ADHD, many of them were. Not all.

COMMANDER COAKLEY: Okay. Because you could see where that would, some people would interpret that data as saying, well, they diagnosed these things afterwards. It wasn't their MTBI, they actually had these other things. Which came first, the chicken or the egg. Do you know what I mean?

DR. PRAMUKA: Well, we do talk about that. You're right. And I think we've actually kind of already talked about this. My point, my concern about measurement, is that different MTFs and places provide rehabilitation on a different continuum. Almost nobody is going to return to duty directly from Walter Reed. So that is probably not a valid measuring for us at Walter Reed. It might be the perfect metric at some other site. Secondly, as Dr. Vanderploeg mentioned, we use the neurobehavioral rating scale, in particular in the PCLS, to report on PTSD. And, in fact, those are kind of generic symptoms. And so when somebody does well or poorly on them, it doesn't tell you how well they are recovering from MTBI or how much they're benefitting from any specific treatment because they're involved in multiple treatments. So it's kind of a generic measurement tool that doesn't let us pin down recovery from

MTBI or the contributions of cog rehab, per se. So I know, I apologize, I've run far over time, but...

DR. GUICE: Thank you very much. Commander, it's your turn now. Excellent.

COMMANDER HANDRIGAN: Good morning. Thank you for the invitation to come and share some thoughts from DECO. My name is Mike Handrigan, and I am the Director for the Directorate of Traumatic Brain Injury Clinical Standards of Care at DECO. And I want to thank my co-panelists for really covering so much information that my comments will be mercifully short. Next slide. My goals today really are to provide an overview of one specific program, that DoD is initiating, to address and focused population for TBI. And my goal is, the population of mild traumatic brain injury that have persistent symptoms and potentially require cognitive rehabilitation therapy. So, as it's been brought up a couple of times, this is a pilot program, although it would not be well characterized as a research effort because it's not intended to be a research effort. And I'll speak to that a little bit more.

This grew out of the recognition that there are plenty of folks who have persistent symptoms resulting from MTBI that can require services. And they're very complicated in terms of evaluation, identification in the provision of the services. And it's worth reflecting on a couple of things that were said by the previous speakers. First, is that the vast majority of concussion, mild traumatic brain injury, recovers spontaneously and completely within a day to a week or within a few weeks, with no permanent neurological problems. There's a very small population that has persistent symptoms, persistent neurological problems that need to be addressed. And teasing those problems out as being primarily related to the traumatic brain injury that they suffered, or to other co-occurring disorders is exceedingly difficult. So when we speak to the community of practitioners that are providing these services and we ask them, you know, is it working? Are you providing it to the right folks? The answers are often very difficult

to come up with. The pilot program was designed after the consensus conference process back in 2009 that was brought up earlier, that brought the best minds together from the civilian sector as well as the military sector to talk about cognitive rehabilitation therapy, specifically for mild traumatic brain injury. And we intended to create a guide for a standardized approach to providing these services in a programmatic fashion. That guidance document was finalized and issued from health affairs as a recommendation to initiate the pilot program at 14 sites across the DoD. Those 14 sites are geographically dispersed to get out to where our service members are, where they're being treated, and where they would likely require these services. And they coincided with facilities that were already providing cognitive rehabilitation services. Not necessarily a cognitive rehabilitation program, but services at the MTFs.

Those sites, because of BRAC, in San Antonio, had two sites, and that became one site. So now we currently have 13 sites within the pilot program that is administering this pilot program. The program was rolled in in July of 2010, so it truly is in its intensity, in terms of development. So we are getting the service representatives and the services up to speed, so to speak, with the guidance document, with what the program can and should look like across the services. But with that said, I want to highlight what was spoken to before by Dr. Pramuka. The services at MTFs vary tremendously. The service requirement and the service members being treated at those facilities vary tremendously. Walter Reed represents a very focused population of polytrauma patients with multiple co-occurring disorders and mild traumatic brain injury. So it's a very challenging and difficult population to tease out, whereas Redstone Arsenal and Camp Lejeune are sort of at the other end of the spectrum. And it really relates to their rural and community hospital level and tertiary referral center type of orientation. So we have Walter Reed at one end of the spectrum, and some of the services, MTFs in the pilot program are at the other end of the spectrum.

So the guidance document isn't meant to be prescriptive in terms of a specific program accomplishment. It's meant to be a guide to holistically think about the provision of cognitive rehabilitation services so that we can try to get towards system attic approach to individuals that require cognitive rehab and providing them with services that they need. Part of the recommendation from HA in establishing this pilot program was that we need to start to look at outcome measures. A, to make sure that we're providing the right services to the service members, but also to start to answer the question about whether those services are beneficial. Are we really making a difference for the service members and the issues that they have resulting from cog rehab?

These are the sites and the geographic dispersion for the pilot program. And as you can see, they hit most of the principle medical centers across the military, and some of the smaller centers.

The program was not intended to be a complete DoD program. It was intended truly to be a pilot program, to look at whether or not we can implement a standardized approach to cog rehab services, and if so, should that program guidance be broad in across the DoD. And can we use that pilot program to start to learn more about cognitive rehabilitation therapy? In some of the outcome measurers that are currently being followed include these, which are symptom inventories, post-traumatic checklists, Mayo Portland Adaptability Inventory. There's a WHO Quality of Life metric that is followed. One of the challenges that the pilot program has is that the pilot sites weren't instructed to follow any particular outcome measure. They were instructed to choose one that made sense for their facilities, for the services that they provide, and for the service members that they are taking care of. So right now we don't have one composite look at cog rehab services across the DoD, but it's our goal within the pilot program to really learn some of the best practices and lessons learned in the short term so that in the long term, this site, the pilot program, can potentially be the test to answer some of the

questions that have come up here, which are, Is cog rehab working? Are we making the right differences for the service members?

GENERAL STONE: So, Commander, is the Defense Center of Excellence the unifying body?

COMMANDER HANDRIGAN: The DECO's role in this pilot program is really as a coordinator. The HA directive to implement the pilot program went to the services, and DECO's role is to help facilitate and coordinate the implementation of this. Does that answer the question?

GENERAL STONE: We've seen tremendous variation in the delivery of services. Now, you've just said there's tremendous variation, even in the pilot because there was no outcome measures. If there's no outcome measures, to what standard by which do we operate, and what should be the role of the defense center of excellence to unify that process?

COMMANDER HANDRIGAN: I think that's an excellent question. And I think in the short term, our role at DECO is to identify what the right outcome measures are. The right outcome measures for the population and patients at Walter Reed, with polytrauma and multiple complicating co-occurring disorders and injuries.

GENERAL STONE: How do we continue with the pilot program if there is no outcome measures?

COMMANDER HANDRIGAN: I'm sorry, maybe I misspoke. Not to say that there are no outcome measures, the sites are following outcome measures. Some of those outcome measures are, for example, the individuals that they're seeing, the demographics for those individuals, and they are specifically following outcome measures that relate to their population of patients to look at the effectiveness for their specific patients. There's no unifying outcome measure for the pilot program, per se.

GENERAL STONE: Since we're struggling so much with this, can you talk to us a bit about the civilian community and how they establish outcome measures?

COMMANDER HANDRIGAN: I think that it's fair to say that, with respect to organized cognitive rehabilitation therapy as a pragmatic approach, DoD is in the lead. I don't think that there are similar civilian programs to speak to.

GENERAL STONE: So then our reserve components, when they seek care out of the civilian community, what kind of thoughts do you have about the level of care they're receiving?

COMMANDER HANDRIGAN: Well, another very good question, and it's basically the same question that was raised earlier. A lot of our Guard Reserve service members will be accessing services through Tricare and through their civilian providers. We have other unrelated efforts to try and help direct folks to the right services. But this pilot project, this pilot program, doesn't speak directly to them.

GENERAL STONE: Thank you.

COMMANDER HANDRIGAN: So some of the lessons that we've learned so far from the pilot is that cognitive rehabilitation, as outlined in the consensus conference can be successfully implemented. Our centers have picked up the guidance, it's being implemented, and I think that it can provide a backdrop to help programs integrate at medical treatment facilities and provides a systematic approach that can help them and help our service members. At this point in time we don't have specific outcomes data to speak to the effectiveness or efficacy for cog rehab. And we won't have efficacy or effectiveness data any time soon from this pilot program. And I would dare to say that efficacy and effectiveness data in cog rehab, because it's so difficult to tease out from other co-occurring disorders, may be several years off.

The recommendations as outlined in systematizing cognitive rehabilitation I think are mainly on target across the pilot program, and I think that the rollout of the pilot

program has been a great success. It has provided an opportunity to focus the services and provide better treatment for our service members.

Most patients with cognitive rehabilitation needs following MTBI have very focused problems, and that requires very focused treatment in a very specific treatment plan. And this is one of the challenges in cog rehab, which is to say that the treatment plan is the first and most important part of cognitive rehabilitation therapy. Cog rehab therapy represents a basket of services, much the way at physical therapy represents a great variety of treatment modalities. Cognitive rehabilitation therapy can provide specific tools and specific treatment therapy options, but they are very specific to the individual's cognitive needs for treatment. So cognitive rehab, per se, is not any one specific thing.

One of the lessons that we've learned from the pilot study is that the concept of a comprehensive evaluation is not well defined. And it's a challenge that we need to address in the pilot program in these early stages so that we can get to a more specific process. And I bring that up because it's, oftentimes the comprehensive nature of an exam can be different for the service members. Comprehensive evaluation for one service members doesn't necessarily mean the same thing as comprehensive evaluation for another service members. So we're working on getting to a better definition for that, and I think that will help improve the program as we move forward.

I want to just mention, I can't speak to these efforts directly, but I want to mention other efforts that are underway to help answer some of the tough questions that you've asked, which is the SCORE trial that was described earlier, which is looking at the effectiveness of cog rehab. There is a Congressionally directed medical research program that has 10 million dollars specifically dedicated to look at the efficacy of cog rehab. And that is rolling out now. And third, the IOM has been commissioned to look at the composite body of knowledge as it

exists now to help us understand what that body of knowledge means in the context of effectiveness for cog rehab. We look forward to the results of those.

DR. PHILLIPS: Mike, just a quick question. Do we have any baseline information that we could use. For example, maybe perhaps Iowa Test Of Basic Skills or SAT score that might be able to help compare the folks before and afterwards? Or is there any recruitment tools, questionnaires that are being developed or used for research?

COMMANDER HANDRIGAN: Well, the answer to that is somewhat. And let me describe. We currently are utilizing the ANAM which is an automated neurocognitive assessment tool, computerized tool, in the pre-deployment venue, Congress has asked that all service members who are deploying have a baseline ANAM done so that post injury and post deployment we have something to care to. So we're working in that direction. The pre-deployment ANAM is being successfully accomplished. A majority of deploying service members. But there are still big question marks about the validity of that information following deployment. There are so many things that can affect your ability to perform that study, to perform that test, following an injury in a combat environment where you're sleep deprived, and have other reasons to be cognitively declined. So putting that information in context will remain challenging for us for some time. But to answer your question, yes, and we're working on making that better.

MS. DAILEY: And real quick, just to follow up on that, any reach back to the ASVAB, which is the single tool that brings enlisted individuals into the, into all the Armed Services.

COMMANDER HANDRIGAN: To my knowledge, nobody is looking at the ASVAB or serial ASVAB testing or post-injury ASVAB testing for this purpose. And honestly, I'm not sure what that would mean if we did.

DR. PRAMUKA: We just got access to the ASVAB data set at Walter Reed. I'm just learning how to log on and make a request. To be honest, I haven't done it yet. But we have been shooting for that.

MS. DAILEY: That ties it back to the recruitment, and we would be a number or a year more out before anything would be useful.

MASTER SERGEANT MACKENZIE: A quick question for you there, Commander. I've asked this question several times and I seem to continue to get the same answer so I'd like to see your perspective on it. Is there any plan to link pre/post reassessments, and then pre and post reassessments again, and again and again as these guys continue to do multiple deployments, some in the realm of nine to ten deployments. Are you guys planning to link them together or, like the other agencies, are you just taking a one deployment snapshot view and not looking at the historical data.

COMMANDER HANDRIGAN: This is an excellent question, and the answer really depends on the validity of that information. And what that information means in the normal life cycle of an individual with the backdrop of deployments and injuries. And I'll give you an example. If we were to take the NCAT -- currently we use the ANAM for the NCAT, NCAT being Neurologic Cognitive Assessment Tools, the current choice for that is the ANAM, and that's pending validation through further infield studying. But if we were to take a 22-year old guy who's coming into the military service and give him a baseline ANAM, and he progresses in his career and it's three or four years before he deploys and we have serial ANAMs perhaps, and then he deploys and he comes back, we get another ANAM, it's not clear what the normal ANAM course is because we all change cognitively as we mature, as we age, as we decline. There's a natural accession and decline to our thoughts. There are very difficult ethical questions about following that information, about making use of that information, not only for our folks who are injured but certainly following that. Those are questions I can't answer.

They're important questions that need to be answered before we were to examine information like that in a serial way. And I don't know that we're at a state that we would understand that information in the context of an injury, but it's a good question.

MASTER SERGEANT MACKENZIE: And then, just because you guys said that the military is leading the way in cognitive rehabilitation and that the civilian market really isn't doing it. But yet, the civilian market is doing it in many facilities. Have we looked at, have you consulted with those facilities or is any of that information being brought to them or are we just doing this within the military and saying that we're leading the way?

COMMANDER HANDRIGAN: Let me just jump in and say let me make a correction. I guess I misspoke. I clearly did not intend to say that the civilian sector is not doing anything. In fact, we're actively engaging civilian sector. I'll give you an example. The mild traumatic brain injury clinical pathway guideline that was developed by the VA DoD evidence-based working group, developed that in accordance with the standard for guideline development, and reached out to the civilian sector. And that guideline is available and utilized on the National Guideline Clearing House, which is administered by AHRQ, the Agency for Healthcare Research and Quality. So we are actively engaging the civilian sector to partner, to try and meet these challenges. Not to say that the DoD is not taking a lead in the cog rehab pilot program in a way that's specific to DoD.

MASTER SERGEANT MACKENZIE: Thank you.

GENERAL GREEN: Gentlemen, I think that you've answered a few questions and given us more questions to think about, so there's a lot of answers that are still pending. We now have about 30 minutes for lunch before we have to come back for one o'clock. So are there any other real pressing questions? I didn't want to cut it off if there's somebody who needs to -- but on the other hand, I think we need to move back towards the schedule. So thank you folks. We appreciate it. You've helped us put this in perspective. Thank you.

MS. DAILEY: Thank, gentlemen. Ladies and gentlemen, we have lunch. We leave this room, my staff is going to take you down the hall, it's not over here, it's down the hall, over the hill, around the bend. So make sure you get in contact with one of my staff if you leave, because you'll be lost.

(Whereupon there was a recess from 12:24 p.m. to 1:10 p.m.)

MR. BERRIOS: Good afternoon, ladies and gentlemen. I'm Will Berrios, I'm the Deputy Director for the DoD VA Interagency Program Office, and today I'm going to talk a little bit about our particular charter, what we have been doing in these past few years, and talk a little bit about how we have facilitated and aligned for better interoperability of electronic records between the DoD and the Veterans Affairs.

I'm going to cover a couple of topics. I'm not going to dwell too much, talk a little bit about how the organization was born and what was its catalyst, talk a little bit about the interoperability objectives that are part of that initial charter and the catalyst, and then we're going to talk a little bit about some of the actual implementations that we have made in these past couple of years in regards To Virtual Lifetime Electronic Record and other reference such as the one of the first integrated federal healthcare center, over at the James A. Lovell in Chicago. And also, we'll touch upon where are we going in the future in terms of electronic health records.

Please feel free to interrupt me at any time during the presentation for questions. I welcome that. I think it's a lot easier than to wait towards the end. So I will, after each slide or each topic, I will pause accordingly.

The organization was a result of congressional language in the National Defense Act of 2008. And even though the act is pretty long, just to kind of summarize with a paragraph, and this is an exact quote, they wanted this particular interagency organization to act as the single point of accountability for both the Department of Defense and the department of veterans affairs, in terms of the development and implementation of electronic health records

into operability. And with that, let's go ahead and see if we can accelerate the capabilities, make sure that we're on track to achieve the type of interoperability in change for medical health records that we were looking for. Now, in the year 2009, that charter was expanded as well to include The Virtual Lifetime Electronic Record in terms of oversight and in terms of monitoring its progress within both departments.

GENERAL GREEN: Can I ask, was there a budget given for this and number of personnel for the IPO? It's General Green, I'm sorry.

MR. BERRIOS: I'm sorry, General Green. I hear the voices and I can't see the mouths moving. Well, the initial budget was 14 million dollars per year. That allowed us to staff 23 government -- correction, 26 government personnel, 13 DoD, 13 veterans affairs. It also allowed us to contract services so the total full time equivalence that we staffed up to was approximately 66 personnel. 66, yes. Now, that ramp up was not completed until May of 2000. So, even though the initiation of the -- even though the office was established starting in 2008, it did not achieve full ramp up, if you may, until May of 2009.

Now, just to establish a baseline for all of us when I talk about interoperability from the perspective of these programs, we talk about four different levels of interoperability in terms of how we change data. The first one, nonelectronic paper based. The second is viewable electronically, PDF files, photos, et cetera. The third level is structured viewable electronic data. So that means now we're starting to input data in electronic format into a system and then that data that we input into that system can be shared electronically with other systems. And then last but not least, level four, and that's full integration. Not only can I input the data but I can alter it. I can create, I can update, I can delete, I can modify. Now, understanding of these are four levels of data, not all data has to be level four, not all data has to be level two, three, or one. A good example would be, there's data that you would not change. Under a particular consultation, you would not change what another clinician or physician would

write. So perhaps level two or four data, one, two, three data might be sufficient. Definitely, you would like to move to level three because you would like to exchange that electronically and be able to look at it from side to side. And I'll pause here for a second.

DR. GUICE: What would be -- give us an example of data that you would change?

MR. BERRIOS: Especially within pharmacy is a good example. You might -- a patient might, in fact, have a prescription for a particular medication and dosages have to change. Or maybe a change in terms of the type of medication. That is something that you would want to ability to change, regardless as to which system, but more importantly, once changed, you want to ensure that that data is then available regardless of which system extracts it and that it is updated in that fashion, and that audit is in place to show that in fact it had changed. The when, the how, the where, and the why.

MR. CONSTANTINE: Would that also include if you have recurring surgeries or something like that, where you want to add to the record and you switch between systems?

MR. BERRIOS: Absolutely. And those are all good examples. Now, I'm going to move to a slide because I think it will help expand on answering your question as well, in terms of capabilities. There is a board known as the ISOB, and Ryan, I'm going to shout out for you to help me because I have tremendous brain cramp right now in terms of the acronym.

MR. COOL: The Interagency Clinical Informatics Board. ICIB.

MR. BERRIOS: Thank you. Now, this is the particular board that is able to prioritize or has the responsibility to identify and prioritize the different type of capabilities that are required in terms of medical records. In the case of the congressional language of 2008, what this slide represents is, these are the objectives we wish you to achieve. Now, mind you, within these objectives there were various levels of data requirements as well. Some of the data

required up to level three, some of the data required level four. Other data was sufficient in terms of levels one and two. So based on that, and I know it's kind of hard to read from afar and hopefully you have copies of it, but the first capability is one of expansion or at least one additional site in each military medical department.

Now, this was a product that is specifically tailored for inpatient record keeping. So it's one of those key clinical tools. Within that status as of September -- and oh, by the way, let me digress here for a second. These particular capabilities, based on the congressional language had to be in place by September of 2009. So we're talking now two years ago Congress said, I want you, DoD, and you, the VA, to ensure that these particular capabilities are met my September of 2009. Is there a question? I'm sorry. General green, no question? Okay. I'm not going to read the list of the objectives there, but in terms of what the status was, I'm pretty sure you could read from there yourselves as well, one of the key of these three capabilities, the key here was really showing that even though the Department of Defense and the VA had different medical information systems that they were able to exchange portions of that patient data and show that there is a capability to do so, these things weir accomplished and briefed to the Congress as yes, we have proven initial capability and the IPO was involved and also assessing that report that was rendered to say yes, we concur that there is initial capability available, and was available by 2009. Let's not confuse capability with fielding. Two different things, right? Yes, we could prove it can be done. Now, how far we have implemented it is a different story altogether, and I'll go into a little bit of detail on those two. And if there are no questions I'll proceed here. This particular matrix shows those particular capabilities in terms of ICIB. They prioritized for us these three particular capabilities. What this slide shows is not only were they, did we demonstrate -- when I say we, the DoD and VA, those initial capabilities -- it also shows that these particular limited user test sites were done in the first quarter of 2010 and have continuously gone on from 2010 to 2011. And I'll talk a little bit about

some of those projects specifically as we go on and talk a little bit about the capabilities that have been demonstrated in each of these limited user tests or what we call pilot sites. I don't want to mislead you when I say pilot that is something that is done and forgotten. No. These sites, once established, and these systems, once operational at these particular sites, are continued to be used to provide service. So I want to leave that particular note with you. And we'll talk a little bit about how we are trying to evolve and expand. Any questions when it comes to capabilities, please? No? Okay. Thank you.

So of course talking about interoperability, a lot of times we think, well, gee, whiz, this should be a piece of cake. Electrons, wired, they go from one place to another. What's the big deal? Well, both particular departments worked slightly different in terms of how they administer clinical services. And even though the patient is the same, the way in which we administer sometimes varies from department and department. So of course you couple that with also the legal and regulatory requirements that we must be both from the federal and also from the administrative side of the house of each department, it becomes very, very interesting and challenging to go ahead and do that. One of the key challenges there, in terms of actual linking, in the fifth bullet down, and that's identifying, prioritizing, and implementing those common services that can be shared and should be shared across the two departments. Right now there are a total of around 43 different categories of common services of -- of services. That's the way we've cataloged it -- of which 33 of them are common within both departments. The variants really rest within a couple of areas, and that is in terms of recruitment and readiness for the Department of Defense, of course, and theater operations, a little bit in the way they administer and the systems that are required to do, to administer clinical services there. In the VA's case, long-term care. Also, some other variations such as pediatrics is a good example, within Veterans Affairs, few and between, it's more geriatrics, which is really not the case in the DoD as much. So just to try to whine out a little bit what those common services might be.

Of course the other challenge we face also in doing this is synchronizing and insuring that the acquisition cycles and the moneys associated with any projects that are developed are in sync as well. Very interesting, when you consider that DoD has a yearly process and five-year budget plan, while Veteran's Administration has the benefit of multiyear dollars at times, and also a mix of yearly dollars as well. So all these particular things kind of add to the complexity, and we've been learning as we've been moving along. I'll pause here just a second. Any questions? Okay.

So there are going to be three particular interoperability initiatives that we're going to address. And please feel free to stop me at any time to say what does this mean. Hopefully I'll be able to explain. The VLER Concept, or the Virtual Lifetime Electronic Record Concept, was the catalyst of that was the President, where he, in April of 2009, said you know, I want both departments to work together and create this virtual electronic record that would follow the service member from the point of induction through retirement through interment. That was the challenge he set forth in saying, I want you to devise a framework that we could build towards that. And that means veterans, service members, the beneficiaries, but more importantly, and what's different here, is care. Providers that are contracted or support either department. Right now, and it could be argued the statistic, that around 60 percent of all care is really conducted by outside providers. But for both veteran affairs and Department of Defense, you have Tricare and with that you have contracted services. One of the challenges in terms of sharing data there is, how do I share data between not only DoD or VA, but between outside service providers as well, be it the large clinic, large hospital, or even smaller clinics. So VLER is an attempt not only to tie DoD and VA together through that methodology, but also outside providers as well.

Now, this is truly a multi-agency effort. You have health and human services really takes the lead in terms of developing what I call this transport layer, this highway,

the means of how are we going to communicate and exchange records. Well, it's something that we call the National Health Information Network. Now, what HHS does is defines the standards that are going to be used for every single data element associated with the record, and with that they also administer the standard to ensure that people are complying with it. So once they define the standard they're able to test against the standard, they're able to certify that you're consistent with the standard, and the overall objective of this is that ultimately, if you build an application that is consistent with the NHIN's standards, you should be able to plug and play and be able to exchange data seamlessly. That's the logic behind it. I like to think of it like, just like an iPad, if you may. If you build our application to an iPad and you throw it out there, hey, it should work. And that's the whole concept behind it.

Now, within this initial exchange, in terms of VLER, again the ICIB helped us by saying, let's go ahead and take the following data ailments, the following records, the following tables, and based on that, let's go ahead and move forward and start building standards to meet these particular priorities and tables and types of information, and start moving it towards this model and start testing out to see how it does. And we have launched -- right now we're at the third stage, if you may, of it. And we decided that VLER would be conducted in four phases. Phase number one was to show and demonstrate the capability of being able to exchange, at a minimum, the data, the ICIB identified that basically said this is the minimum data set that we need in order to provide care to a patient. And that's what we call VLER Capability Area 1, or VCA1. VCA2, or VLER Capability Area Number 2, is starting to link not only strictly to the medical but using that very same information to go ahead and link into benefits. So VCA 2 objective is to take whatever necessary medical data is needed in order to make a benefits determination. VCA Level 3 is now to go ahead and grab those things and integrate them all together. And VCA Level 4 is to have a single portal. So three, you had the capability for the dream is one portal where you could access both medical and benefits data

from one particular source, instead of going to various websites, various clicks, and whatnot.

Questions on this concept or framework? Okay.

This is another depiction here that shows who is participating in the logic behind this, and we talked a little bit about it. If you're able to go ahead and build this standard, then regardless if you are an outside provider or even a private doctor who bills or has a small application that meets those standards, they'll be able to connect to that particular network and be able to change that information as well. Today we have other things, and I'll probably be mentioning, Blue Button is a good example of what I call right now, a sneakernet version of this. You're able to download on a thumb drive, on a disk, any medical information that you have within your medical records, be it at VA or DoD, and have minimal essential data that you can carry around in your pocket as well that your able to offer different clinicians.

DR. TURNER: Mr. Berrios, could you briefly go over permission and your security structure for this, who gets to sign on to what parts of this?

MR. BERRIOS: Sure. One of the challenges in terms of security is one of insuring that those particular roles for each person, depending on where you are in this chain, are clearly identified, but more importantly, not violated and be able to be audited. So it could very well be that one particular piece of your medical information through your consent you might want to release to others, while other types of information you don't want to share. You want to share just between yourself and that particular clinician. Or anyone else for that matter. So the permissions models associated with this is pretty complex and has to be defined every time we establish any type of interface. And in these pilots that we have been doing, it's one of those key type of frameworks that we have to concentrate on, because DoD and VA have two different models there too, right? Because within the DoD systems, you're running a very, very highly secure area. Different type of classification, whatnot. Not as high in the Veteran's Affairs. However, when it comes to privacy, still both rules apply. So those particular permissions and

access rules are quite challenging and have to be negotiated ahead of time before an interconnect could occur. And I know it's a round-about way. I don't know if I answered your question, but if you wish to follow on, I'm be glad to entertain.

DR. TURNER: I just don't see how you're going to do it. Because of the -- I mean, there has to be an immense training tail with this as well. For everybody that's on there, there has to be training and recurrent training as well. And how much does the individual patient, how much can he interface this system?

MR. BERRIOS: Right. And I think when you look at this particular layer, you can get that impression. When I look at an iPad, for example, and I have all these little icons on it -- and this is my way to access data. You might prefer a PC with your little icons or whatever, but this is my way to do it. The infrastructure associated with what makes this simple to access or to control who I want to access or not, is built into that framework. We don't want the patient, the customer, the clinician to have to worry about the mechanics of the back office. We have to worry about, when they look at that front end, those things in terms of permission are insured, those things in terms of accuracy of the data is insured, and that integrity is insured in its transport too, right? Because data that moves from a lab through that chain and received on the other side, we want to make sure that that data hasn't been tampered with, it's exactly what was inserted in point A and received in point B. Doable, as long as those rules are established. That's what makes this work, for example.

DR. TURNER: And just if you could answer the second part of the question, how much access does the individual patient have to this information?

MR. BERRIOS: Well, by HPPAA laws, patients have the right to all their medical information, so it becomes an issue of insuring that the system that is built, you want to provide that -- I mean, ultimately, anything that could be provided electronically based on your

military history should be available. I mean, that would be utopia, right? To be able to do that electronically. You have that right as a patient to that data.

DR. GUICE: I know you already have done exchanges. How successful have they been, the three-way exchanges between DoD facility, VA facility, and a private health center located in the same geographic region?

MR. BERRIOS: Thanks for the question, Karen. We've been very successful in terms of ultimately exchanging that data. A lot of lessons learned as we were doing it, especially in the permissions side of the house and in the data integrity side of the house, to insure that records that were transferred from one place to the other, in fact transferred very accurately. In the case of velar, up to now, and we've demonstrated -- the first capability was to demonstrate it in San Diego in 2010, was the first initial demonstration of that exchange of data using velar. Very immature, where all of this is going. The second type of exchange out of velar was being done in the Hampton area here in Virginia, where there's been exchanges of these tables, what we call a C32, which are those minimal medical data allotments required, and that seems to be working as well. And now, we are launching a third pilot site in Spokane, Washington, and that should be going live here in July of this year.

DR. GUICE: One additional question: How is this, with the VLER initiative and the new focus on IEHR going to kind of fit together into one unified approach?

MR. BERRIOS: Well, IEHR is kind of, I would call it the umbrella term for all exchange of data. This is one particular way in which you can exchange data. It could very well be that as this evolves, we use this technical solution as that transport mechanism and plug it into this big framework of IEHR. IEHR, and I'm going to go ahead and move to that slide very quickly, just so that we have common view of it. But IEHR, its overall objective is to take those common services that I mentioned a little bit earlier and try to standardize them in such a fashion that you only build them once and either department then uses that common service within their

environment without having to re-create it. So it's what I call the ultimate -- I keep on pulling this up. It's really the ultimate iPad. A really good example is your travelocity.com, for example. The reason you're able to go out and search for information in different hotels and cars and whatnot is because everybody agrees to a particular framework and subscribed to that framework, so that when they built their application they're able to go out and reach that data and retrieve it to you in the way in which you like it. And if you look at it, you know, they're kind of all the same but a little bit different. Because Travelocity is slightly different than --

DR. PHILLIPS: Expedia.

MR. BERRIOS: Thank you. And but still, when it comes to the information they provide, it's identical. So the logic behind the IEHR is just that. Let me establish an environment that allows me to present those common services that I'm looking for, i.e., if everybody looks for a car, they're looking for, let's go ahead and set the environment and the rules to do that. VLER is a transport -- I call it a transportation mechanism to go move that data around, and fits into this model as well because you've got to move the data. You have to find the data, you have to extract the data, and you have to move the data, along with modifying it, creating it, updating it, and whatnot. And I don't know if that answers your question, careen, in terms of the interrelationships. There are those who might argue that VLER is the umbrella while IEHR is the subcomponent of it, being that VLER encompasses not only health bullet benefits as well, but either way they're interrelated in that health piece.

GENERAL GREEN: Can you go back to the NHEN slide?

MR. BERRIOS: Sure.

GENERAL GREEN: In actuality, the IEHR, I represent all three Surgeon Generals on that group that's putting that together. The IEHR actually is the first decision that was made was to go to common data centers, which means that on your slide, under IEHR, VA and DoD from a health standpoint, would just become a single entity.

MR. BERRIOS: And that is correct, General Green. A single entity, because logically, regardless of the number of centers, you'll have one common data center and hopefully collapse it as much as possible, because there's --

GENERAL GREEN: Actually, there will be six data centers by the agreement right now and a common GUI. So let me ask you a couple of questions. So how do you interface with the IT, since your charter says that you own anything that comes to the JEC. Do you have visibility on the dollars that are spent in DoD and VA on the electronic health records?

MR. BERRIOS: We do, but at a very macro level and different levels of granularity, depending on the project or the phase of the project. So that has been -- that was an extremely challenging endeavor to do. People tend to not protect their money, but depending on how you're going to present it, they want to make sure that they're presenting you with the right numbers. So yes, we do have budget data associated with it, and we have the relationships to establish to where we can definitely identify exactly how much is being spent, what and where. At the macro level and depending on the level of granularity, then we also query.

GENERAL GREEN: So how do you interface with that? You've got, you say about 66 full time equivalents and 44 million dollars. Are you actually funding these efforts that you're showing or is that all, is the 44 million -- I'm sorry, 14 million, I'm sorry. Is the 14 million just basically your management oversight of that?

MR. BERRIOS: It's just management oversight strictly. The interagency program office is not the execution arm of these projects. They were just the oversight arm of these projects and these programs. They serve as that third independent party that is able to help the departments reach consensus. When they do, it helps facilitate, bring them together, but not only that, can conduct independent assessments, because it just helps validate in fact the views from a joint, if you may, perspective.

DR. GUICE: I have a question about that. Given that the ICIB existed under the HEC, and the BEC IT group existed under the BEC, is the IPO just extra, what? I'm -- I think this has been part of the struggle is to, since there were already existing frameworks for discussions and moving things forward and then kind of the role of the ITP, so could you kind of clarify how the IPT really works functionally, knowing that each of those committees was DoDDA people at the able anyway?

MR. BERRIOS: Right. My impression, in terms of congressional language is one to help that particular governance structure that was established. Requirements, of course, are identified on the benefit side, you look towards the BEC who has that responsibility to prioritize, to provide guidance in terms of what benefits are going to be provided and how they're going to be provided, and of course they have working groups associated with it to do the nuts and bolts of, this is the how we're going to do it, while the BEC at the senior level says this is the what. The same holds true with the HEC. They are responsible, and the ICIB of course is one of those committees or subsets under the HEC that helps identify the technical aspects of priority of medical requirements in the form of data. So the IPO basically served as that, and the intent was to have it serve as that interagency program office in which any of those programs that are, quote, joint in nature, they would have oversight for. And that's the way they drafted that charter. The congressional language was not very detailed in terms of how to do it. They said, I want you to be that single point of accountability and left it to the department to say, okay, based on that departments, what are you going to charter this organization with, in order to carry out those responsibilities as a single point of accountability. And you get the information or the priorities or the strategies that you need. Yes, sir.

DR. TURNER: Just a simple question. I got lost. Could you comment on where does the money come from. I'm unclear who ultimately controls your money, whether it's DoD, VA or HHS. And what is your long-term funding plan?

MR. BERRIOS: That's a great question. In terms of the labor associated with oversight, that labor is provided -- the bulk of that labor is provided by DoD. The contractual moneys, for example, right now, even though VA has contributed at times, right now the agreement is that DoD provides the facilities and the equipment necessary to manage and administer the organization. So, and there is a budget line placed in throughout the five-year plan within the DoD to do so, and then, the part of -- I'm sorry. Go ahead.

DR. TURNER: So it's a DoD budget line item?

MR. BERRIOS: For the facility and DoD personnel and contractors. For the VA personnel, that budget line comes from Veteran's Affairs to fund the labor of its government employees that work within the IPA. And they also have a plan, in turn. So right now those physicians are fully funded both in the DoD as well as in Veteran's Affairs for not only this budget year but also in the up years.

DR. TURNER: So are you POMd?

MR. BERRIOS: We are POMd on the DoD side, and we are programmed on the VA side.

GENERAL GREEN: So do you have oversight, once money is put into a joint program such as the North Chicago Program, do you have oversight of those dollars or is it still managed by the two departments? Because I know they match funds on the joint initiative, but I don't know how that funding is actually managed once they put it together.

MR. BERRIOS: We do not manage the funding. The funding is managed by each of the departments. So even when you have -- even within the joint funds, each department manages and has the mechanisms and the infrastructure to manage an account for it. What we do is have further visibility and track in fact are they spending it where they said they were going to spend it and are they accomplishing what they said they were going to accomplish with the moneys that they said they were going to spend.

DR. GUICE: So keep going with that. Given that that's what you've now defined as your role, what's your statement of -- is it being accomplished the way that -- is the money being spent like it's supposed to be spent and are we getting further along to, if you're sort of accountability office, what would you say about the progress of the two departments, given the portfolio of the things you've told us you're watching over?

MR. BERRIOS: Well, right now in the past year, we have, unfortunately, undergone some staff reductions, and the continuing resolution has really limited the amount of oversight that we could provide. Now that the CR has been lifted, that will improve and we are re-staffing again because we've had a lot of turnover in this past year. That being said, still, if we were to ask the IPO, IPO, can you show what has been spent on the VLER project for a particular point in time, for example, they would be able to provide those numbers for you. The same in terms of North Chicago. Now, that being said, can they manage the priority of where those dollars go for each department? Absolutely not. They could suggest, they could recommend, but they have no execution authority. We have no execution authority.

GENERAL GREEN: So if we ask about a specific project, I'll go back to North Chicago, so with North Chicago, I believe there's about 100 million dollars that went into that project. And I know there's specific areas in terms of what was supposed to come out that, are you telling us that because of the CR, you really had no oversight as to whether the money has been spent effectively or not? Is that what I'm hearing?

MR. BERRIOS: In that particular instance, in terms of moneys, we do have the oversight. But any detail that we would need or analysis in terms of how well they spent it would be very limited right now because our personnel status is very... now that the CR has been lifted, we are able to go ahead and exert more in terms of doing that.

DR. GUICE: And you do have recommendation on the IEHR working group, right?

MR. BERRIOS: Yes, we do.

DR. GUICE: Are there any other questions? Do you have any other slides you want to run through?

MR. BERRIOS: No. I think we've talked quite a bit about it. The only thing I was going to mention was the North Chicago project, and here is an example of interoperability. We are learning a bunch of lessons because in this particular case, you know, in VA we talked about having this common framework so regardless of what you do you are able to exchange the data. In this particular case you are working in an integrated fashion. So you are using one facility to serve two different customers, so to speak. And it's proven to be extremely, extremely informative and challenging in terms of doing that because of the difference in processes in the way both departments do their business. It has served, however, as a good example or a good template as to what do we need to fix in order to move towards truly an integrated her in the future. So this becomes very key, and this is going to become the alpha site, if you may, or the pilot side as we move further to further experimentation and collaboration within her. North Chicago is going to be our alpha site for all these testing.

I think that's it in a nutshell. There's been a lot of questions, is there anything else that you would like to discuss?

DR. GUICE: Any questions? All right. Thank you very much.

MR. BERRIOS: Thank you.

(Whereupon there was a recess from 1:58 p.m. to 2:28 p.m.)

DR. GUICE: All right. We will go ahead and reconvene. Welcome back and for the Task Force members, we are on Tab L. We're now going to begin our counterpoint panel. We specifically brought this group together to hear some of their views on current programs and policies within the two departments. We have Mr. Michael Parker, who we've heard from before. Welcome, Mr. Parker. And Mr. Brian Buckler, representative from the

American Legion. And they will talk about concerns with the disability evaluation system. The other two panel members, Ms. Patty Horan and Staff Sergeant Nicholas Lanier, will address concerns with the Wounded Warrior Units as a model for delivering services to injured service members. So, I believe, it looks like Mr. Parker, you're up at the microphone first.

MR. PARKER: All right. Thank you. Let's make sure we're on tap here. Okay, and thank you for allowing me to brief you today. My name is Michael Parker, retired Army Lieutenant Colonel. I'm a wounded warrior advocate/barracks lawyer that you've been hearing about. I understand that that's somewhat of a pejorative statement, but I stand behind it. I think at the end of this briefing, at least you'll have an understanding of why I say things like that. I'm going to start off with somewhat of a little bit of a poke here that this counterpoint panel, you know, is an hour divided among four folks here. And yet, the last four meetings were all about, you know, for the most part, government entities, DoD, VA coming in a briefing. I'll ask in the future that there been more parody between the government and the nongovernment entities, in terms of identifying and talking about issues. I would further recommend that the public comment be first order of business on the first day, so that we see what's going to be briefed, we can get up and speak about, you know what concerns we have relevant to those topics and allowing you guys to ask better questions or have at least what we are concerned about in your minds as those briefings are being done. Now, I make my public comments, I'm blind as to what is going to be spoken about because I have to turn it in like a week and a half before. So if there's any way that I can have visibility of what DoD and the VA are briefing, then I can tailor my statement better to those concerns. So I just ask for you to consider those as the first thing I brief about here today.

I'm going to talk about the purpose of the DES, what I believe we owe our wounded warriors who are kicked out of service for being unfit for service connected disability. And then my top evaluation system concerns, which I will not be able to go into, you know,

some of them not at all, and nowhere need to depth I need to. But I have tagged them to places where you can get all the dirty details that you want.

Okay. The purpose of the DES is to maintain a fit force, first and foremost. That second one there is to provide career compensation for careers. It's not about disability compensation. That's what the VA does. The DES compensates for a career cut short due to a service connected disability. And it doesn't do either of those very well. There are people who should be found unfit who are found fit in many cases to avoid disability payments by DoD. Many are not properly evaluated at all by the DES. And then when they do get the career compensation, it's killed by the VA offset of their disability compensation basically wipes it out and they get no career compensation when they leave.

What do we owe? We owe them career compensation that is not offset by VA or disability compensation, plain and simple. You know, if I do ten years of service and I get hurt in combat or whatever, and they say here's your check for your career, and then it disappears because the VA takes it away either by you know a separation offset or by offsetting my retirement, I really don't get career compensation like I should. We also have to be worried about the insurability of wounded warriors and their families. You have an 18 year-in-service gentleman who hurts his knee, legitimately rated 20 percent and separated, and his kid has cancer. He's out of Tricare, good luck getting insurance. So we've got to be worried about those things. But what are we doing for these wounded warriors and their families, the way the current DES is structured?

The VA stuff, I'm not going to go into, but I think, you know, when you get to disability, the healthcare and everything else, I'm not going to speak to that. It works fairly well, there's always some issues there. But it's a fairly robust system.

I want to quickly brief what a federal employee gets when he's no longer fit for service. First year, you know, if they're found unfit, can't do your job, can't put you

somewhere else, they get 6 percent of their government pay for the first year. That second year, until their age 62 they get 40 percent and at age 62 they get a first retirement as if they'd never stopped working. They keep their health coverage, they keep their thrift saving plan that they've contributed to and the government contributed and all the benefits that come out of that and all the gains that come out of that. If they happened to be part of service and have VA compensation, they will not offset FERS their retirement. And they also get preexisting disability coverage at 18 months of service. It's a fairly robust disability program, and my position is, our military members deserve at least this if not more.

So on the military side, if you're found unfit and rated 30 percent by your PEB, you can get retire, be it on the temporary list or the permanent list. And that's going to be based either on your disability percentage or your link to service percentage, whichever you find most beneficial. The DoD retirement pay is offset by VA compensation, in many cases unless you're CRDP or CRSC eligible, both of those are current receipt programs, and you maintain your Tricare coverage. However, you do not get disability coverage in the military for a clear and unmistakable preexisting condition until you have eight years of service or for the reserves, 15 years of service, as opposed to the 1.5 years for federal employees.

Now, those who are rated less than 30 percent, they're going to get a onetime severance pay, which is based off two months base pay times their years of service. That severance pay will be recouped by the VA. If I get a \$20,000 severance and the VA owes me 1,000 bucks a month, they won't pay me for the first 20 months. They'll recover that career compensation that I allegedly got unless your condition incurred in a combat zone. That's a 2008 change, and I'll talk a little bit more about that later in the brief. So that severance pay effective becomes nothing more than an advance on your VA pay. I still would like it in advance, value money, but it really does wipe out any career compensation they were supposed to get. And

these guys again don't get any Tricare benefits for their wounded warrior, for themselves, or for their family members.

My overarching concern is that DoD and the military services use numerous techniques and processes that cheat wounded warriors out of their DoD disability benefits, and my remaining slides will cover some of the key ones. I can't possibly cover them in the detail that I needed to; however, I have a series I write called the DES Outrage. It's on PEB forum. I briefed about that in January. Have any of the panelists or Task Force members been able to go to either PEB Forum or been able to read any of those outrages? Is it useful for you? Does it contain the points? I appreciate that. Here's a list of the topics. I won't go into them, but I've written 17 so far. The last ones I can favor. I kind of do, but I've been busy in other aspects, so. This covers by and large the biggest issues that I'm seeing, but there are more to be covered as well.

I'm not going to read through these, I'm just going right to the slides. This one jumps to my mind: The Navy is basically -- and I use the word scheme, and I probably should have used something even more harsh than that. What they are doing is that they will find the person fit for service. They'll then go through suitability screening and say, sorry, you're unsuitable for service, so out you go, administrative leave without any DoD disability benefits. DoD first attacked this in '07 by putting out a DTM that said, hey -- originally the DoD document said you can't use deployability as the sole reason for finding somebody unfit. The DTM changed that, and none of the services have adopted it. So they can continue to do the fit but unsuitable. This year Congress and the MDA(?) did write something that says you cannot administratively separate somebody for the same condition that the PEB already found them fit for. As soon as that came out, the Navy and Marines said, yeah, well that doesn't mean we can't deny them reenlistment. And I have Sergeant Sanchez, DS16 is a good example of that. He was

found unfit three times, until I had him in a corner showing that the rating had to be greater than 30 percent, then they found him fit and denied him reenlistment.

The members eliminated for service and who fought DoD disability benefits, because of this condensable medical condition, they ought to be found unfit. And again, on some of these slides I've put where you can find this discussed in detail in these PEB Forum Outrages.

Incomplete, incompetent medical boards. This happens all the time. Forever in a day, at least 1996 when DoD I-1338 came out, all medical conditions had to be covered in MEB, with full clinical data. And since 2008, when the DTM came out implementing the MDA changes, they have to put in that MEB the information that's in the VA ME worksheet for that condition. And that basically makes sure you get all the data so that you can properly evaluate it and rate it. That's being ignored in way too many cases. The PEBs are refusing to return incomplete MEBs so that they're done right, and it's a trash in, trash out. If you have an incompetent or incomplete MEB, you are going to end up getting shorted on your DoD disability benefits. There is no quality control of MEBs. I've been to these hearings since January, and the recurring theme is the DES process is taking too long. What I'm not hearing is, what about the quality of the DES process. Are they doing the MEBs right? Are they including all conditions? Are they rating them right? Are they being arbitrary and capricious in the way they determine which conditions are fitting and which are not fitting? That has to be key. Don't worry about time until you worry about the quality.

MASTER SERGEANT MACKENZIE: Mr. Parker?

MR. PARKER: Yes, sir?

MASTER SERGEANT MACKENZIE: Have you, in your research, have you seen any changes since they've initiated the legal assistance to the DES system?

MR. PARKER: Are you talking about the MEB outreach counselors?

MASTER SERGEANT MACKENZIE: Correct.

MR. PARKER: I don't know if that's caused by that. That's absolutely needed, because before the first time you saw your lawyer and many cases was the morning before your PEB board, and he would dig your case out of a hundred and say, okay, let's go through this real quick and go in. And you just can't do it that way. These PEB counselors at the PEB level are overwhelmed, understaffed. In the case of the Navy -- see, in the Army and Air Force, they are solely dedicated to doing PEB. In the Navy, they also have to do court-martials and everything else. And I have done several Navy cases with them as co-counsel, and you know, sorry, I'm out of town, I've got to go do a court-martial somewhere. So they are extremely, you know, not only busy but busy doing other things as well.

Post Separation Review Board Issues. I certainly want to get into this one. There are all kinds of these, there's the BCMR, which I think people are familiar with. There's a Disability Review Board, a Discharge Review Board. In the 2008 NDAA, as a consequence of the Walter Reed coverage, they developed what was called the Physical Disability Board of Review. I've got Review Board, it's Board of Review, actually. And what it did was, they realized that these guys were getting screwed and low-balled in their ratings. And they said anybody who got rated less than 30 percent since 2001 to the end of 2009 can go to this board. DAV says that about 77,000 people in that cohort, under 30 percent during that timeframe, but they absolutely refused to notify them that they're eligible for this board. They have gone out to the DAV and other folks, saying here, here's this, and it's on their website. But they will not write a letter to them saying, be aware, you qualify for this board, you may want to apply. The reason they do that is they can't -- it's a staffing issue. They can't even handle the cases they've got now. And they know if they go out and reach people, I mean they've had I think somewhere between 5 and 10 percent people apply, most of them have not. They're doing them about, I don't know, about a case a day. About 30 cases a month is what they're doing. And if you

extrapolate that out, it's going to take them decades to get through these 77,000 people. Now, the cases that they have adjudicated, there is some good news. 62 percent of these cases are changed and said oh, yes, you're right. It should have been other 30 percent, you should have been retired. Well, if you extrapolate that to the cohort, that's about 47,000 plus wounded warriors who erroneously were denied disability retirement.

And that's just from 01 to '9, and the problem goes back to decades since the 1949 implementation of the Career Compensation Act. The IDES I think will help solve this, but it's going to take time. We've got the IDES in. When Congress put that cutoff of December 09, in their mind IDES would be fully implemented, we've still got people going through the legacy case having the same problems that they've always had, yet they're ineligible to go to the PDBR review because of this arbitrary end of December cutoff.

PDBR is always ignoring VA ratings. I've got people for PTSD that they will admit they should have been 50 percent for six months. The VA never rated them less than 30 percent in one case, 50 in another, and 70 in another, and they said sorry, they must be doing it wrong. We're giving them 10 percent and separating them. And that's the same problem that costs us in the beginning. It was a dichotomy between how the VA was rating and how DoD was rating it, and that same problem is existing in some of the cases I'm seeing. Done a lot of g but there's a lot of ones that hurt your head. Now, the Navy is ignoring PDBR recommendations. They're saying this guy should have been 30 percent retired and they're saying now we don't -- we disagree, we're going to keep him at 10 percent, and they're using their old non-VASR D criteria to make their case. And those are written about in those DES Outrages, particularly 15 for that issue.

Then they have the gall not to tell the member that the PDBR did say they should be retired, then the Navy turned it down. They just send them a letter saying, the

outcome of the process is you get retirement for six months and then separated. It's absolutely atrocious.

We had the DoD folks come here. They have been good to me. You know, they read my e-mails and respond to them, but basically my position is, all they do is tell the services they ought to be doing things better and nobody is putting a boot where it needs to be put to make sure that they're falling well-established and long ago established DES laws and regulations and policies. And quite frankly, the DODS standards are quite good, they're just not being followed. And you know, you'll see that theme continuously in my DES Outrages.

Paragraph three out of seven of the DoD director requires uniformity among the services, and we are nowhere close to that standard. We've got services driving the training, they're driving it in different directions. In fact, I gave a piece of paper this morning to Ms. Dailey. Congress has looked at the issue of a unified DES, and the House and DEA has a position for DoD to write a report ability the benefits of having a joint DES. And the reason they're asking that is because they're seeing disparity between the services and how they're implementing and acting on DES laws, regulations and policies.

Combat related -- I'm not going to go too much in detail. In DES -- I'm sorry. In Outrage 8, it's about eight pages of detail. I walk you through various scenarios of how these guys are not getting compensated right for their combat related, special compensation. Congress understand the problem, Congress and DoD got together and wrote, along with Military Officers Association, wrote a fix but it got tangled up in a bill of amendments that got killed by one poison pill and never regenerated. But it still goes on to date. People being denied proper CRSC payments because of the way DoD came up with the calculation methodology. Again, DoD will admit that's wrong, but they say Congress has got to change the wording before, to implement it. Meanwhile, our combat related guys are not getting their due.

Enhanced severance pay came out of the 2008. Again, as I spoke, people would have their severance pay offset by VA. Congress said okay, but if it occurred in a combat zone, we're not going to do that.

Now, the problem is the combat zone. If I hurt my knee playing basketball on the Green Zone Gym, my severance pay does not get offset, I get to keep my career compensation. But if I hurt my knee in an airborne jump at Benning, I do not because it's not a combat zone. Somebody confused combat zone and combat related disability when they wrote this law and that's the impact of it. They both should be able to keep it. But the way it's now, it's just all kinds of screwy. This is kind of the nature of the patchwork methodology that we go through in DES law changes.

For over today, at least 1999, DoD had the same standard as the VA. That if you were to say something was ETPS, Existing Prior To Service. You had to show clear and unmistakable evidence that it was existed prior to service and that it was not, clear and unmistakable it was not aggravated by service. The DES was used on much lower presumption. Our preponderance of the evidence standard, and a lot of people are being tossed off by ETPS, without any justification whatsoever. 2009 Congress changed the law and said DoD follows the same standard as the VA. VA follows their Court standard, which says it has to be undebatable. DoD has slipped back to their, well if we can find any hook based on the medical principle, even though there might be 12 things against it and one thing for it, if we find one thing for it we can say it's preexisting, and that's our clear and unmistakable evidence, even though there's more evidence on the other side, as opposed to the VA standard that must be undebatable.

Also, the IDES DTM says that DoD can ignore VA service connection calls. So if the VA says it's service connected it, DoD can say we think it's ETPS and not rate it.

TDRL issues. TDRL is a burden, one of the problems is, if you're on TDRL if your rating is not stable for, or your condition is not stable for rating purposes. There is some

probability that it could get worse or better over a five years period. That's the case, we're supposed to put you on the TDRL. The hook in there is that if the rate never falls below 30 percent on a TDRL evaluation, they can eliminate you right then and there, regardless if they know that it's going to get worse. And cancer is like that. You might be in cancer 100 percent, go into remission, oh, you're out, you're in remission, then it kills you. And you lose your disability retirement as soon as it drops below 30, they cut you off. Congress tried to write a law on this one too, the Senate killed it. This is back before Walter Reed broke. It needs to be regenerated. Same thing happens on the initial PEB. That if I have cancer or some kind of condition that is going to kill me or get much worse but currently rated at 20 percent, they kick me off right there and don't have to worry about the fact that it's not stable. Stability only applies to conditions that rate over 30 percent to begin with. Another quirk on the law.

MS. DAILEY: And Mr. Parker, is there something you'd like to wrap up with?

MR. PARKER: I'll just conclude. Obviously, I did not get through all my slides. I hope I did a good job of getting the major bullets in there and tagging them to the DES Outrages that I wrote. Again, I would wrap up by saying, let's make sure before we worry about the timeliness of the IDES, we worry about the quality. That all laws and regulations are being followed. Because nobody, as General Schoomaker said, is in a hurry for a bad decision. Thank you.

MS. DAILEY: Thank you. And who's my American Legion rep? Mr. --

MR. BUCKLER: Brian Buckler.

MS. DAILEY: Hi, Mr. Buckler. Mr. Buckler you have a very good briefing in here on the PEB Program 101, and I'm hoping that you'll be able to just cut right to what do you think are the concerns with this medical evaluation board and physical evaluation board, versus taking us through it step by step.

MR. BUCKLER: Correct. First off, the American Legion provides three service officers to assist service members in their PEB and interview process. We have one at Walter Reed, one at Sam Houston in Texas, and I am at Joint Base Lewis-McChord . And whenever I mention Ft. Lewis, I just love the faces I get. These are the regulations we study and go by, and I want to make more of my briefing about what I'm seeing on the ground and some of the complaints and issues we're getting. And what we're also seeing is that when you're appealing an MEB, it's really easy to bring up these regulations as to why something should be found unfit. But then you get these funny WTU consolidated notes from the Army side of the house, saying we, because of that, that's supposed to override what's in the 4501. And to me, they look like PDFs that were ripped up in a day just to find a bunch of people fit for duty.

MS. DAILEY: Just for -- this is an excellent briefing, and I've been through it. It's very good as a kind of a primer, and I'm going to keep it as a primer. So that's why we've got some gaps. I've thrown him off his game here by asking him to kind of talk to us about issues.

MR. BUCKLER: I have an issue for each slide. I know each slide is going to look like an information but trust me there's an issue for a slide that I stop on. While the change through the system mentioned the VA as kind of being at the forefront of the MEB policy. The truth is, they're more in the backseat. It's administratively still run by the DoD. And the VA does the QTC appointments to make recommendations for what diagnoses should be added to the NARSUM cover page at the end of the MEB, however it usually just looks like a bunch of fluff and fit conditions put on the front cover. There's actually an issue I have with a client right now that went through a sexual assault getting unfit for depressive disorder, according to the Army. Went to the VA side of the QTC, and it's got pull PTSD based on the repercussions of the sexual assault. And our argument was, well, this is the one thing you're going to find them unfit for, can it be a PTSD since PTSD textbook definition is life or death

situation, which I'm sure we would all say a sexual assault is. Army said no, it's still depression, and he got out with I think just 30 percent.

When the results of the board come out, they have two -- everyone knows they have two opportunities to appeal. One for the MEB appeal NARSUM, and then they go to a formal PEB hearing to argue with members once more. And the results of the board are really still a DoD effort, as far as what's unfit and what's being considered and what's being truly looked at. And a lot of the times, the Army will -- and I'm only speaking for the Army because I work at Joint Base McChord. I honestly have no issues with the McChord Air Force Base. All of these issues are coming from complaints I have from the Joint Base-Lewis McChord side of the house.

And with the Army sticking to their guns on what the end result is, we're seeing a lot of somatoform disorder diagnosis, a lot of stuff that just kind of placed in there when they can't really realize what it is that's bothering the service member, especially if it makes up five to six compensatable conditions. To harken back on the PTSD issues of the MEB, another client, breast cancer survivor, was diagnosed with PTSD actually by the DoD in her AHLTA notes. Due to her intense chemo, you get a bunch of appointments to go to and she misses out on her actual QTC VA PTSD appointment. But the Army already had her as PTSD. However, when the appeals time came and we argued a couple of things, she had more anxiety disorder diagnosis and adjustment disorder diagnosis, so the Army's answer was, well, you got more of those, we're just sticking you with adjustment disorder, and was found fit for duty.

And this is just a quick reminder that 27 percent is just severance pay. We're still seeing a lot of severance pay. I know that IDES original claim was to try to cut down a lot of the ripping off and being cheap with the schemes, but to tell you the truth, it's still a lot of severance pay out there. And I just want to harken on some views that are being seen on the ground level when it comes to Joint Base Lewis-McChord's WPD. The CTP plan that was

mentioned earlier by our AW2 presenters, it's on ACS, it's online, but for the patients, the soldiers, it's nothing more than a piece of paper they put in their pocket, and they write this piece of paper out. And it's what do you plan to do with your life? What are your issues you need to focus on? Oh, and if they don't have that piece of paper on them, they get counseled.

And of course, like the VA system that none of the DES programs have really been properly updated since 1946. And any questions?

DR. GUICE: I don't see any right now. We'll, have to ask you to go ahead and take your seat back at the table and then I'm sure there might be some questions for the panel as a whole once we're completed.

MR. BUCKLER: Thank you.

DR. GUICE: All right. Ms. Horan, are you next?

MS. HORAN: YES. Hello. My name is Patty Horan. And I'd like to thank you for asking me to be part of this panel today. I am the wife and caregiver of an army captain who suffered a gunshot wound to the head while suffering in Iraq. My husband and I have been in the DoD medical system for the past four years, with the first year and a half spent in the private sector. He'll be transitioning out this fall and we have been assigned to the Ft. Lewis WTB as well as Walter Reed.

During our time in the system, lots of progress has been made. But I think there's a ways to go and today I'd like to highlight four areas I feel could use improvement. Number one, traumatic brain injury rehabilitation and transition leadership; number two, nonmedical attended orders; number three, life at the WTB; and number four, sustaining the caregivers for the long haul. But first, I'd like to introduce you to my husband, Pat. He is unable to make it here today, but I'd like to show you a few pictures of him so that you can understand the extent of his injuries.

This is pre-injury. One of Pat's doctors summed it up perfectly. Pat's injury is not just physical weakness on the right side of his body. It's also the loss of his ability to problem solve; adapt to a changing environment; to independently take public transportation, let alone drive; to prepare meals; to shop; and to manage his own personal affairs.

So you can see as a caregiver, I have many roles. I am his chauffeur, his cook, his personal shopper, his case manager, his secretary, his social activities coordinator, his therapist, his advocate, his nurse, his navigator, his legal aide, and his job coach. I am his eyes, his ears, his voice, and on really good days, I am his wife. Recovering from traumatic brain injury takes time and support of a small army of professionals. Pat has wonderful therapists at Walter Reed and excellent doctors. But what we are missing is someone who is leading the fight. So it becomes my responsibility to keep Pat's recovery, his transition and vocational training moving forward in the right direction. We have two case managers, one federal recovery coordinator, a primary care physician, two neurologists, three occupational therapists, a physical therapist, a speech pathologist, a special ed teacher, an AW2 rep, an ASAF professional, vision therapist, vision rehab -- rehab aide. We have assistant technologists, and not to mention all the folks at WTB, Pat's internship and medical board. But what we don't have is a person at the helm. Do you know, until this year none of these people ever talked to each other? It wasn't until I insisted on a transition plan for my husband did we start having monthly meetings. I lead those meetings with the help of the FRC. But still, things fall through the cracks. For example, next week Pat's vision therapy expires and not a soul is tracking it. In the private sector, we had a physiatrist specializing in traumatic brain injury, along with a neuropsychologist plotting the course for Pat. Every traumatic brain injury is unique, and creating a road map for treatment, community reentry, and vocation is essential but it should not fall -- it should not fall solely on the shoulders of the caregivers. We hope someday that the NICO will this gap. But now, right now, Pat is not eligible to take part in that program. He is too severely injured. Some medical

professionals should have a global view of Pat's functional ability and be able to formulate a plan to ensure his successful transition.

Okay, moving on to number two. Nonmedical attended orders. I was on orders for the first two years of pat's recovery. But once we PTPTS'd to Walter Reed and he became an outpatient, I was no longer eligible. Because we live within 50 miles of the military treatment facility. I know in the past this program has been misused in the Army, and we've really had to crack down. But I would like to make a few points to why I believe that seriously injured soldiers should be allowed NMA no matter where they live. Number one, in many cases, the caregivers give up everything -- their career, their education -- to help their service member heal. Number two, my husband needs an NMA, but he cannot have one officially, so the WTB is not as willing to work with me. And it sends an erroneous message that my husband is able to make his own decisions, sign and read documents, and follow through on tasks. Number three, I am no longer on NMA list as Walter Reed so I do not get any information about caregiver meetings, resources, or anything that could help me or my family. And last, I'm no longer eligible for respite in the DoD system. Before, Pat's mom, the Army would fly Pat's mom in, and I could take a week off here and there, but I do not have that luxury anymore.

Number three. Life at the WTB. As a caregiver, working with the Warrior Transition Unit Brigade has been a real challenge. To me, the Warrior Transition Unit Brigade has become a standardized system that my husband has a very hard time being successful in. In 2006, there was no accountability and people were falling through the cracks all over the place. Now, many years later, the leadership in cadre run it as if it's a line unit, a healthy line unit, requiring injured soldiers to jump through hoops that they can no longer jump through.

The reason being that we have combat arms taking care of our most serious injured. Not the most compassionate group, and I can say that, because my husband is one of them. This form of leadership in a hospital healing environment causes distractions from healing

as well as undue stress for wounded and their families. And ultimately, what it does is it leads to the mistreatment and alienation of our more seriously injured. Where is the middle ground?

The Warrior Transition Brigade has the ability to make such an impact on these soldiers' lives that they have lost the respect and trust of many of us in the wounded community, and it's not a place I go to for help or support.

Solutions. Number One: To take a higher look at the cadre and am the commanders chosen for the WTB. The Army should find a way to make this a prestigious assignment to serve at Walter Reed Or BAMC.

Number two: Traumatic brain injury and PTSD training and needed, and I would suggest you have cadre that specialize in these areas so that they can better support soldiers like Pat. And also I'd like to take one minute to talk about the WTB Work and Education Program and Operation Warfighter. This program is still very new. It's an excellent idea. Again, it could make a world of difference for these wounded warriors, but it has a very difficult time supporting the population that can't get out and hit the ground running. Ways to improve: Hire HR professionals to go out and find organizations willing to take the seriously injured wounded interns. Establish job descriptions and mentors within the organizations. Number two, keep the OTs to do scale and interest assessments and to consult with the HR recruiters. Number three, hire some seasoned vocational specialists. The current staff are all new graduates and they just don't have the expertise to work with my husband. And four, create a database a network of vocational supports. Walter Reed should be in close contact with DoD voc rehab. They should get soldiers in early, reach out to organizations that put people with disabilities back to work, find job coaches, and present the appropriate assistive technology. Number four, sustaining caregivers for the long haul is vital to injured service members. The VA Caregiver Bill is a great start to caring for those family members who are on the job 24/7. Last week, I got a call from a good friend and fellow caregiver who was about to hit the

four-year mark. Because of her husband's traumatic brain injury, he needs 24-hour supervision. On top of that, they have a three year old who is also demanding of her time. Her call to me last week was a call to help. She said, Patty, I just can't live like this anymore. This chilled me to the bone, because she is one of the strongest, most put together young women that I know. And if she's not making it, nobody is. Best case, what will happen to the soldier if she leaves? The soldier does not have a lot of family support. So best case scenario, he will go to a nursing home for the rest of his life. Worse case, he will become homeless, incarcerated, or maybe killed.

So how can the military better have supported this family who is now in crisis? Number one, which I'm going to talk about, again is transition. WTB and voc rehab, could do a better job helping these service members finding purpose. Many of them are capable of doing something, and the something could get the injured soldier out of the house and give the caregiver a much needed break and time to pursue their own goals.

Number two, marriage counseling, support groups, and mentors should be strongly encouraged for this population. It is very hard to adapt to the new roles, and these roles evolve and change over the course of recovery.

Number three, somehow caregivers must be forced to take breaks and have secondary caregiver vetted and available to them. Too much togetherness in a marriage is a recipe for disaster. In some cases, to save a marriage the wife should have the option to give up caregiving for a period of time and bring in a professional. Today, I hope I shined some light on the needs of wounded warriors with traumatic brain injury and their caregivers. Leadership, long-term NMA orders, finding a middle ground at the WTB, extra support for work and education, and coping tools for caregivers will greatly improve to the overall recovery and transition. Please don't count us out. We have the ability to succeed and become productive members of society. It's time to bring us into the fold. Thank you.

MS. CROCKETT-JONES: Wait there, because I want to ask you some questions. The nurse case manager that -- you said your husband has two?

MS. HORAN: Yes.

MS. CROCKETT-JONES: Is one of them -- are they both medical case management? Is one a nurse case manager and one a different --

MR. REHBEIN: Primary care.

MS. CROCKETT-JONES: Primary care.

MS. HORAN: No. We have a nurse case manager that's kind of in our chain of command, that's WTB. And truly, she hasn't done a lot for us, so we go to our TBI case manager at the hospital, and that's who we do most of our work through because she gets the job done.

MS. CROCKETT-JONES: Have both of those been long term with the same person?

MS. HORAN: Yes, they have, actually.

MS. CROCKETT-JONES: If you needed information, is there a person or a place or resource you'd go to first for information?

MS. HORAN: I guess it depends what it is. If it's medical, I go probably first our TBI manager.

MS. CROCKETT-JONES: All right. What if it's issues like respite care, where are you looking?

MS. HORAN: I went to FRC first.

MS. CROCKETT-JONES: Have you used SVAC, have you used Military 1 source?

MS. HORAN: No.

MS. CROCKETT-JONES: Have you used the National Resource Directory?

MS. HORAN: I've used them a little bit.

MS. CROCKETT-JONES: Okay. When it comes to WTB cadre, has anyone done any proactive reach to you?

MS. HORAN: No. They don't even attend our monthly meetings where my husband is transitioned.

MS. CROCKETT-JONES: Has anyone tried to connect you to specific training or resources as a caregiver?

MS. HORAN: No.

MS. CROCKETT-JONES: Does the WTU have a family readiness officer position, outside of volunteer, paid?

MS. HORAN: Yes. They do but I'm not clear what the role is. I'm not clear. Because it seems like an activities director, bringing in celebrities and things like that. They're not really reaching out to us, having meetings, giving us resources or information.

MS. CROCKETT-JONES: What was the cutoff? Why are you no longer eligible for respite care?

MS. HORAN: Because my husband isn't an outpatient and we PTS'd to Walter Reed. So now it's our permanent duty station.

MS. CROCKETT-JONES: So it was an administrative change, not a medical acuity?

MS. HORAN: No. They don't, they don't...

MS. CROCKETT-JONES: Okay. I might have more questions later, but I'll defer and let someone else.

MR. CONSTANTINE: Patty, thanks. I have a few questions too. Thanks for coming and sharing that with us today. I'm just going to ask three questions, you're going to

answer them. What hoops does Pat have to jump through now? What is his internship? And how do things look as far as him getting a job down the line?

MS. HORAN: I guess I could, maybe it's too much information, but I did want to, I thought of something, because I thought this question might come up. As far as my husband -- it's a little personal, but we've got --

MR. CONSTANTINE: Just answer whatever comes, Patty. If you don't want to answer it, that's fine.

MS. HORAN: No. We've gotten a call like at six a.m. at our house in Bethesda and say you need to be in an hour for your analysis, and my husband has a severe traumatic brain injury. And the cadre, I try to explain to the cadre, my husband needs to have -- he needs to get up, it takes him a while to wake up, to have medicine, to eat. He can't just jump like he used to. And the answer always is, well, the Commander said so you have to be here. So that's kind of -- and then we did go in eventually, but then for my husband, too, he has some issues because of the brain injury, 4 hours, he missed a lot of his appointments that day for a urinalysis. So that's just one example of things that are difficult for my husband. And the other one is, we got him into an internship at Walter Reed. He's doing okay. He needs more support, possibly a job coach, voc rehab. We're going to try to -- but WTU doesn't have access to these resources for some reason. We're working with them but they just don't have any outreach or -- I'm not sure why.

MR. CONSTANTINE: And so have you talked with folks there about what -- I mean Pat's going to get an... at some point. So have you talked to them about what Pat can do for a job after this?

MS. HORAN: We're hoping this internship might work out. It's in medical contracting at Walter Reed with people who are very understanding, they're willing to give him a lot of support. And you know, they're part of DoD, so they get it. So we're hoping that that's

going to work out. But a lot of it is us communicating with the department. The WTB is kind of taken a step back and they're not that involved right now.

MR. CONSTANTINE: Okay. Thanks.

MASTER SERGEANT MACKENZIE: First of all, I just wanted to say, when you made the comment about your friend and how are we going to survive, you being here right now shows your strength. And I just want to commend you on that. But along the lines of the education is, is this just an internship you found at Walter Reed or have you attended any kind of conferences? Or has anybody brought you to any job searches or any of these kinds of things where your husband's true capability could be assessed across the spectrum of government agencies, versus hey, this is something we just fell into just because we happened to be at the hospital so we're trying to make this work because we think this is our only choice?

MS. HORAN: Yes, that's kind of what happened. I mean, there are some job fairs that come to Walter Reed. We originally -- I found my own internship for my husband because they originally told me he was too injured to even do that or participate. The WTB told me that. So we went out to Ft. McNair and we worked at the History Center, the library for a little while. Not a lot of support, Pat had some trouble there. And so we pulled back into Walter Reed and they suggested this internship for Pat, so...but no, he has not been out to really get a full skills assessment or been out to government agencies or anything like that.

MS. DAILEY: Let me just wrap here quickly, and then we'll talk with Staff Sergeant Lanier and then we'll come back.

STAFF SERGEANT LANIER: I'd like to say it's rather difficult to follow something like that. I honestly think when we're talking about warriors, we're talking about people. We need to keep that at the forefront of your minds. At the end of the day, yes I'm Staff Sergeant Lanier, I'm assigned to the Third Infantry Division Rock of the Marne. You want to do thunder runs into Baghdad? Check. Got you. You want to do the hard jobs? Every warrior

that's out there does the hard job. But at the end of the day I'm a husband, and I'm a father. And this will come off eventually, and that's how I think we have to look at it. And the past. Was an incredible example of that. If we ever lose focus as to the humanity of the warrior, we're wrong. That's my brief aside. Now I'll go into the formal portion.

I'm Staff Sergeant Lanier. I was actually medevac'd out of theater May 2009, through the wonderful flight from Baghdad to Balad, Balad to Landstuhl. 42 hours at Landstuhl, I was at Andrews Air Force Base and woke up and said, holy cow, I'm in the States and proceeded down to Ft. Gordon, Georgia, where I was assigned to the Warrior Transition Unit there. August of 2009 I had back surgery, and proceeded to go through the necessary steps and executing the triad of care and the paradigm that is currently established over WTUs in coordination with my nurse case manager, Ms. Mosely. I said, hey, listen, I want to get back to my house. I just came out of theatre, I want to go home to be able to heal. And in November I was able to make it back out to Ft. Steward, and I returned to duty February of this year. I say all that to say this: I'm going through the MEB process as of last Friday. So the system itself works, but I think there are some severe caveats that we need to take a look at that identify the whole soldier concept, and I will be very honest with you. I have no skin in this politically. It is the reality for me as an adult and as a man.

It is difficult for me to hear the Warrior Transition Unit Command tell you that there are systems in place when I've been a part of that system and it is a failure. There is an automated CTP. That is a correct statement. It is a force function that I would use on my squad of privates to insure that they have all of their gear. I could self-recognize -- I'd like to think I'm self-actualized enough to say, you know what, as a man, I'm having some issues. Maybe I'm having some anger issues. I know I'm having some depression and anxiety issues. Riding on the Metro this morning, you know, thank God they invented the iPod because I was able to kind of find my focus and make it here without wanting to go absolutely crazy. And I don't say that in

jest, but that's the reality. I've been deployed multiple times. I've seen things that really no human being should have a right to see; I've smelled things that no human being should have to smell. This doesn't make me better or worse than anyone else, but it's to say it has changed my focus on what reality is. And if you're going to give me a CTP to say hey, self-assess, tell us where you think you're at, and I am ethically honest with you, and say you know what, I am having anger issues, I am having some depression issues, and it takes six weeks for me to go see behavioral health because there aren't enough providers on the ground? Ladies and gentlemen, that's reality on the ground. I'm from Ft. Stewart, Georgia. I made an appointment, and once again I'll be completely honest because I've got nothing to lose here. I went to behavioral health at the end of April. I said, I am having some issues. You know how I became of this? My wife told me. She said, Nick, the way you're acting at home is affecting our children. You really need to check yourself out. Please, get some help. And thank God I have a wife who's been married to me for 15 years and has tolerated the Army that long and knows me well enough to say hey, you know what, you do need to get some help. So I did that. It took me ten months to come to that point as a man to be able to make that decision. So I go in dutifully as a staff sergeant and I go to behavioral health and say, you know what? I need help. The answer was Sergeant, we'll see you in six weeks. My appointment is June 6th.

Ladies and gentlemen, that's reality on the ground. It's not that the paradigm is broken, it's that the paradigm does not have enough providers on the ground to ensure that warriors transition. I made it back return to duty because that was my sheer and singular focus. I wanted to be back with my guys. I had to leave my guys in theater. And I am a noncommissioned officer through and through. That ate me alive. My bobbas are a box of rocks, but they're my box of rocks. And I had to leave them. So my entire goal was to get back to those guys. That became what drove the train for me.

And when we talk about are soldiers able to be educated while they're in the Warrior Transition Unit, ladies and gentlemen, I would ask you what 19 year old who gets blown up by an IAD has had the opportunity to get an education? Are we establishing unrealistic expectations on what we think this system can and can not do? Are we being honest brokers when we discuss this with soldiers? My job is to bring that kid home. And I take that very seriously. And I joke with them all the time. I grew up on Ataris and 8 tracks. They grew up on cellphones and iPods. There's a cultural difference there, but I promise I'm going to bring them home. I'm going to show them the right way. Are we doing the same thing for our warriors that are in transition or are we trying to look for quantifiable data that makes a really good PowerPoint slide? Ladies and gentlemen, I'm not a number. I'm a soldier in the United States Army who's come to the Warrior Transition Unit. I'm going to go in with pride and I'm going to exit the service with pride. Not because I'm an outstanding human being or man, but it's to say that I've served my country with pride and with dignity, and I will leave the same way. What I ask of you, ladies and gentlemen, is to be honest brokers. I love the question and answer, when you're forcing people to hold accountability, because quite honestly, that's what needs to happen. In two different Warrior Transition Unit I was assigned to three different companies. There was one PCM. That is one provider for a company of soldiers. That is anywhere from 100 to 200 soldiers, one primary care manager. The difficulty at Ft. Gordon was I had to go into the family care clinic at Eisenhower Medical Center. So here's Sergeant Lanier having run the sprint in his deployment coming to a full stop, waking up in the states, and now I have to go gain care through my primary care manager at a public hospital. That's not a good balance. I regret to inform you. That's not the best place for this NCO in particular to go to. I love kids y love my own kids, but if someone else's kids are screaming and hollering and I'm coming back with what we know as post-deployment junk or whatever my box is full of, that is not a healthy place for me. And so I would ask you, is that going to tend for me to lean towards gaining help or am I

going to withdraw? I'm also mourning the loss of something that I am. I'm a soldier. And now all of a sudden I have no idea if I'm going to be a soldier because once you're in a WTU, there are two routes of exit: Congratulations, you return to duty; thanks for playing the game, here's the DES and here we go. That's reality on the ground, folks. That's reality on the ground. I think we need to step back sometimes, and while we can brief paradigm and we can brief, here's quantifiable data to show, you know, we're putting numbers to seats. Are we looking at the totality of the soldier or the airman or the Naval personnel or the Marine that comes in and how they come out?

Thank you very much for the time, it let me come TDY here to D.C., it's been great. I had dinner with my sister, so thank you, Denise. Have a wonderful day. Thank you.

DR. GUICE: Thank you, sir. All right. We have a few minutes to talk to the panelists as a whole, and the floor is open for questions.

MASTER SERGEANT MACKENZIE: On your comment there, Sergeant Lanier, you're ready to go through this DES system and you've been through the two different WTUs, and some of the briefing that we got today was based on this how we make education, and the opportunities for individuals getting out. You said you've got two courses of action and you're probably going -- you probably have a good assessment of where you're headed.

STAFF SERGEANT LANIER: That would be correct.

MASTER SERGEANT MACKENZIE: So how do you see fitting in that education? Do you see the opportunity to fit in that education? Do you see the ability to have an education manager and a trainer for that?

STAFF SERGEANT LANIER: I think you're really kind of dealing with two issues at that point. Number one, the Warrior Transition Unit's education system is tied into the Army education system, and that's a big hurdle. That's where we dealt with the issues of, can

a soldier take one or two courses in general education without having to have to go through a get a SOC agreement. Well, GoArmyEd.com says, no, you have to have a SOC agreement. So I think that's one hurdle we have to look at. The second one, I've been in for 12 years so I pretty much knew from the, you know, when I finally have a chance to go get my education, we're going to ride that train. I think if soldiers are going to use tuition assistance, there may need to be the development of, if you are in a WTU, you do not have to make that long term a plan. Or maybe we'll default to an associate's degree in general studies. But we need to build that in. Because the difficulty is there are too many other things going on for that soldier at that moment in time to be able to make any kind of coherent decision as to what the state of my future is going to be. The state of my future, at that point in the WTU, is home . And I'm an active duty soldier. I feel worse for my National Guard and Reserve brothers. I cannot imagine coming off of demobilization being caught up. Next thing I know, my Title 10 orders are continued, so everybody else gets to go home. I'm now stuck in a WTU that is probably not close to home, and I have to write Title 10 orders until medically they find that I'm okay, and then maybe I can go to community based WTU. We've built in stressors there without really addressing the system itself. So that's I think one of the -- there's so many factors that are going in there and I don't know if one singular answer, you know, is going to cover it all down. But I think we need to look at specifics and say if we're going to say that education is important, then it needs to be okay. Here's how you go about doing it, and let us help you get to that next level. Not a drill down or forced function that says, well you're at the WTU, you will do these things. Because once again, the tendency is going to be you're going to back off of that. Because now you're telling me how I have to take care of myself. And that's a bit of a gray area when you're there.

GENERAL GREEN: Staff Sergeant Lanier, just a quick question. So we talked a little bit at lunchtime. Where is your family now? Are you in the WTB Warrior Transition Unit up here at Walter Reed now?

STAFF SERGEANT LANIER: No, sir. I'm actually back in the Third Infantry Division. I returned to duty down at Ft. Stewart in February, that's where my wife and children are and have been, you know, we came off the deployment cycle so we're in that whole reset, ready trained phase of the R4GEN training cycle. God love the military. In coordination with my doctor, I have nerve damage in my foot stemming from my back surgery, and I have been injured for four years. So I'm 37. I can mentally acquiesce, okay, yeah, the old gray mare ain't what he used to be. So I'm rather comfortable with that, and then going into the MEB process that way. But my entire goal, sir, when I was in the WTU was get back to my guys. I didn't care what it took. That's where I wanted to be at, and I was able to achieve that.

GENERAL GREEN: So I guess my question now is about where you are now. So will you stay in the unit while they do your medical board?

STAFF SERGEANT LANIER: Yes, sir, I will. My understanding at this point is that there's one PEB officer for my entire brigade combat team of 3,520 soldiers, give or take. I have not been in it long enough to be able to give you a very firm answer of okay, here are the number of providers that I will see. I can tell you that I have seen off-post providers as well. So one of the concerns I immediately have is, how do I get HPPAA released to make sure that all of those pieces of paper are in the book that has become my medical record. I think some of that has to be personal responsibility of the soldier or the service member because I wouldn't ask anyone else to do that anyway. Having said that, though, that's an immediate concern is to make sure that whatever issues I may or may not have are fully diagnosed and that we're talking about them in honesty. You know, I don't believe any soldier goes into the DES. I would like to think that -- subdivision of the DES say how I am going to get over? Typically, it's how did I get here? And now what paperwork am I supposed to have? And those are two different questions. I think sometimes, in hearing the two other briefers, maybe there's a misunderstanding there. No soldier, I think by rights, and forgive me for just saying soldier, I am he. But I don't believe any

soldier goes in thinking, okay, I have X injury, how am I going to get over on the system. No. It's I have X injury, what am I going to do next? And I have six to nine months to figure out what that's going to be. That's a very short timeline. And I think that's another hurdle that we have to address, certainly inside the WTU but I would think across the service as a whole as well.

MR. REHBEIN: Sergeant, you're a fairly senior NCO with the skills and the aptitude that got you to that rank. What do you think we need to provide to the PFC that finds himself in that situation that maybe doesn't have quite the skills that you have? How do we help that person navigate the system that you're finding frankly difficult to navigate?

STAFF SERGEANT LANIER: I think, sir, the first step is upfront honesty. And that is to say that this is a long system, that there are some hurdles you're going to have to overcome, and it's not suggesting the soldier based on that. When I was -- let me back up a little bit sir, so that I can kind of qualify my point here. The difficulty when I was in the Warrior Transition Unit was not that the Warrior Transition Unit wasn't 100 percent. There's always going to be failures in systems. I think we mentally understand that. It's that I was treated at other. That is not a fun place to be. When I was at Ft. Gordon, everybody else in the United States Army gets to wear the beret. Regardless whether they like it or not, but the beret is the prescribed uniform of the United States Army. At the Warrior Transition Unit, you wore soft caps and PT belts. Now, that was one of those things, and as my buddies and I as NCOs, we literally went to the chain of command and said you're setting this up for a monumental level of failure because you've already separated these soldiers out and said, CAIT privates at Ft. Gordon who don't have any experience whatsoever, look at those guys, they're different than you. I can still lead a troop, broke or not. I promise you that. I may not be as fast as I used to be, but I can sit there and train soldiers until they come home in one piece. I take pride in that. For the young PFC, then, we need to do this: You are not other. You are still a warrior. We need to culturally change the way we address people one to one. Because I was wounded does not make be better

or worse. It just means in that situation I was wounded. I still live the warrior ethos, I still put on the uniform. I still do what I need to do. And if we can ingrain that in the young soldier, then at least there's more understanding as to what the process may take. But there needs to be value added. There needs to be an investment that that soldier feels like they're being invested in to move forward. You can't just make that, okay, here it is, go. Joe will listen. Joe is trained to listen. But when Joe has to look at the next step of the rest of my life, he is going to want some investment. He is going to want to know that somebody at some level has invested in him as a human being and says I want to make sure that you get to that next level and that you're okay. Is that a cadre issue? Perhaps. Is it a squad leader issue? Perhaps. Is it a nurse case manager issue? Perhaps. A PCM? Maybe. What we need to do is identify how do we go about getting those helping agencies to recognize that. This is a 19, 20-year-old kid. You know, really good at playing Call of Duty on the Xbox, can't tie his shoes, 19, 20-year-old kid. You know, I joke, he's a box of rocks. But he's my box of rocks. That's how we need to look at these warriors: They're ours. That's who they are. So we have to do right by them. And we will break the code on this. And no amount of DoD CFRs, there are rules that make up rules to other rules that shift the paradigm, they're still my guys. And I think we need to own that and be honest about that and not hide behind anything except to say we owe this to you, let's make it right. And when you do that for yank young private, sir? That young private will go to the edge of the world for you. Twice.

DR. TURNER: Just to follow up on that a little bit. Now, you guys are both married, I think and have families, right?

STAFF SERGEANT LANIER: That's right.

DR. TURNER: Now, while you were inside navigating in the system, did you ever get the impression that it was more difficult or different for the single guys, the young single guys? Or was there anything that you thought they might have to face?

MR. BUCKLER: I'd like to answer that. At Lewis-McChord we have a vast majority of them are younger, less than ten years, single. And they just won't leave. And unfortunately, those are the ones you see hold up in their rooms, trying to stay out of sight. The resources are there but when I would you want to -- but cadre is walking around, the whole command is walking around, why be visible if they're just going to tell you what to do to go to the next place? And that's what we see over there. The ones that are married, the ones that have families, a husband, wife is the caretaker, they're active, they're out there. They see me, then they see... and then they'll go see someone down at the SVAC. Those are the ones that are more active. But the single ones or the ones that just have boyfriend and girlfriends, they want to be invisible.

COMMAND SERGEANT MAJOR DEJONG: I think a lot of you guys have just to reinforce, a lot of things that we've heard, while I'm new to the Task Force but I've heard it throughout. I was in a Warrior Transition Unit twice throughout my career. And ma'am, you know, thank you for your statement and what you gave. And you are exactly correct when you talk about cadre. It is not a normal every day staff sergeant of the army job. It takes a special individual and a lot of training. And that has been recognized, and I just wanted to tell you that you guys have done nothing but reinforce that to a lot of us on the panel that have talked that before. So thank you.

GENERAL STONE: I wonder if I could make a couple comments. First of all, we've entitled this section counterpoint. And I submit to you that we've mistitled that, because you are the point. You are the reason that we all exist here. And I'm especially respectful of the power in which you bring your stories and the continued struggles that you have. I wish I could tell you that in our discussions as we've gone to the field and made our visits, that your stories were unique. And we have been every place, hearing the exact same stories that you have gotten. I continue to struggle on what the right model is, though. We have

heard some argue that keeping soldiers for as long as you can with the line allows a sense of recovery. We even heard it this morning. We've heard others say that, especially in the Marine Corps when you're out at 29 Palms say that the line commanders overriding physicians orders to move to Warrior Transition Battalions is a disservice. I wonder if any one of you could come back to that concept of whether you think we can choose one model over another, or if it has to be individualized completely.

MR. PARKER: Let me take a stab at that. One of the issues I saw in the WTU, you've got this friction because line commanders are trying to go to war. And when you have somebody that goes through the DES who's non-deployable, you're going to war under strength. And there's a lot of pressure and bad juju put on that person to get out, except at IPEB, because I need to get a replacement for you. And that WTU ought to be for those who can't do anything for a unit. If I was in that situation, I'd like to be back in that unit. If I do nothing more than answer the phone, help run the rangers, what else, so that the guys that are deployable can train for the fight at 100 percent strength. My recommendation is that whenever you have somebody go through the IDES system, you allow that person to be double bulleted in that unit. So they can stay in the unit and receive, you know, that camaraderie and be part of the fight, and yet he's got a replacement there that's actually going to keep that unit 100 percent strength. I've seen too many cases where soldiers have been told, except the IPEB, don't you dare challenge it because you'll be here. If you don't, we'll find another reason to get rid of you. And that's why, when you see Mr. Cook who was here yesterday talk about the WTUs being dumping grounds by commanders, because if they keep them, they're going to war under strength and you're going to end up with more people in the WTU.

MS. HORAN: I guess as far as models, it is difficult because I think some of them are a dumping ground to the WTU. So then there's over at Ft. Lewis, they just couldn't even fathom the extent of my husband's injury. And mostly they dealt with maybe commanders

who had guys they wanted to get rid of, and they just dumped them, and all the troublemakers end up in the WTUs. I don't know what the solution is but there needs to be a separation from those who are very seriously injured. And also, a behavioral separation. They started it at Walter Reed where, I don't know what happened but they through it out the window. If you go to all your appointments and you do what you're supposed to do and working with everybody, you're green and everybody kind of leaves you alone. And then there's yellow and red for discipline, pretty much. There's different categories. I don't know.

MR. BUCKLER: I can attest that most of the sentiment, when it comes to appointments of medical purposes, the VA QTC appointments, they bend you, they move you, they look at you, they talk to you. But when it comes to DoD forensic psych, it feels like malingering hunters just trying to find the bad ones that shouldn't be there. And I think that purpose overlooks what should be looked at, which is the medical care. But since the DoD side looks like a team of people trying to round up malingerers, that gets lost.

STAFF SERGEANT LANIER: And sir, to answer your question about the model, I think the model itself is not, is not really the issue. You need command structure. I mean, there's no doubting that you need to have controls in some aspect. The question would become are we putting the wrong emphasis on things as a measure of that control? All right. Once again, if I have a squad leader and that squad leader and I are at the same rank, or he's asking me when my appointments are, he produced this sheet so that I can say, whoa, now we're starting to cross the line here. Here's how it should work. Just like any other Army unit. I've got one formation in the morning, I've got one in the evening. You're all adults here. Now, if you don't do the right thing -- much like I tell my young privates -- if you want to be treated like an adult, act like an adult. If you begin to act like young privates that can't make a decision, you've pretty much forced my hand. But there needs to be accountability on both sides of this issue. I'm accountable for my care. I need to make sure that I am doing what I need to do to make sure

I take care of myself and I heal. But that chain of command also has to be accountable to is, you know, are we making sure these systems are in place for this soldier to receive that care. It's when it becomes, well, you know, you didn't make your appointment here, here, and here, okay now we're going to do is have four formations a day and we're going to keep that until 2400.

And once again, I grew up on the line. I get it. I've had some pain in my life based on really bad decisions made by young Private Lanier. I understand that executable factor. We're dealing with soldiers who are wounded and either seen or unseen, so we use the same paradigm of chain of command, but we need to look at what are the focuses that that chain of command is putting on. If the triad of care once a week is having to brief stats, you've turned that care into a quantifiable number that goes on a PowerPoint slide and it has nothing to do with the wellness of that soldier. It has to do with has he checked the block on CTP? Has he checked the block, you know, with SVAC? Oh, this guy is going to be chaptered out, looks like we're going to have to send in some ACAP. ACAP is wonderful if you're fully healthy and leaving active duty. If you are being medically disabled -- if you are medically disabled and being medically retired, ACAP is nothing for you other than to say you've checked the block and you're going through the Army Career Alumni Program, good job, huah. We need to be, like I said, honest brokers about what is it that wounded warriors need. If that means we need to grow out of some of the systems that we be and make them specific, yes let's do it. But let's insure that these soldiers can transition, and do so with honor and not limp out. Because I doubt anyone at this table or any warrior that has to transition out of the service wants to walk with their head down and say, well that kind of bit. No. I want to walk out with my head held high, saying I gave my all for something I believed in when I volunteered and they took care of me from the time I hit the Warrior Transition Unit till the time I sat there and walked off the gate for the last time and got the blue ID card.

MR. PARKER: I would like to add that if you really want to streamline the ideas, the number one thing you can do is do it right the first time. I am the chief culprit when I

get PEB forum postings that say hey, I just got my PEB results, I got 10 percent for this, but they didn't cover this that and the other thing which I told them about but they said no, you go to the VA for that. That story gets told over and over again. And when I've got the contacts where I call to the Army Navy and air force, you guys, you're supposed to cover everything, you know T. Okay, we'll send it back. And back they go through the MEB process again to cover all those conditions that should have been covered the first time. Now, Mr. Cook has written several times that these people are in the WTUs gaining the system. And gaining the system is demanding that laws, regulations and policies are followed, then label me the chief game master, because that's what I do. I tell these folks, here's what you need to do in your MEB. The best posting I get is the guy saying I just got told I'm going to have a MEB. Because then I can steer them, educate them, and let them know. Yesterday we talked about the fact that these people have no idea up and down when it comes to the DES. When I get a posting from somebody that just says I'm in the DES or I'm going to a MEB, what should I know, golden. I can steer them in the right direction. They may not be treated right, but I set them up for a winnable court case should they get screwed over. When I get the one that says I just got my results and here are my results, oh, boy am I paddling hard. So again, if you want to streamline the IDES, enforce the rules and make sure it's done right the first time.

DR. PHILLIPS: That's one thing I wanted to mention, and you certainly have eluded to it, and Sergeant, you have as well. And I've heard this on many of the site visits. And I don't understand this at all. I mean, if you're wounded and injured and you're in a WTU, it seems to be a general consensus, not 100 percent that you're looked down upon. You don't get to where you were or whatever made me. And again, it's such a paradox in my mind that you should at least be held equal to if not higher esteem than line units and people who come back whole, because you've given above and beyond more. And one question I'd like you to comment on perhaps is, should we be looking at a mechanism or situation where you can be proud to be in

a WTU, you're recognized, there may be a special patch? I'm just making things out of the air but is that something that you feel is important?

STAFF SERGEANT LANIER: You know, I think a lot of it is an internal cultural issue, to be quite honest with you. I mean, I think we're still dealing with the force that we're going to war. And we say the warrior mentality, and you get enough soldiers together and we can re-create Sparta and Thermopylae. That's the way we think. The fact of the matter is that we as a military culture need to realize that no one goes to a WTU by choice. At the end of the day -- I did not raise my hand and say, you know, I like Iraq a lot but what I really want to do is go to the WTU. No, that didn't cross Sergeant Lanier's mind. But we need to understand that if these are units that are designed to heal soldiers, then we need to empower those units to be there to heal soldiers. Use the command and control that they have, but allow them to heal soldiers. And when you do that, then you can start talk across the board as to hey, yes, I'm in the Wounded Warrior Program or yes I'm part of the WTU, and that's okay. But when there's an overall feeling of hurting cats in the rain to make sure that they go through a town hall meeting at Ft. Gordon -- you know, the home of the Signal Corp, God love them -- and I grew up in grunt, I'm sorry. There's a massive disconnect between those two. I just want to go to my appointments, I want to do what I need to do, and I want to heal and move to the next level. So I think we can create a feeling of respect if we treat ones with respect. I think you get that when you talk back and forth to people.

DR. PHILLIPS: Again, I might add I was also alluding to the cadre and the caregivers and the staff who would want to compete to perhaps doing that at a certain point in their career, as opposed to saying well, I have nothing else to do. I'll do that.

MS. DAILEY: And ladies and gentlemen, we kind of need to wrap it up. Patty, why don't you close for us.

MR. REHBEIN: Can I ask a request?

MS. DAILEY: Sure.

MR. REHBEIN: Mr. Parker and Mr. Buckler, if you would, I think some basic demographics on who's coming to you for help, I don't think anything identifiable, but maybe a branch of service, enlisted, senior enlisted officer, male, female, and what kind of issue. MEB, PEB, I would find that interesting -- I'd find that information very useful more than interesting. Very useful, but I respect what Denise has to say about timing here, too.

MR. PARKER: That's a very easy one for me because 90 percent of the people I help come to me via PEB Forum. And there's a zillion of them there that I don't have time to help. I have to kind of pick the cases I think I can make the most hay with. But if you want to know what's going on with the user end, PEB Forum is where people go if they find about them, and obviously not everybody knows about it. But those who do find it are there because they perceive they're not being perceived correctly or things aren't going right. And you'll see a dialogue. That site was created by a JAG attorney who used to represent people at PEBs. He got so disgusted with what was going on, he resigned his commission and started PEB Forum so that he could educate people correctly and get it done right. So again, if you want to know my demographics, PEB Forum is the place you need to go.

COMMANDER HANDRIGAN: I guess the only thing I had to add was that I'm not sure exactly how the cadre is evaluated or reworded. It seems like that their performance is based on all these boxes being checked. And maybe you could take a look at how they're evaluated and what's important, because I'm at a loss at their mission. Their mission is to help -- and I just, I feel there's some other mission up there that I don't know what it is but it's not -- their primary mission is not to help us heal.

MR. BUCKLER: It's a numbers game. A lot of the civilian employees play a numbers game and they all compete, and if you don't have a good enough numbers, you'll get pressure from either the SVAC director, MWR director, but it is a numbers game and they look

at CTS and they want you to do CTS and they want you to keep count. So that's why I would attribute to that.

MS. DAILEY: Thank you very much. We'll take a 10 minute break? 5 minute break? 10 minute break.

(Whereupon there was a recess from 3:35 p.m. to 3:47 p.m.)

MS. DAILEY: Let's resume our activities.

GENERAL GREEN: Okay. Welcome back everybody. We are about to hear from Lt. Colonel Katryna Dreary -- Deary, I'm sorry.

LT. COLONEL DEARY: That's okay, sir.

GENERAL GREEN: Who is here representing Special Separation Command Care Coalition, whose material you'll find in Tab K. The Special Operation Command Care Coalition has a different model for service than the military's department models that you've seen in the previous meetings. And so the Care Coalition liaisons assist special operators from all services and works with the individual service programs. VA hospitals and the Federal Recovery Care Coordinators to facilitate the care of the Special Operators. It's a good model to look at for best practices, and next year is an opportunity for us to talk to special operators to gain individual service members feedback on their experience in their recovery programs. And so over to you, Lt. Colonel Deary.

LT. COLONEL DEARY: Yes, sir. Good afternoon. My name is Katryna Deary, like he said, and I am the Deputy Director of Operations for the Care Coalition Program. Here's our agenda. We're going to go over several things. How many of you are familiar with the Care Coalition, besides Mac, who works with us. Okay, we originally had a different brief to try and answer the questions that we thought you wanted to hear, but I figured we would give you the overall brief so that you can understand exactly what we do in the Care Coalition. Our

mission is to provide special operations warriors and their families a model advocacy program in order to enhance their quality of life and to strengthen special operations headiness. We were established in 2005, when then SOCOM commander general brown said that we need today focus and make sure that we were taking care of special operations and their families to insure that they were fit for the fight. Our model, we focused on the mission. What we do is, we work to return as many wounded, ill, or injured to duty as quickly as possible, insuring they're operationally fit and mentally prepared. And as of the 4th of April, 2011, our return to duty rate is 84 percent. Let me give you some numbers. We have currently 4,258 that we have in our tracker. 84 percent returned to duty. In the last 12 months in combat, we've had 581 injuries, and 67 percent in the last 12 months have been returned to duty. We want to insure family security, safety and wellbeing are critical to the mission's success. If our operators go down range and they understand that we're taking care of their foams, they're going to be able to focus more on the fight. We accomplish our mission by, through, and with other organizations, be it governmental or nongovernmental, to insure that we provide the best service to our forces. And Mac, if I say something that you want to elaborate on, please jump in.

This is what the previous speaker, Patty, was talking about. On the right-hand side you have the casualty, the family and unit, and on the left you have everyone that they may be involved with when they are in the hospital, be it if they're wounded down range, if they're in a car accident here in CONUS, or if they are diagnosed with cancer. These are all the different folks that are, that bombard them and try to give them information and help them. And they're all great entities that work very well to support them, but what we do, we're the line right, the Care Coalition. We service the liaison or the conduit of information. So she said that they didn't really have anyone at the helm? We try to serve as the helm to get everyone the care that they need but not overwhelm them.

This is our structure. We are currently without our director. Our previous director retired about two weeks ago, and they're in the process of hopefully getting someone soon. I am The Deputy Director of Operations, and with that I'm responsible for all liaison activities, our Care Coalition Recovery Program, our advocates, our VA LNO that we have that works in our office side by side with our folks. We have on AW2 LNO. We're supposed to have a Navy Safe Harbor, we just currently don't have that filled. And then our military family life consultant.

LT. COLONEL KEANE: Ma'am, I have a quick question.

LT. COLONEL DEARY: Yes, sir.

LT. COLONEL KEANE: You don't have a Marine Corps Regiment LNO?

LT. COLONEL DEARY: We currently do not, but about 10 minutes ago I got an e-mail that Marine Corps is working to fill that and we may have someone identified.

LT. COLONEL KEANE: Thank you.

LT. COLONEL DEARY: We do have folks that are working hand in hand with the Marines at Lejeune and, where's the other one? Pendleton, yes, yes.

MASTER SERGEANT MACKENZIE: We're filling the positions right now with embedded LNOs and then, because of the youngness of Marine Special Operations, they themselves have created a position to assist us and that cross back and forth between the Special Ops community in the Marine Corps and us, so we have subject matter experts to call back on when we need specific Marine Corps type questions and answers. That's soon going to morph over into, we'll have that LNO. But this is just -- you have to understand that MARSOC has only been here since 2007. So we're still building that structure.

LT. COLONEL DEARY: We do have two hybrids, one at Camp Lejeune -- by hybrid I mean a liaison/advocate, they function in both lanes, as well as at Camp Pendleton. We're working to get another person to assist over at Camp Pendleton, just due to the geographic

range that one guy has to support. We also have commander Pam Huey as our Deputy Director of Policy and Programs, which covers what you see up there, policy, legislation, casual record, plans and our wellness community outreach.

I'm going to go through each of our different sections and how they do what they do, and break it down a little bit. We have liaisons that are regionally based for in and out patients. We have our advocates who are our folks that focus on return to duty. Our retirees and those who are separated. We have our recovery advocates, which is our Care Coalition Recovery Program, and they focus on the most critically injured soldiers and family members for mentorship, wellness and reintegration, and they're our support personnel, which is our casualty tracker, IT folks, and then again our policy folks.

This is where we currently have folks located liaison, but there's one more place that we added, actually one month ago, and that is Bagram Airfield downrange in Afghanistan. We took our lead advocate, Captain Dawn Paul, who's been with the Care Coalition since the day it began and we sent her downrange for one month to pave the way for the folks that we're trying to get. We're currently working with the special operations community to have three liaisons sent downrange. We have one at Bagram; somewhere either Iraq or Kuwait, depending on whether medevac platform is going to be; and most likely Kandahar, since we're seeing a lot more coming out of theater there.

Captain Paul spent the last 30 days there. She actually arrived back today. When she left, we put another person in there for six months who is also an advocate, and we are extremely surprised at the overwhelming welcome that we received from the commanders. While Captain Paul was there, she was able to brief the theater command and several folks on the JOC floor, and they are very, very excited. She also has gone -- when she was there, she met every single patient that was in our lane that was going to be evac'd out of theater. She explained what we are, who we are, and what we do. And surprisingly, a lot of folks still don't know about

us, even when you would think they do. So again, we have one in, currently just one in Bagram. We have some Landstuhl, which is our initial platform, entry platform into the system. And then in most of the regions where a service member will get some care, covering the special operations areas. Any questions about that?

This is our liaison structure. As you can see, we have Army, Navy, Air Force, there's no Marine yet. We have just civilians and we have civilians contract. We rely for our liaison folks, we rely very, very heavily on the units that we support. Half of our manning comes from ranger battalion, the special forces groups to provide us with quality people to go and do the mission. A lot of the folks that work with us have been previously injured and are in their almost recovered process and working with us to support us until they can return to duty. We have one of our guys that has been an LNO at Bragg, he was the third group guy that was injured very severely, and has recovered very, very well, and is going to be leaving us unfortunately to -- no, fortunately for him too, back and take a team. So we were just a stepping stone for him to get back to operationally fit. And by the way, he did a wonderful job as a liaison for us because he gets it. He's been there.

MASTER SERGEANT MACKENZIE: I'm going to touch on some of this stuff. If you notice as you look at the slide, there's, except for three or four particular cases, the liaisons are all enlisted operators. From the chief of the liaison, going all the way down. The reason this construct was set up was because the credibility of a liaison walking in the door at the most critical time. This is an individual that can move and shake and think outside the box, has led a team or in operations that has that credibility. I don't have to understand where this person is coming from, I don't have to understand what this unit is. I already know. The family can look at you and say, oh, you were an operator, even me being a helicopter guy. That bond is already created at that moment. And also, the preponderance of our wounded are also enlisted.

So we've created this liaison to hub around those key points so that we're able to get right to work, we're able to get right to the heart of the problem and address these issues right away.

LT. COLONEL DEARY: The majority that you see, the names, have been injured. Actually, our chief of liaisons is actually an amputee that has a stability dog that he brings to work every day, who we love, Cocoa. This is Lance, our liaison support coordinator. Her husband was severely injured and actually works for us as well under a different, under policy and procedure. So these are folks that have been through it, understand it, and, you know, go in and, like Mac said, represent us well because the folks we're taking care of understand what's going on.

There are three categories of wounded, ill, or injured service members that we take care of. You're either going to be wounded, injured, or become ill and be evacuated out of theater through the MEDEVAC system. They're going to be wounded, injured, or ill, returned to duty and then redeployed normally. Or injured or ill, not in support of the Global War on Terror. An example of that is one weekend, unfortunately, we had nine service members that were involved in a hit and ran or an accident, and so in one weekend alone we got nine more people to take care of. And you know, car accidents, folks diagnosed with cancer, those are the ones that we take on that are not injured in combat. This is just kind of the flow through theater. I'll go over this very quickly. But we didn't notify --

GENERAL GREEN: Can I stop you just a second?

LT. COLONEL DEARY: Yes, sir.

GENERAL GREEN: So in your categories, your first second and third categories, I see that there's no one there in terms of people who have had to be separated. So do you track for any length of time those who have to go through an MEP?

LT. COLONEL DEARY: Absolutely.

GENERAL GREEN: Which category does that fall into?

LT. COLONEL DEARY: A totally different one. This is the liaisons. This is generally the folks that are initially injured, wounded or injured. Advocacy follows full life through the separation process or our recovery program. For the severely wounded that will -- I'll talk about that in a minute.

We used to be notified by the CJSOTF Combined Joint Special Operations Task Force about casualties, and we're still notified that way. But also, with our person on the ground, it's kind of like a head start for us because we can start from the unit and have everything from the initial point of injury forward. Our liaisons receive the SM and possibly their escorts. We do have some folks that come out of theater that because of the nature of what they do, they come out with an escort. And so we treat them the same way. We, you know, take care of them, get them fixed for their flights, et cetera, back to the States. The liaisons will then contact the rear detachment of the unit and then share or inform them that we're tracking them also.

Upon arrival to Landstuhl, LRMC is Landstuhl Regional Medical Center, the liaisons will meet. They meet every single plane that has someone on it that we know about that's coming in. We get a status and update and we report forward as well as to the units. And again, we have our tracker which I'll talk about in a couple of slides further. It's a casualty tracker over a secret Internet site. And so especially now that we have folks in Bagram, from point of injury we're putting in, you know, what exactly happened so that the units either downrange or in the rear can see and follow and track the person's progress through the system.

Open communication is established between the liaisons and the receiving facilities when someone comes to Landstuhl, our folks are coordinating with the next point of entry, if it's going to be Walter Reed or for someone who's burned, /EUTSZ /R-R going to be BAMC. So they're already coordinating and letting them know time, et cetera, so that our liaisons can be there to meet them.

Again, you know, we just, we track their movement. When they land, in almost all cases a liaison will meet them, either at the plane, plane side, or in the emergency department. A lot of what our liaisons do is they work closely with the families before the soldier or SM has arrived in the States. When the family is notified that somebody is coming, we are already working to try and get invitational travel orders for the family members to meet them at the bedside to the facility that they're going to be located at. Sometimes we, we have a little bit of a gap because there have been times when the soldier is leaving Landstuhl and we think they're going to go to Walter Reed, but they end up being diverted and they go somewhere else. But we generally have the families within what, 24 hours or less. And if we can say for sure, like if they're severely burned and we know they're going to BAMC, we're working with the families to get them there even prior to their spouse arriving.

MASTER SERGEANT MACKENZIE: One of the things with that is this coordination prevents those vague, unknown areas. In other words, why aren't we assessing family member needs, dynamics of the family, what's going on, how we're moving these whole pieces. The idea is to put the family at the bedside of their loved one and have them not need anything at that initial moment. So you're already tracking this stuff, you're already moving forward, you're already figuring out what's going on, you're building, you know you're back stopping support coming out of the unit as well as the support that's available at that facility. The average family that say, for instance comes into Walter Reed, until they get their SVAC briefing they really don't know what's there. My guys already know what's there because I'm briefing them. I'm discussing that with them. Literally because of my connection with the liaisons downrange, I can literally describe how the guy is going to look when he comes through the door because I'm already talking with my guys downrange. That open communication between us is one of the things that makes us successful at that.

MS. CROCKET-JONES: I have a question about that. Do you get -- how do you get information about the families? Does that come from the unit itself? Do you ever -- isn't that a smooth process getting information about, is the family situation a stable one, things like that?

LT. COLONEL DEARY: Yes. We work hand in hand with the S1 personnel. We cannot do -- we don't speak directly to the families until they have been notified. So the J1 is the one notifying the unit. And they give us the information on their DD -- what's it called? Well I guess different service. Your DD-31, your emergency data sheet.

MASTER SERGEANT MACKENZIE: It's a DD-93.

LT. COLONEL DEARY: Okay. DD-93. This is, you know, these are the folks that will be contacted, this is where they are. Now, generally, and again, we're fortunate to have folks downrange because they know their people and they can say yeah, this person and his wife, they're separated and you know. There's all sorts of issues. That doesn't always happen, and we do have cases where it's kind of not very nice. But we do. We get the information from multiple sources because the way we get notified is we get the casualty reports but we also get the GO-1 reports, we get the unit reports. So we probably receive six to eight reports on any given day on any injury, injury or illness.

Okay. Follow-on for the liaisons. They make an assessment of the recovery plan and if the criteria is met, then they'll recommend the folks for the CCRP, which is our Care Coalition Recovery Program. This again is for our most severely injured. If someone's coming out of the theater and we know that they're, for example, a triple amputee or a spinal cord injury, you know, anywhere -- well, anywhere. And that they're going to take at least six months or longer, then they will simultaneously be enrolled in the CCRP. So at points, a soldier may have more than one Care Coalition person working with them. They may have a liaison in CCRP, and as they, you know, go in and out of the hospital to have a liaison when they're inpatient, they'll

have an advocate when they're outpatient. And we all work very, very closely together to insure they're getting what they need.

We report -- their inpatient report, we report on a daily basis. And this information is shared with obviously us and the Care Coalition, but we have different views, and I think there's a slide in there further down. We have different views that the units are authorized. You have the leadership view so the commanders can see X amount of information. Then you have to medical folks. Then you have the chaplains. You know, the chaplains have actually asked, hey, can we be put on your tracker so that we can see who's injured and where and what we can do. Everyone that does have access to our tracker is HPPAA certified, and we keep up with that. And we monitor and we-control what views they get.

When they no longer require extensive follow-up, they're transferred to the advocate section. We currently, as of today, we had 136 this morning in our tracker. But we were notified of seven more about 2 hours ago. So we're now up to 143. And there are 94 that are -- no. 37 that are inpatient and the rest are outpatient, but they are still followed by a liaison because many of them are folks that are at the MATC at Walter Reed. They may be outpatient but they're continuing to do daily therapy and have daily follow-ups. So our lazes are still interacting with them on a daily basis. When they are -- when they have, you know, advanced a little bit and they no longer require that extensive follow-up, then the advocates will take over.

This is, again, folks that are going to be returned to duty. We'll have someone that will get shrapnel or, you know, something that they're not going to have to be evac'd out of theater.

But what we do is we take them and we put them in our tracker because we never know, you know if they're going to have a long-term effect. And one of the big things with this is possible TBI. They're in this type of injury, you know this type of accident or whatever, and in the tracker it will say possible TBI so that we can track them in the future if

they have ongoing issues. Even if they weren't evacuated in the theater, we were made aware of it.

Again, they move back and forth between lanes, they're a liaison when they're inpatient or doing extensive follow-up. Then they may go out to advocacy. And then they may have to come in for a different procedure or if they're reinjured. We have some folks, not a lot, but some folks that have been injured more than once in different years. Like they're injured in 2005 so they're in our tracker, and then they're injured in 2009. So it's the same sheet of information, we just discuss the new injury. And so we track them that way.

Okay. This again is our folks that are injured or ill, not in support of the Global War on Terror. We get notification of this all sorts of ways. You know, our reports that we get on a daily basis, unit notification, if someone is in a car accident on leave somewhere and they're very severely injured, the unit will usually call us up and say hey, this is someone you that you need to start tracking, or word of mouth. We do have some folks who are going through something and they say, have you heard about the Care Coalition? No. Well, let me tell you about them. And then they contact us. And if they meet our criteria, then we take them on as well.

This is our advocacy section. Our advocates are most of them have been in some form of leadership position in the past. Senior leaders, like sergeant majors or full sergeants. We have masters prepared social workers. I'm a master's prepared registered nurse, I'm an ER nurse. And that's our group of advocacy.

And again, you can see we have Air Force, we have Navy, we've got the whole mix. Each wounded, ill, or injured is assigned a Care Coalition advocate. In 2009, they developed the charter that stated that our advocacy is going to be for life. And it's -- advocacy is provided regardless of the status. If they're return to duty or if they're retired or separated, we're still going to advocate for life because some folks may be, you know, injured and then transition

and go back to active duty, and then four years later develop some issues and then we're still tracking them. We're still engaged with them. The advocate will provide educational benefits related to healthcare, pain entitlements, medical and physical evaluation boards, transition assistance, and other government and non-government programs pertinent to the individual cases. And right here you can see, these are some of the things that our advocates do with our folks.

PAC entitlements. If you are injured in theater and you are medevac'd out of theater, you are entitled for a continuation of your specialty pay for, it's up to one year. And that is, for example, if you're downrange and you're receiving jump, pay demolition pay, whatever other pay you get downrange, you're entitled for up to one year. And we track that very closely. We have a very, very good working relationship with DFAS.

And we speak to them pretty much once we submit a PAC list. Our advocates go through and scrub it, make sure everyone has their profile and, you know, we make sure that if they are eligible, they are receiving the benefits. If they are no longer eligible then we take them off, because we don't want anything to happen to have an "no pay due."

In our office, we're fortunate. I actually worked for three years as a Tricare person at one of the facilities. And then one of our guys did years and years working with Tricare, so we still have some contacts in the community and we still have some of that institutional knowledge. So, you know, Tricare is a big, sticky thing, and we're fortunate that we kind of know how to navigate that. But that's what our advocates do. They also assist with Tricare when needed.

This is our Care Coalition Recovery Program. And you -- I don't know if you can see it. We have folks in the Southeast, Ft. Bragg, the West Coast, Tidewater Center, and the Midwest. And these are when we have, again, the severely wounded, ill, or injured service members or their families, they are enrolled in the Care Coalition Recovery Program. What they

do is they provide Hope Through Mentorship. We have several folks that are mentors. They have been, you know, previously injured. A lot of them, folks that are in a wheelchair or that are double amputee, or that have a traumatic brain injury, they, once they've recovered, either -- and either have separated from the military or remained on active duty, they become a mentor. And so when someone, you know, first arrives at Walter Reed and they're a triple amputee, if we have someone who's a mentor in our program who's a triple amputee, then them, they, and their spouse will go to the bedside and say, you know, look where we are now. And it's been a very, very successful program because, you know, it does. It gives them hope that although I'm injured right now catastrophically, you know, look at this person. They were injured four years ago but look where they are today.

Wellness activities focused on the individual interests. We have several organizations that work closely with us. If you, prior to injury were a scuba diver and now you have no legs, what we do is we try to work to connect folks to being able to do the activities that they were able to do or that they did prior to injury. So we will arrange wellness retreats, scuba diving trips, hunting. We don't arrange it, we hook them up with the folks that do that.

And then return to duty or civilian employment. We have several -- our CCRP advocates focus or work with a large number of companies that want wounded folks to work for them, and they advertise and they reach out and they say, you know, well, they're moving -- I think it's a rifle? Mac, what is it? The rifle company? Someone that makes some sort of gun, is moving to the Tampa area, and he contacted our CCRP folks and he said, I only want to hire wounded guys, you know, at this point, and so can you hook us up? And that's one of the ways that folks -- we have some work with the, some of the agencies here in the beltway. Like one of our gentleman that's a double amputee, he's doing an internship with the FBI. So the CCRP folks will try to get them hooked up with opportunities for after either they get out of the Army, Navy, Air Force or Marines.

MASTER SERGEANT MACKENZIE: A good portion of our CCRP folks are retired senior level operators. Obviously, by the nature of our business you understand the associations that we have across the board. Those associations and relationships are then capitalized on as to how we get these guys looked at. And these guys come to us going hey, you know -- because we used to work together, we used to fly together. It's whatever. You remember the guy you used to serve with and you went to war with and almost died with. You're running a business, you go hey, buddy, who do you got out there? Or I went to this Fortune 500 association, they're looking for people. A lot of it is word of mouth, which is why it's very, very hard to document, but it's that effective use of relationships providing that level where we get these picked up in men, many areas.

LT. COLONEL DEARY: This next slide is our MFLC slide. It's where we have our MFLCs. MFLC stands for Military Family Life Consults. And these folks became a part of our organization, Special Operations Organization, in 2008, when it was identified that a lot of Special Operations soldiers and their families go through a significant amount of stress, have a significant amount of issues related to frequent deployments and reintegration. And so the MFLC, they have a secret clearance. And when they speak with a service member, there is no documentation. In the past, operators were afraid to come forward in the fear that it would hurt their security clearance, whatever. And spouses were afraid as well because the spouse didn't want to come and say, my husband is acting strange, we're having these issues with our kids. So in 2008 in the opening months they started with, I'm going to give you the numbers that they projected in 2008 and in the different places and then numbers where we are today. Camp Lejeune, they projected 56 and we're currently seeing about 36 a month. In SOCOM, they projected 20 visits, you know, interactions, and they're currently at 132. Joint Base Lewis-McChord, 46 was projected, they're at 112. San Diego, 137, 121. Drag is probably the biggest. And they projected they'd see about 21 encounters a month, and our current numbers

are 268. So you can see that the MFLCs are having a huge impact. And the good thing is that they all do have clearances, so when the folks talk to them, obviously they're not discussing things that they shouldn't, but they do discuss, you know when I was here, this happened and now I'm back. And reasons for consultation, 20 percent -- 27 percent are for deployment or reintegration issues; family dynamics is 28 percent; stress, work stress is 18 percent; and communication is 13 percent. And the component usage Special Forces is at 27 percent; the Seals are at 18; MARSOC is at 14; the Rangers are at 11 percent; and AFSOC is at 9 percent.

We have -- Denise Grant is currently stationed in our office, and she was just absolutely amazing.

MR. REHBEIN: The dates on many of those folks looks to me that there's a huge amount of turnover.

LT. COLONEL DEARY: There is. It's currently they -- the current plan is every six months the MFLCs turn over. What they have proposed is that you have two people that kind of rotate in one area, meaning you'll have someone, let's say Denise will come in, and she will spend six months with you and you'll have like two sites. And she'll come in, build the relationships, of course when she leaves -- our Denise doesn't move, I just don't know all the other names -- and then she will be followed by, for example, Jim, and Jim will come in. And then when Jim is done, it's Denise's turn. So you are able to build that long-term relationship. This is something that I know that's in the works. It's currently not the way it is. They do rotate. The folks that we have right now, according to Denise yesterday, are not scheduled to rotate any time soon. They're all there for about the next six months.

MS. CROCKETT-JONES: What was initial reasoning for setting up six month blocks?

LT. COLONEL DEARY: I don't know. But I can find that out for you and have you an answer.

MR. CONSTANTINE: Are the people happy about that, the people doing the work?

LT. COLONEL DEARY: No. They're not happy that they rotate, which is why they're proposing to not rotate them. And I'm not sure of who they fall under. It's someone that supports us. They have their own bosses who have said, you know, this is the way it needs to happen. But again, you know, at Ft. Bragg, when you're seeing 268 people, they don't want to, you know, go through the whole thing every time someone changes. And again, if you -- if they can get it to where you have the same two people, you can still -- like if Denise is there for six months, when sheep rotates out, she'll still maintain the relationship. Which, you know, Denise has been other places, and she still keeps in contact with some of her folks. And then they rely on her. And if you have just two, you can flip back and forth and hopefully build a relationship. Yes, ma'am?

DR. GUICE: When you say they rotate, where are they rotating to or from?

LT. COLONEL DEARY: It's generally around their regions.

DR. GUICE: So Denise would go to --

LT. COLONEL DEARY: Right, yes.

DR. GUICE: Denise would go to where Ed is, Ed would go to where Barry is, Barry would go to where Cody is.

LT. COLONEL DEARY: Yes, and it does not make sense.

DR. GUICE: No. It does not make sense.

LT. COLONEL DEARY: No, ma'am it does not. We agree 100 percent.

MASTER SERGEANT MACKENZIE: Once again, the MFLC program was actually, if I remember correctly, was actually DoD or Joint Chief Directed program. What we did was simply take, try to get a couple of permanent people, that's where Denise Grant falls in. But we provide that security clearance, that qualification allows these guys to work with our

guys that operate an entire secure environment. For instance, Canon Air Force Base have a MFLC assigned through the Air Force, but nobody would ever talk to that person because they had no security clearance, they had no briefing, they had no knowledge whatsoever of what Air Force Special Operations was, and it was an underutilized person. So with that we tasked a person with a security clearance, the brief and all the read in, went out to Canon Air Force Base, he had two MFLCs on his Air Force Base, but the only one that was working was ours because that person was cleared, that person had the training and the understanding of what was going on. We're not trying to supersede the service abilities. What we're doing is identifying this unique need within our particular service, our particular operation, to get that done. But who manages a program? That's why we still got to get back to you because I'm not familiar with who manages that DoD wise, and that's leverages against us, which is what causes some of these rotations.

LT. COLONEL DEARY: I have Denise's brief and it still doesn't answer the questions. In 2008, SOCOM requested the MFLC program. And because they do have the security clearance they can provide a broader range of services. I mean, it just talks about, you know, how we utilized folks. It does not, unfortunately, address the rotation. One thing it does address, though, is that it is form -- and this is for security folks that have a TS SCI security clearance. SI 86, which is our security clearance form, question 21 excludes MFLC services. And I think that this is very, very important for the operators that use this service because you are directed to answer no if your counseling was not court ordered. For example, if, you know, you come home and you and your wife are having -- or husband, because I have deployed three times, and when I came home -- when you redeploy, if you seek counseling related to a post-deployment issue that is not court ordered, then you do not have to report it. You write "no" so that, you know, it doesn't look like you've been counseled. Now, of course the MFLC has a duty to warn if someone is, you know, homicidal ideation, suicidal ideation, or sort of spousal or

child abuse, they're going to warn. But that question, you don't have to answer it. It's not that you don't answer truthfully, you just don't have to answer it.

MS. DAILEY: I think it sounds like it comes out of military community and family policy at the OSD level, and that's what -- yes, so.

LT. COLONEL DEARY: Still, I'll get you the answer on why they rotate. I've heard it but I don't know. Here are statistics. And actually, these, I apologize, were a month ago. This morning our statistics were 4,158, now plus seven. 2883 return to duty. You can see them.

Here are some of our initiatives. Rapidly raising level of fitness post hospitalization. Exercise smarter, not harder. And with that we have folks who are going to return to duty who we help them by sending them to the athletes performance institute in Florida, and they are able to get back to their optimal level of mental, as well as physical fitness prior to going back into the fight.

Pain management. Pain management is a big issue with everybody. The Care Coalition, you know, we're working to do what we can with it. We don't necessarily have a lot of say in the fight but we are educated on the issues that folks will go through. And so we try to leverage programs, et cetera to insure that if this isn't an issue that's identified, that we work to get the person where they need to be to get back to their norm.

Our casualty tracker. This is a super net based singular point of casualty input information. And we have personalized webpages that feeds all into a central database. It is secure. Like I said earlier, we have different views for different command sections based on your need to know. If you're a medical provider, obviously you get pretty much the whole thing because you're going to need to know so you can follow them. If you're the chaplain, you don't need all that information. We track and support all wounded, ill, or injured, local, regional and national. And one thing that we started approximately a month ago is we developed a checklist.

And what we found at certain points was there was some duplication of efforts between the units and between our advocates in the Care Coalition. You know, two people were trying to do TSGLI at the same time. And so our checklist is in there. And as you go in and do some sort of action with the SM, the soldier, when you close it, when you've completed it, it will have a date time stamped. So, for example if Ranger Battalion has a guy and they go ahead and put him in for his TSGLI because they're right there at Benning. We don't have to do it because we know it's done. So we're not doing the duplication of efforts, and it's a great thing for us. It's fairly new so we're not sure, you know.

MASTER SERGEANT MACKENZIE: We're still fine tuning. One of the things is to clarify in that casual tracker which is not out there and something I wanted to clarify. If you're the Chief Sergeant for the Ranger Regiment, you can see all Rangers. You can't get on there and look at Seals, you can't get on there and look at AFSOC guys. He can see all the Rangers. First Battalion Surgeon can only see First Battalion guys, and so on and so forth. It's literally broken down by what your area of responsibility is. So that's how we insure that privacy of data and all those kind of things. And then within that, based on your position is where it's broken up even further. But these guys log in and they see a full page. You're The Chief Medical Officer For Marine Special Operations Command, when he pulls up there, it's a Marine Battalion page. It's his input. How do you want this to be laid out? How do you want this to show? How do you want this to be briefed? So it's a collaboration between the unit and so forth to get the best possible information to the war fighting units and also, they have input authorization as well as we do. So they're seeing our inputs, we're seeing their inputs, we're continuing to go back and forth as this stuff is done.

LT. COLONEL DEARY: And our IT, our tracker IT guy works very, very closely with the different units on what they want, how they want their pages to look, what kind of information they may want compiled. And you know, we can -- they can export it to an excel

spreadsheet or whatever format they want. And so if the commander comes in and says, I want to know how many guys were injured and what their injury was, you can go in there and pull all that out.

We have been working very, very hard to get our tracker to be the main source of information for our wounded, ill, and injured in Special Operations, and we have been very, very fortunate that we have some very good relationships with the command. And we have currently added several units that have their own trackers but they are doing away with their tracker to use ours solely as the main point of information.

GENERAL GREEN: Are you getting a data feed or is it all done by your people?

LT. COLONEL DEARY: Oh, no. It's other folks. People don't have access to put it in. For example, before we had our folks downrange, the CJ service, once someone was injured, they'd go in and they'd enter the data.

MASTER SERGEANT MACKENZIE: It is still all hand gen, sir.

LT. COLONEL DEARY: Oh, yes. Sorry.

MASTER SERGEANT MACKENZIE: So we get these reports and then have to hand gen the data in. It's not directly connected to these other resources, mostly because these other resources are either incredibly on a different secure network or don't have the authorization to interface with the informations in our tracker.

LT. COLONEL DEARY: Again, this is a full-time job. This is the only thing that we do. Our folks focus 100 percent of their efforts on insuring the wounded, ill, and injured in Special Operations are taken care of. It's not what you know, it's who you know. I mean, we have built so many relationships with the VA, with, you know, all the other organizations that I think that's one of the reasons we're so successful. Plus, having the folks in our office, the VA, the FRC and AWT guys, we can just turn to them and say hey, can you help

me with this? We're having to fight this battle, what do you know about this? And they work it with us side by side. And again, the majority of the folks that work with us have a very strong connection to the Special Operations community. So when they speak to the command, the command understands that we know what we're talking about.

Pain management. Everyone needs to develop strategies. I mean, it is what it is. We realize that it's a big problem and we work to, if it's identified, to try to get the person the help that they need.

Information. We use our tracker for information. Preserve our human capital. Insure to take care of our most important asset, and that is the special operator and their family. Legislation to policy. Our prior Director, Mr. Lorraine was extremely active up on the Hill, and I know that he was instrumental in several, several policies. So as we identify things, hopefully our new director will be coming forward and, you know, working to continue to sustain everything that Mr. Lorraine put in place.

Some of our challenges, again just greater awareness of the Care Coalition. My husband is in a Special Operations Unit at Ft. Bragg, and he just finished his tenth deployment, he's getting ready to go on his eleventh. And I go to most of the briefings. I've only been in this job for four months, so prior to coming to this, I knew what the Care Coalition was but I didn't know what the Care Coalition was. And I went to almost every pre and right before they come back briefing, no one ever discusses the Care Coalition. Ever. And so we recently had a video done. It's about 4, 5 minutes? Our video? You know.

MASTER SERGEANT MACKENZIE: It's actually almost 10 minutes.

LT. COLONEL DEARY: Is it?

MASTER SERGEANT MACKENZIE: Yes.

LT. COLONEL DEARY: It didn't seem that long. I just watched it.

Anyway, we have a video. What we have done, we have given this to almost every single person

we meet. I handed out probably 30 yesterday. I briefed the Special Operations command general officers wives yesterday, and I handed them out and they kept asking for more because a lot of folks just don't know about the Care Coalition and what we offer. It's trying to get that information down on the lowest level. The command may know us, but the people don't even think about us until they meet us, and sometimes we get in a little bit later than we would like because there are already things in place that, you know, we can't fix.

Partnering with the units to support casualties and families. The soft casualties and families, understanding what opportunities and support is available to them and who's able to adequately provide those. One thing I do want to say, it's on the next slide, is there's probably just a handful of our folks that are enrolled in a -- or assign to a WTU. All of our folks, we -- well, not we -- their unit, they're assigned to their unit. They are attached to a WTU for medical purposes only. But keeping them with their unit. And it's through an MOA that was developed with USASOC, we help with one of the issues when the folks are going to go back to duty, and that's reintegration. They feel like they are still a part of the unit, and for us, it's proven extremely beneficial.

DR. GUICE: How do you actually make that operational? So you say that they're attached to a WTU for medical. So tell me how that works in reality. Because we've seen the WTUs, we've seen CBW2s, but can you explain by what you mean by that?

LT. COLONEL DEARY: Mac, help me out with this. But they, they don't fall under command or control of the WTU, so they're not -- they don't have to do all the formations, et cetera, et cetera. Their medical needs, like if they have to go through a PEB -- go ahead.

MASTER SERGEANT MACKENZIE: Let me back it up just a little bit. One of the things that happened as all this stuff began to transition, especially with the WTU came around, the WTU construct started to absorb some of the resources within the hospital.

Case management, PCM. Those kinds of functions, MEDCOM, Army MEDCOM, and USASOC sat down and said how do we partake in some of this stuff. Also, some of the resources and benefits that were forwarded to the Army personnel were then put under the WTU. And immediately you had to be assigned to a WTU to have access to these resources. SOCOM has always maintained commanding control of their personnel. So what happened was, and it's all drafted out. I mean, it is a matter of public record. But the memorandum of agreement is that the WTU will provide access to these resources, those case management, medical management. The functions of the WTU that the Army soldiers need to have access to, but yet the commanding control of the individual is still maintained by the unit.

DR. GUICE: Okay. So let's say down at Ft. Campbell, let's just say there was a Special Operations guy in that WTU. Where would we have found them if we'd look for them?

MASTER SERGEANT MACKENZIE: You would not have found them in the WTU.

DR. GUICE: With his unit?

MASTER SERGEANT MACKENZIE: Yes, that is correct.

LT. COLONEL DEARY: With the exception of the reserve folks, who under Title 10, big Army is going to pay for it. So the reserve special operators are assigned to a WTU.

MS. DAILEY: But his nurse case manager would have been in the WTU?

MASTER SERGEANT MACKENZIE: Yes, that is correct. And that contact between the cadre and that soldier would have still been maintained.

MS. DAILEY: If he wanted the SVAC, he could use the resources at the SVAC?

MASTER SEAGEANT MACKENZIE: Absolutely. That kind of stuff. So it opens that door to allow that while yet still the unit still maintains commanding control. That's something that USASOC and most importantly MEDCOM came up with, to balance that agreement. Prior to the WTU construct, they didn't touch metal or anything at all..

LT. COLONEL DEARY: And also, the folks that are still assigned to their unit can be utilized in whatever capacity they're able to function. So they're not assigned to the WTU where they, you know, recover. They're recovering, but they're assigned to a unit so if someone needs you to assist as a pack clerk because your unit is getting ready to deploy, if you are physically and mentally able to do that, then you are still gainfully employed and doing what you do, supporting your unit, and you still feel like you are a part of the fight, and then you still get the care that you need.

MASTER SERGEANT MACKENZIE: However, the attachment to the WTU still maintains the integrity of those appointments and the medical focus. So therefore, the command can't override that stuff to try to get a mission done.

LT. COLONEL DEARY: They don't. I mean, it's a very, very mutual beneficially MRA at this point. Some of our hot issues are the software foundation 2K check. Just education -- I don't know why it's a hot issue. I guess it was. It's no longer. I mean, we pretty much have it. TSGLI. There are occasionally issues that come up with TSGLI, and that's like the lady over there spoke about family issues. Sometimes that does create a problem. And we hope that our liaisons or advocates or whoever are working that piece are cognizant of some of these things. I mean, we've had in the past where folks have been awarded their 100,000 and then their significant other, be it whoever, takes it all. That's not really that hot of an issue, because it's few and far between that it happens. And hopefully, if the units give us a heads up that there's some, you know a bit of a contentious background, then we're aware of that. And then we work to, you know, we will say hey, let's not submit your TSGLI right this minute. Let's

get you a little bit better and then, you know, we'll submit it at this point because you're eligible for it. Let's just do it here.

Again, PAC entitlements. I guess there are service specific issues, which Mac can speak to. But for a little in March there was a little bit of a bumpy period because the -- what's it called? The statement? The Hour Act expired and so the commands were like, well, they're not entitled to this. Well, actually, they are entitled to it. So we got the DFAS. DFSA said, although the new policy has not been written, it is going to be the same. So there were commands that were trying to say, you know, you can't pay this person this pay anymore. And we just got with DFAS and had a new policy written or an interim policy written, and it continued on. And then continuation on active duty and reserves. We work very well with, we have our AW2 rep that assists us with us with the big Army piece.

MASTER SERGEANT MACKENZIE: One of the biggest things about those is the knowledge. The knowledge base. I mean, you see that, we've all been looking at a lot of these programs, and you see the number of personnel with the amount of work that has to be done, it doesn't make sense. The reality of it, too, it is the basic fundamentals of the job is done and each individual has their expertise. You know, until we hired the second AFSOC guy, I was that AFSOC liaison, as well as being liaison to the joint service that I was working with. Same thing goes with our advocates. TSGLI experts that are keeping track, they've got those contacts. As soon as that new package comes out, everyone in our community has got the new copy. Hey, this is the new sheet, this is the new information. The person that's working the PAC pay. Department of Army has given us the authority -- they've respected the relationship that they take the final guidance of anybody authorized for PAC out of our office. However, now the Air Force and the Navy, they work a little bit differently. So then your unit is building relationships instead of being responsible for it. So each one of those persons has, they delve into these areas specifically. It's like it's their additional duty, to look at that kind of stuff, giving

us that reach back ability to say who knows what's going on. So that's where a lot of that stuff comes in.

LT. COLONEL KEANE: Ma'am, I have a few questions.

LT. COLONEL DEARY: Yes.

LT. COLONEL KEANE: How many Marines are part of the 143 injured?

LT. COLONEL DEARY: If I had my tracker I could tell you. I could tell you -- I could tell you.

LT. COLONEL KEANE: An estimate?

LT. COLONEL DEARY: -- injury, et cetera. Currently? You know what, I'll tell you afterwards because I have it on my BlackBerry. They sent me the update before I came in here. I can't remember.

LT. COLONEL KEANE: This committee covers, represents wounded, ill, and injured?

LT. COLONEL DEARY: Yes.

LT. COLONEL KEANE: And we found from the other services around 30 percent are from combat. Do you have an estimate of what combat injuries are from your committee? Is it higher than 30?

LT. COLONEL DEARY: Combat zone injuries?

LT. COLONEL KEANE: From combat.

LT. COLONEL DEARY: Well, within the last 12 months, 67 percent of what we track. Battle injuries in the last 12, which are not necessarily combat is 37 percent; non-battle is 27 percent; combat zone disease is about 3 percent. We have, let's see. Our cumulative population of 4,152-ish, 84 percent are combat zone injuries; 16 percent are CONUS ill or injured; 18 percent are severely wounded, ill, or injured; 2 percent, which that seems low, are amputees; 2 percent are spinal cord injuries.

LT. COLONEL KEANE: That's good. You've answered. That's great. Just a couple more questions. I think on one of your slides you mentioned that you do contact for life. What's the contact plan, where the member goes back to active duty or medically retires, how often do you contact them?

LT. COLONEL DEARY: Well, it's going to depend on what they need. For example, we have quarterly, every six months, yearly. If someone -- I mean, we have tried to make contact -- for example, my husband was injured in 2005, and they try once a year to contact him. And he looks at me and he says, why are they calling me? I don't need anything. So we do it annually. We will make contact, say we're here for you, if you have any issues, please let us know. On the folks that have returned to duty and didn't have very significant injuries, it's going to be annually. And if they at some point, like when my husband gets ready to retire in six years or so, he may have some issues and it may become more frequent as needed.

LT. COLONEL KEANE: The biggest question I have, and Mac I want you to stay in your seat because you and I have discussed this. I don't know why we need your command. Why can't the Marine Corps cover down on their injured? Why can't the Army cover down on their injured? You've talked about Stressed Secret having to have a clearance. All services have a clearance. I think the medical care probably would not need to be secret?

LT. COLONEL DEARY: All I can say is that when the commanders of Special Operations Command say this is what they want for their services, we're going to do it. We're going to do everything we can to support them. We are one conduit for all Special Operations you know, families and service members. And you know, if everyone's peacemealing it, you don't have the big picture, whereas our office maintains the big picture. If they want to know how many Marines -- I mean, we work hand in hand with you guys. We work extremely well with the Marines. We have a very good relationship with the Marines.

We're developing a very good relationship with the Navy. And that's -- you know, the Marines do a great job, and we do a great job as well.

LT. COLONEL KEANE: I guess the last thing I'll say, I've just come from the J5 and one of the last tasks I had to do was get together a Tiger Team of five action officers that had to go join the Joint Staff Secretary Gates, and I'm going to say the wrong thing. One of the military members a going to help me. But it's not redundancies, but it was something like that. Where can we save money? And it was -- what was the actual term. Does anybody know?

MS. DAILEY: Efficiencies Task Force.

LT. COLONEL KEANE: Yes. The Efficiencies Task Force. So we had to provide five people for this and it's still ongoing. Just, I guess, a comment. I don't know if there's anything else to add to that, but just in some aspects they're saying why can't the Marine Corps handle our Marines? I don't know, I can't speak for the Army or the Navy or --

LT. COLONEL DEARY: I don't know how -- I don't know the Marines, I don't know how they're made up. But the Care Coalition's sole purpose is to support wounded and injured special operators, whereas I'm sure that the Marines have another mission as well. I mean, you may have the -- I don't know because I can't speak to the Marines. But we exist to take care of you all. And if you're doing it, whoever would be in your lane, maybe they're detracting from their other missions. I'm not really sure.

LT. COLONEL KEANE: I'm coming from the Wounded Warrior Regiment, so, I mean, that's our mission.

LT. COLONEL DEARY: That is your mission, and you guys do a very, very good job.

GENERAL GREEN: Let me ask. So on the advocacy role, do you do it for all three categories that you outlined earlier?

LT. COLONEL DEARY: Yes, sir.

GENERAL GREEN: So basically even your ill and injured, not in support of GWAD, are going to get advocacy forever?

LT. COLONEL DEARY: According to our 2009 charter.

GENERAL GREEN: Interesting.

MR. REHBEIN I'm going to pick up for a minute on one of General Green's opening comments about this being a different model for service. And maybe Mac's a better person to answer this question or maybe it's a totally unfair question. I don't know. Do you see limits on how far this model could expand? This is a very personal, hands on type model. If we were -- if you were bringing home a dozen through Landstuhl every day, do you -- would the -- do you see limits on -- when would it get too big?

LT. COLONEL DEARY: Well, currently we're constrained by Manning. We grow every day. We don't provide direct patient care. We provide non-medical management, case management. And as our needs grow, as our populations grows, if our units can support us with Manning, which we're currently right now trying to get more Manning. We need more Manning in the liaison area.

MR. REHBEIN: What I'm -- the line I'm thing along is, somebody looks at what you do and says, you do it really well. Let's do it for everybody. Is that possible?

LT. COLONEL DEARY: Go ahead, Mac.

MASTER SERGEANT MACKENZIE: The answer to that is no. It is not scale because it is such a personal touch. It can only go so far. You've got to figure we're only deal with 4,000, 4100 total people tracked. Since just this small group. And it can reach a level that gets too big. Because it is personal, it's personal communication. You could imagine right now I communicate with 19 other liaisons. It'd be impossible for me to communicate with 150 liaisons. So in the environment, in the small percentage of the military that we operate in, this works very, very well. It is a model that can be used in other small populations. For instance,

let's just say a state for National Guard. But to look at it in a global scale, I don't think it can get that, I don't think it can get to that size and maintain the personal one-on-one touch that we have with our guys.

LT. COLONEL DEARY: I agree.

MR. REHBEIN: That seemed to me to be to the case from looking outside, but I wanted to get your perspective from inside the system as to whether or not that was possible.

COMMAND SERGEANT MAJOR DEJONG: Do you know what your approximate operating budget is annually?

LT. COLONEL DEARY: I don't. I'm sorry. I thought someone might asked that. And I answered, asked the question, by BlackBerry didn't get it. I've only been there four months. My four months I have spent trying to meet every single person that works with me that I can. So I have been --

COMMAND SERGEANT MAJOR DEJONG: Sure. I understand. I was going right along with what Mr. Rehbein was going down, with a lot of questions.

MR. REHBEIN: You can go down any line you want.

COMMAND SERGEANT MAJOR DEJONG: And there was one I came up with because, especially on the National Guard Bureau side, it is a good model and it is working. But in order to present that at the state level, somebody is going to ask me, what is this going to cost? And I'll keep hitting up Mac on it until I get an answer.

LT. COLONEL DEARY: Well, again, some of you have had some questions, I can get the answers for you.

COMMAND SERGEANT MAJOR DEJONG: Thank you.

MR. CONSTANTINE: I think there's also some intangibles there, the fact that it's Special Operating Forces, there's elite units. Clearly the most valuable asset is that

operator where, for better or worse, we're more dedicated to them I think than the run of the mill soldier. We're really focused on them, we know how much he brings to the fight. The nation has invested so much money in them, everyone cares just a little bit more, I think. And that's why another reason I think it's...to that environment.

MS. DAILEY: Colonel Deary, on page 8 of your original briefing you have assessing effectiveness. You have an annual survey data collected via Survey Monkey. How do you -- can I get a copy of that or do you have presentations where you correlate it into, synthesize it into one quick bullet or five quick bullets?

LT. COLONEL DEARY: I have it with me.

MS. DAILEY: Okay.

LT. COLONEL DEARY: And unfortunately, it's the only survey that we have, it was conducted in April of 2010. We sent out 2500 questionnaires. We only had 430 answered, so I don't believe it's a good sampling of what we do. We are currently in the process of getting another one out there. Most of our, I would say our success stories, are based on word of mouth. And in our return to duty rate of 84 percent. I can get you the survey, just I don't think it's a good sampling.

MS. DAILEY: Yes, I mean we get lots of surveys that they don't believe in the data, but that -- comparison across the board, even if they don't believe in the results.

LT. COLONEL DEARY: Our data is good, it's just very small.

MS. DAILEY: Okay. Good, small, big, bad, it's all the same to us.

DR. PHILLIPS: Just really, one quick question. I'm just wondering, do you have any handle on why your return to duty rate is 84 percent and the rest of the forces is 10 percent? I mean aside from motivation and --

LT. COLONEL DEARY: I mean, sir, I believe that that is part of it. These folks that are injured are generally physically and mentally fit when they get to where they are in

the Special Operations environment. And they have a very strong will and desire to get back to what they've been trained to do. I mean, we don't have any true data. But if you go out and talk to them, I mean, in January I had just gotten here, I went and met a guy at Walter Reed that's a triple amputee and all he's talking about and when can I get my legs so that I can do my job. And I was like, wow.

DR. PHILLIPS: I understand that. I was just wondering if there was some identifiable characters or the personal touch, something you talked about that might help get to that extra level?

LT. COLONEL DEARY: We are very, very involved in their life and their recovery from, if we can, the point of injury through whatever point they get to, either return to duty or out in the military. We do have a personal touch, so if they have a question, all right. We are able to -- we use government and non-government organizations, which everyone could do. We just maybe have the resources and just the small amount of folks that we support to reach out. You know, if someone needs to go to the API, the Athletics Performance Institute, we can arrange that because we know about it. We probably utilize programs out there that not everyone is aware of. And so if someone is injured and they have -- for example, we have a gentleman in our tracker that was recently injured, and he's now blind. We are aware of the institutes out there that can focus him getting the best rehab. And that's because we work so closely together.

DR. PHILLIPS: It just might be interesting --

GENERAL GREEN: Steve, I just was going to say, remember you're talking about elite forces trained to work in small teams that in large part are hand selected. Okay. And so you're going to have a very high motivation to get back to that. They've actually, just from the standpoint of resiliency training, to survive some of the different training mechanisms they've gone through to get to where they are. They've got a different level there.

DR. PHILLIPS: I certainly understand that, but what I was driving at, someone needs to go to an appointment two hours away. The next day there's someone there to drive them, as opposed to some of the folks that we hear sitting in languishing, waiting. I'm just trying to say, are there some metrics that we could learn about? I know the motivation is there, I know I've been involved. But there has to be some other little things that really keep them going. My buddies are here, they'll take me, they'll sit with me, they'll support me.

LT. COLONEL DEARY: I got a briefing yesterday when I was at the General's Spouse Briefing, and it was from a wife of an injured guy who was injured in 2007, severe traumatic brain injury. And you know, he's still in a vegetative state. His unit, she's in Birmingham, Alabama now with her husband; his unit is at Ft. Benning. They drive over for all his birthdays, they take Rhyanne out. The wives, you know, they take -- they have people come in and help care for her husband so that she can go out. When you're in a unit like that, you form a bond like that, so yes. They have folks that will take the wife for wherever for an appointment and take the service member wherever. And rally around them long after they are, whatever they are.

DR. PHILLIPS: They are held in esteem as compared to perhaps some of the other places that we visited. There's a reason for them to want to get back.

MR. REHBEIN: The number that surprises me is not the return to duty percentage, it's there seems to be a low injured in training number. And I would have thought that the type of training that special operators go through, that that would have been a higher percentage.

LT. COLONEL DEARY: I don't know how many we have. We can see if I briefed on those that were -- because we do have training. Because our injured, when we say non-battle, it's also a car accident or, you know, a mugging or whatever. Mac, go ahead.

MASTER SERGEANT MACKENZIE: Once again, you're taking an individual who's probably sustained some of his training injuries early in his career. You're taking an individual now who's -- you're dealing with injuries within a WTU that's maybe this guy's third or fourth parachute jump. We're dealing with guys that they're on their second or third hundredth parachute jump as they're going through this training. So you've got to look at it that way. And on your comment, you're right. It's that personal level. You take a guy from 25th ID, there's probably not somebody from 25th ID that served with him that's sitting at the Pentagon. Yet I've got a combat controller with a, you know, a number of combat controllers only in the hundreds, every combat controller officer enlisted that's working at the Pentagon is now at the hospital. You see? That may only be four, or five. Percentage-wise the community is so small that as the word goes out there is that higher level of personal involvement than you're going to see in other areas. And so yes, a lot of it does have to do with personal involvement. A lot of it has to do with leadership, who says I am going to take care of you. You know, and that's -- that word is kept there because the individuals stay within the community. So that's very important there as well. That fosters a lot of those things.

LT. COLONEL DEARY: One other thing on assessing our effectiveness, we do weekly, monthly, quarterly, semiannually, and annually categories of contact rates. And as of 9 May, although we have over 4100 in our database that we are following, we have on 80 percent contact rate. And overall it's 88.6. The 80 percent is for advocacy. And it's 88.6 for CCRP liaisons and advocates. So we have a -- I mean, they're tenacious in their attempts to contact folks. And I mean, some folks call us every single day. They call us every single day.

GENERAL GREEN: And some of you guys don't like to be contacted.

LT. COLONEL DEARY: My husband hates it.

GENERAL GREEN: You missed my pun. But some of you guys are very hard to contact.

LT. COLONEL DEARY: Okay, yes, sir, I get it.

(Laughter.)

GENERAL GREEN: Okay. Thank you very much Colonel Deary. I'm sorry I keep doing that. Thank you very much. Nice briefing.

LT. COLONEL DEARY: Thank you.

MS. DAILEY: Let me let everyone -- we'll do a 5 minute break. We need to come back and our -- sir, you want to do some wrap, we can do that. However, our non-DoD members need to vote and we need to go through the process of selecting a new non-DoD co-chair. So let's take 5 minutes and come back.

MS. DAILEY: Ladies and gentlemen, we should reassemble. Ladies and gentlemen, as we discussed earlier in the week and as we discussed when we opened yesterday morning, we will need to vote, or the non-DoD members will need to vote for a new co-chair. This is going to be done by what is called a simplified Roberts. We will take nominations from the floor. Only the non-DoD members can nominate. Only non-DoD members can discuss and vote.

LT. COLONEL KEANE: I have a quick question. Why is that?

MS. DAILEY: DoD, the language of the legislation, the language in law stated that the non-DoD members will select among themselves the non-DoD co-chair. So it was the language of the legislation.

LT. COLONEL KEANE: Thank you.

MS. DAILEY: Nominations need to have a second. And any non-DoD candidates nominated and seconded will be eligible. Nominees will speak for themselves. And

the qualifications, willingness to serve. We will then close the floor. We have a written ballot for the vote. In Tab O --

DR. LEDERER: N.

MS. DAILEY: N is a nomination form. What we will ask you to do is where your vote will be recorded, and by circling the person they are voting for, we won't do this by voice vote. I need a record of the vote. And we will collect the votes. Non-DoD co-chair is the individual with the most votes for their name. And then when we've done that real quick math, we will announce the new non-DoD-co-chair. Questions, ladies and gentlemen?

MASTER SERGEANT MACKENZIE: Are us DoD supposed to be in the room for this are can we get up and go?

MS. DAILEY: Yes. You're fine. I would like to open the floor for nominations, please.

DR. GUICE: Before we start with the nominations, first of all I'd like to tell you all how sad I am to be leaving. This is such an important work that you all are doing and I'll miss you all greatly. I truly believe in the mission and the hopefully the recommendations that are going to come out of this effort in order to make things better for our recovering service members. And I appreciate all of your services. And if there's anything you need me to be doing for you in my next job iteration, please let me know. With that said, I would like to nominate Suzette Crockett-Jones to be the new non-DoD co-chair.

MR. DRACH: I'd like to second that motion.

DR. TURNER: I nominate Steve Phillips.

MR. REHBEIN: I'd second that.

DR. GUICE: Are there any other nominations?

MR. CONSTANTINE: I want to nominate Dave Rehbein.

DR. GUICE: Do we have a second?

MR. REHBEIN: Before that, before anyone seconds that, and I know we will all have a chance to speak, but at this point, my life simply does not allow me the time that I believe it would take to do that job the way it ought to be done. So I appreciate the compliment --

MR. CONSTANTINE: Forget it --

MR. REHBEIN: Thank you.

DR. GUICE: Any additional nominations? All right. Suzanne, do you want to talk to your qualifications first?

MS. CROCKETT-JONES: Well, I feel fully competent to do this job, but I think more importantly I have a dynamic interest in this commission's work. It is personal for me, but in a larger sense there is a group of people to whom I feel very responsible, and that is the other family members and spouses and all of my husband's soldiers. When he became an officer -- actually, before then. The first time he started taking care of soldiers, it was clear because of the way he chooses to be a leader in the military, that this is not something that doesn't encompass me. There was no way for this to not be a joint effort. So from the minute he was a squad leader, when he was a -- you know, right after he was a private and went to Ranger school and became a leader of other soldiers, he never did it in a way that didn't include the whole family. They just become extended parts of our family. And so I feel a serious obligation to those folks and to their families and to the people that we've known all along. And I am an educated and qualified person, and I feel that I have the time because I have luckily reached a point in my life where my main job, which was being a stay at home mom, as ebbed a good bit. My children are old enough they don't need me as much, and so I have time to dedicate to it, and the motivation, and I have a reasonable skill set having had a history of during this whole time I've been a person who volunteers, who has been driven to give back to my community

everywhere we've landed. And this is where we landed in 2004 was in the community of recovering warriors. And so this is a serious and compelling obligation I feel.

DR. GUICE: Thank you. Steve?

DR. PHILLIPS: Thank you. This is part of my full-time activity. It's part of my day job. I'm passionate, like the rest of you, in making sure this goes forward in a very professional and formal way. And I'm happy to do this, but I'm absolutely delighted to support Suzanne, because she's been there and done that. So I'm fine with that. I was just jumping in because of being local and being involved, so. But Suzanne -- and Karen, your leaving leaves us a huge gap in knowledge and ability, but also puts the burden of co-chair on probably Suzanne, so thank you.

DR. GUICE: Thanks. I think if there aren't any questions of the nominees then I think we are ready to vote.

GENERAL GREEN: While you're in the process of voting, I thought I'd just say a couple of things. Karen has been a wonderful partner. Okay. I gave her a coin earlier and told her she had earned it multiple times over. I am going to miss you dearly. Okay? Thank you for all your efforts trying to bring this together. And you truly have done a great job here on the commission. Thank you.

MR. CONSTANTINE: Do the rest of us have to wait five years for our coins.

(Laughter.)

MR. DRACH: If I could I'd like to just add something, I've known Dr. Guice now I guess for a year and a half, maybe a little bit longer than that. I met her -- when I first met her, I went over to talk to her about what was going on with the FRCs, because as I mentioned yesterday, I had been involved in it from the outset and wanted to see how we could work closer together. And I got to know Dr. Guice a little bit and then got to work with her more

on the National Resource Directory when I served on the governance board with her -- and I just lost her name -- Susan Roberts from DoD. And it's been a real, real pleasure, Dr. Guice, working with you on the VA on this Task Force, and I hope to maintain a friendship and relationship with you in your new job. Thank you very much for all you've done.

LT. COLONEL KEANE: Ma'am, I'm not sure if I'll get a chance to mention this, but whenever you come down to say hello, you take the time to say hello to my little office. When you walk away, everybody else in my cubicle says, what's going on with you and her? She likes to talk to you all the time. I appreciate you coming by to say hello and check on me.

DR. GUICE: I've just got to make sure you're working. Colonel Mayer asking me to check on you.

MS. DAILEY: Ladies and gentlemen, Ms. Crockett-Jones has been selected as the new non-DoD co-chair. Congratulations, ma'am.

(Applause.)

GENERAL GREEN: So that's it.

MS. DAILEY: Yes.

GENERAL GREEN: Okay. Well it's been a busy two days and until the next time we meet there's a lot of work that's going to be going on as we all kind of formulate now with the data that we've brought together, what's going to go into our first report. So take a little time, think this through. I think that the hardest piece in my mind is going to be not that we don't have kind of a common understanding at this point but finding words that we all understand the same way. So the language is going to be difficult, and we need to think it through and make sure that we get where we want to go. Again, Karen, you've been a wonderful partner and I don't think we would have gotten as far as we have without you. So we're going to miss you. And she's going to be in an office just below me, she's now one of my bosses. But I've told her that

when the office drives her completely crazy, to come up and say hello. And with that, do you have any final words.

DR. GUICE: I don't. Godspeed, everybody.

GENERAL GREEN: Thanks, everybody. Safe travels.
(Whereupon the meeting adjourned this day at 5:20 p.m.)